The Repulic of Uganda

MINISTRY OF EDUCATION AND SPORTS

THE NATIONAL EDUCATION AND TRAINING FOR HEALTH POLICY

2025

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THE IMPLEMENTATION STANDARDS FOR THE NATIONAL EDUCATION AND TRAINING FOR HEALTH POLICY, 2026

FOREWORD

The Government of Uganda under the 1995 Constitution and the National Vision 2040, recognizes the importance of human capacity development for social economic transformation. Accordingly, the country envisions the need for highly specialized health care services that would make Uganda a regional hub for quality health care.This requires that Uganda doubles its current efforts in identification, educating, training, recruitment and retaining a robust workforce that is responsive to the needs of its population.

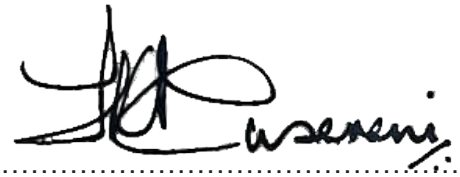
To this end, training and developing a competent workforce for the health sector as a core function of the Ministry of Education and Sports needs to be strengthened in collaboration with Ministry of Health and other key stakeholders to achieve the desired vision. To broader serve this purpose; this policy has been developed in order to provide a general direction of training and development of health professional trainees right from their admission up to the qualification, and license to practice.

This policy envisions a vibrant and transformative Education and Training for Health. The mission for this policy is to transform the Uganda health workforce by providing; quality, sustainable and equitable health education and training which is responsive to the requirements of the labour market. This policy has been designed to achieve the following objectives: to attain adequate quality and quantity of health trainees, increase enrolment of specialized health trainees, increase the quantity and quality of professional health trainers, improve the quality of health training facilities, strengthen internship, clinical rotation and practice; and to implement continuous capacity development in health sector.

The implementation of this policy, will strengthen the health systems with adequate competent, responsive, motivated and productive health workforce that is equitably distributed. This will help the country to stride towards the achievement of the Universal Health Coverage and the Sustainable Development Goals, as well as the African Union Agenda 2063 Goal 2 which focuses on well-educated citizens and skill revolution underpinned by Science, Technology and Innovation.

I would like to thank all stakeholders who supported the development of the National Education and Training for Health Policy. I call upon all Ugandans to support the implementation of the policy, so that education and training for health optimally contributes to Uganda's human capital development and socio-economic transformation.

For God and my Country.



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Janet K. Museveni
FIRST LADY AND HON. MINISTER OF EDUCATION AND SPORTS

LIST OF ACRONYMS

AIDS	Acquired Immuno-deficiency Syndrome
ASSA	Admissions Scholarship and Student Affairs
AU	African Union
BTVET	Business, Technical, Vocational, Education and Training CAP Chapter
CSOs	Civil Society Organizations
DIT	Directorate of Industrial Training
EAC	East African Community
EOC	Equal Opportunities Commission
ETH	Education and Training for Health
FM	Frequency Modulation
FY	Financial Year
GDP	Gross Domestic Product
HET	Health Education and Training
HIV	Human Immunodeficiency Virus
ICT	Information, Communications Technology
KPIs	Key Performance Indicators
LGs	Local Governments
M&E	Monitoring and Evaluation
MDAs	Ministries, Departments and Agencies
NCHE	National Council for Higher Education
NDP III	National Development Plan III
NGOs	Non-Government Organizations
NITA (U)	National Information Technology Authority of Uganda NPA National Planning Authority
NRF	National Research Foundation
PDM	Parish Development Model

PPE	Personal Protective Equipment
PPPs	Public Private Partnerships
PSFU	Private Sector Foundation of -Uganda
UHC	Universal Health Coverage

GLOSSARY OF KEY TERMS

Complimentary Medicine. Complementary medicine refers to additional healthcare practices that are not part of a country's mainstream medicine. Evidence-based complementary medicine has the potential to support mainstream medicine and more comprehensively support people's health and well-being needs.

Clinical Consultants. These are professionals who analyse the processes of Healthcare facilities or individual to determine proper use of resources and to streamline general practices or deduce the optimal course of action.

Clinical Instructors. This is a registered health professional before undertaking tutorship training working in a health educational institution for the purpose of teaching and supervising the acquisition of clinical skills.

Clinical Placement /Clinical Rotation. This is a practice of attaching trainees in the health profession for practical skills acquisition in the world of work depending on the specialization requirement.

Clinical Rotation/practicum. This is a practice of attaching health professional trainees for practical skills acquisition in the world of work.

Education. This is the process of developing, transmitting and acquiring behaviours, skills, knowledge, attitudes and values in an environment guided by a curriculum.

Field work. This is a practice of attaching trainees in the health profession for practical skills acquisition in community/or any other area that provides learning opportunities as part of the world of work depending on the specialization requirement.

Health. Is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Health Tutors This refers to a health professional, who has completed health tutorship training at bachelor's level, advanced diploma or post- graduate diploma at a recognised institution fully registered by a health professional council.

Herbal medicines. Herbal medicines include herbs, herbal materials, herbal preparations and finished herbal products, that contain as active ingredients parts of plants, other plant materials, or combinations thereof.

Indigenous Knowledge. Traditional knowledge and practices existing within and developed context around specific conditions of communities that are unique to a particular location.

Integrative medicine. Integrative medicine is an interdisciplinary and evidence-based approach to health and well-being by using a combination of biomedical and traditional and/or complementary medical knowledge, skills and practices.

Internship. This is a supervised hands-on training for the prospective health professionals usually for a period not less than one year following their completion of the bachelor's degree in health training.

Medical Interns These are Health Professional trainees from a recognized university after their final year of training with provisional professional licensure but before Graduation undergoing supervised practical training at an accredited training centre. They include; Medical Doctors, Dental surgeons, Pharmacists, Graduate nurses, among others.

Preceptors. This is a qualified health practitioner who in addition to his/her daily patient-care duties takes on clinical teaching responsibilities for purposes of developing a health professional.

Profession. This is a paid or volunteer occupation, conducted under prolonged training leading to a formal qualification and the application of training to practice.

Traditional medicine. Traditional medicine refers to codified or non-codified systems for healthcare and well-being, comprising practices, skills, knowledge and philosophies originating in different historical and cultural contexts, which are distinct from and pre-date biomedicine, evolving with science for current use from an experience-based origin. Traditional medicine emphasizes nature-based remedies and holistic, personalized approaches to restore balance of mind, body and environment.

1.0 INTRODUCTION

1. Health systems are highly labour intensive, and health workers play a key role in performing or mediating most of the health system functions. Thus, an effective health care delivery system depends on having both the right number and the appropriate mix of health workers, and on ensuring that they have the required means and motivation to perform their assigned functions well.1 Efforts to scale-up health services to achieve Universal Health Coverage (UHC) and health development goals are confronted by acute shortages and inequitable distribution of skilled health workers that present a binding constraint to the delivery of essential health services in many low- and middle-income countries.[2]

2. Education and training can play a significant role in determining health care professionals' proficiency with the most recent interventions and technologies. Training programmes and policies also have important implications for labour market issues in the health care sector.

3. Education and Training for Health is defined as the process of developing, transmitting and acquiring behaviours, skills, knowledge, attitudes and values in an environment guided by a curriculum to support the provision of services which promote a state of complete physical, mental and social well-being of an individual.

4. Education and training for Health involves among others the: identification; admission; training; assessment; certification; internship; professionalization; continuous capacity development; upgrading; research; specialisation; and lifelong learning; as well as mentorship and coaching of the Health Workers.

5. Education and Health are core public services, critically interlinked with the basic needs of citizens. Since formal health and education services were introduced by the British colonial government in the late 1890s, the interconnection between the two sectors supported the progression of professional training in the various sectors of our economy including health services.

6. This policy provides government's direction to the overall training and development of Human Resource for Health in the country. It provides the overall policy objectives, the key strategies and the specific interventions to guide all stakeholders involved in the training and development of the health work force.

7. The policy development process was largely consultative and participatory involving key stakeholders from both the public and private sector. It is divided into three main parts.

(a) Part one focuses on the; introduction, background, problem statement, and the policy justification.

(b) Part two outlines the; policy direction, policy scope, relationship with other sector policies, policy objectives, key interventions and the cross-cutting issues and,

(c) Part three outlines the; policy implementation arrangements, coordination mechanisms, monitoring and evaluation framework, financing arrangements and the policy communication strategy.

2.0 BACKGROUND

8. The evolution of education and training for health in Uganda has undergone mainly three historical phases namely; Pre-colonial period (before 1894), the Pre-Independence colonial period (1894-1962) and the Post-indepence period (1962 - 2023).

2.1 The Pre- Colonial Period (before 1894)

9. Before colonialism, families and communities were the main transmitters of knowledge mainly using informal systems characterised by community and home schooling.

10. Enlightenment was passed on from generation to generation through; languages, folk tales, rituals, rites and ceremonies, stories, traditional dance and music, hand crafts, blacksmithing, hunting, farming, traditional medicine among others.

11. These were promoted by the traditional institutions like kingdoms, chiefdoms and clans who played a fundamental role in preserving the norms, values, practices of the society.

2.2 The Pre-Independence Colonial Period (1894-1962)

12. While the Church Missionary Society arrived in the country by 1877, it introduced formal education 1897. Later, the British colonial government introduced formal education through communal schools and which were later transformed into pre-school, primary, secondary and tertiary education. By 1922 Uganda had a college at Makerere – the first in East Africa. The colonial Government introduced more formal schools and colleges offering health training for clinical medicine, nursing, midwifery and related services.

13. Modern health training was started by a missionary doctor called Sir Albert Cook who established maternity training centre at Mengo hospital in 1897. Later on, medical assistant training centre was established at Mulago Hospital. The first medical college was established at Makerere in 1924. However, by then, this college could only train Africans to the level defined by colonial government as —Asian sub-assistant Surgeons.

14. Other medical schools include: Mbarara University School of Medicine (Public) -1989; Gulu University School of Medicine (Public) – 1989; Kampala International University School of Health Sciences (Private) – 2008; IHK Postgraduate Medical School (Private) – 2008; Uganda Martyrs University School of Medicine (Private) – 2010; King Ceasor University (Formerly St. Augustine International University), College of Health, Medical and Life Sciences (Private) – 2012; Busitema University School of Medicine (Public) – 2013; Habib Medical School – Kibuli under Islamic University in Uganda (Private) – 2014; Kabale University School of Medicine (Public) - 2015; Soroti University School of Health Sciences (Public) – 2016 and UCU School of Medicine (Mengo) (Private) – 2018.

15. Other health training institutions such as Nsambya School of Nursing, Mulago School of Nursing, Masaka School of Nursing, The Uganda Institute of Allied Health and Management Sciences, Jinja School of Nursing, among others were also established.

2.3 The Post-independence Period (1962-1989)

16. After independence in 1962, Government deliberately expanded formal education by increasing the; primary, secondary and tertiary institutions apart from the minimum application of technology

in provision of training. For instance, the medical school at Makerere University later became a college of East Africa in 1963 and was required to admit medical students from Uganda, Kenya and Tanzania on equal quotas. Other health training programmes were introduced as follows: Dental Surgeons (1970), Pharmacists (1980) and graduate nurses (1993). While medical internship was introduced in 1965, Nurses internship commenced in 1999.

17. Privatization and Economic liberalization (1989- to-date) which came with increased creativity and reawakening of Ugandan education system buoyed by the policies of privatization and liberalization. The emergence of private sector led economy characterized by commercialization led to a gradual monetization of health education and services provision. On the supply side, due to the increased demand for skills attainment arising out of liberalization, entrepreneurs have continued to invest in the establishment of educational and training institutions in the health sector.

18. However, this has also put pressure on the upholding of professionalism needed to ensure high quality services provision.

3.0 SITUATION ANALYSIS

3.1 The Global and Regional Context

19. According to the Global Strategy on Human Resources for Health and the report of the High-Level Commission on Health Employment and Economic Growth, there is evidence of growing mismatch between the need (the number required to attain the health system's objectives), the demand (the number of funded positions for health workers based on the country's domestic and external resources) and the supply (the actual number of trained health workers recruited) resulting in skills and staff shortages, even in high-income countries. Shortages are driven by both demographic and epidemiological transitions facing countries and by the ambition of Universal Health Coverage (UHC) and integrated, people-centred service delivery models:

(a) Health systems can only function well when they have a health workforce with sufficient numbers, and equitably distributed health staff that is competent, responsive, motivated and productive.

(b) The World Health Organization has calculated that, in order to achieve Universal Health Coverage and the United Nations‘ Sustainable Development Goals, a country needs to have at least 4.45 skilled health workers for every 1,000 inhabitants.[9]

(c) The African Union Agenda 2063: Goal number 2 focuses on well-educated citizens and skill revolution underpinned by Science, Technology and Innovation. However, not all Health training programs and qualifications are harmonized across the region.

3.2 The National Context

3.2.1 The Health Skill Set Requirements

(a) According to the Uganda Vision 2040, the country envisions highly specialized health care services that position it as a regional hub for quality health care through specialized training. However, by 2020 the country had not realized this vision. According to World Health Organisation by 2030, the total number of skilled health workers required in the country would be 167,765. However, according to the country‘s State of Population report of 2020, the number of health professional (that is; Doctors, Midwives, Nurses, Pharmacists and Allied health professionals) was just about 28,000 in 2019. This implies that if the country needs to reach the desired number by 2030, it will have to increase the current number of Health workers by eight times.

(b) According to the Human Resources for Health Strategic Plan 2020-2030, the current staffing gap is 16,356 (Specialist Doctors/Dentists-801; General Doctors/Dentists-506; Pharmacists-85; Nurses- 6,722; Midwifes-1,248; Allied Health Professionals-6,994). The strategic plan also indicates that the health workforce requirement to achieve 2.3/1,000 population by 2025 is 20,982 (Specialist Doctors/Dentists- 145; General Doctors/Dentists-1,877; Pharmacists-656; Nurses-808; Midwifes2,597; Allied Health Professionals-14,899). However, the Health workforce requirement to achieve 4.5/1,000 population by 2030 is 35,951 (Specialist doctors/Dentists-1,324; General doctors/Dentists- 2,123; Pharmacists-1,543; Nurses- 8,989; Midwifes-10,457; Allied Health Professionals-11,515).

(c) In 2005, the Health Sector Strategic Plan II (2005/2006-2009/2010) stated that —availability of trained health workers is perhaps the most critical limiting factor for the delivery of the Minimum Health Care Package (p.10, p.51). The Health Sector Strategic Plan (2021- 2025), lists one of the many challenges facing the health system is inadequate availability of pre-service health training, training capacity and quality among Health Training Institutions. These gaps are as

follows:

(i) Whereas the World Health Organization recommends a Doctor to Patient ratio of 1:1000, the country's current Doctor Patient ratio is 1:25,000. This implies a high healthcare care deficit when compared to the East African Community peers. For instance; in Kenya the Doctor Patient Ratio is 1: 21,000 while in Tanzania it is 1: 20,000. This scenario is similar even for other health worker categories.

(ii) There are high out-of-pocket costs for health care per capita. For instance, in public hospitals, the out-of-pocket costs for health care are estimated at 3 USD10 (UGX 11,302.24) compared to USD 29 (UGX, 109,255.01 or in private hospitals.

(iii) High cost of education for health training. For example, in the private sector, one requires at least USD 1,500(UGX 5,651,121.00) to train and qualify for a certificate in nursing per year.

(d) By 2020, the country had a total of 29,790, health workers (Clinical Officers, Laboratory, Nursing, Midwifery, Theatre, Pharmacists, Dispensers, and Anaesthetic Officers. This is a very low number compared to 167,765 recommended by the WHO. Table 1 illustrates that Uganda still falls far below the international standards.

(e) However, it is not just the numbers but also the skill set of our health professionals that should be addressed. Attainment of the needed number of skilled heath workers requires government to more than double its current efforts in identification, educating, training, recruitment and retaining a workforce in line with the population needs.

Table 1: Gaps in Human Resources for Health Compared to International Standards

Health Workforce standards	Recommended	Uganda' Status
Physicians to population ratio	1:1,000	1:25 000
Specialist/consultant to-patient ratio	1:1,000	1: 66,574
Medical Officers to-patient ratio	1:1,000	1:16,742
Dentists to the population ratio	1:7,500	1:175,000
Nurse to the population ratio	25:10,000 (1:400)	1:11 000
Midwives per 1,000 people	5:1,000 (1:200)	1:1,000
Ratio of midwife to mother	1:2	1:16
Doctor-nurse ratio	1:5	1:0.09 (1 Nurse to 9 doctors)

Source: Ministry of Health, 2020 and World Health Organisation, 2016

20. The National Development Plan (NDP III), list a number of health skills that are in short supply in Uganda as detailed in Table 2 below.

Table 2: Type of Health Skills in critical short supply

Qualifications and skills	Status	Estimated 5-year Gap
Cardiologist		209
Colon and Rectal Surgeons		239
Dermatologists		568
Gastroenterologists		538
Geriatric Medicine Specialists		418
Haematologists		229
Neurologists		1,123
Oncologists		717
Otolaryngologists		538
Plastic Surgeons		418
Plastic Surgeons		490
Podiatrists		118
General Surgeons		478
Anaesthesiologists		837
Emergency Medicine Specialists		418
Pathologists		1,135
Radiologists		2,868
Vocational Education Teachers		2,868

(Source: The National Development Plan (NDP III)

21. In addition to table 2 above, there are other health skills that are in short supply including; Medical Officers; Gastroenterologists; Endocrinologists Paediatricians; Immunologists; Neurologists; Nephrologists; Medical Geneticists; Geriatric medicine specialists; pulmonologists, emergency including aviation and marine physicians. Also, there is critical shortage of skills for the nurses, midwives and allied health professionals as indicated below:

22. Nurses and Midwives: Under the Nurses and Midwives, the following are some of the critical skills required: General Nurse; General Midwife, Critical Care Nurses; Paediatric Nurses; Neonatological Nurses; Oncological Nurses; Burns Nurses; Theatre Nurses; Surgical Nurses; Cardiological Nurses; Neurosurgical Nurses; Urology Nurses; Nephrological Nurses; Palliative Care Nurses; Geriatric Nurses; Mental Health and Public Health.

23. Allied Health Professionals: The Allied Health Professionals that are in critical shortage include among others: Ear, Nose and Throat Officers; Anaesthetists; Haematologists; Microbiologists; Clinical Chemists; Histopathologists; Parasitologists; Virologists; Physiotherapists; Radiographers (medical imaging and ultrasound); Clinical Officers; Health Promotion and Education; Environmental Health Officers; Ophthalmic Clinical Officers; Clinical Psychiatric Officers; Occupational Health and Safety Specialists; Nutritionists; Medical Entomology and Parasitology; Orthopaedic Medicine; Public Health Dentistry; Emergency Health Care; Physicists; Medical records and health informatics; Biomedical engineering.

24. Pharmacy Professionals: Under this, the following are the critical skills in shortage: Pharmacists; Clinical pharmacists; Pharmaceutical chemists and Pharmacognosists.

25. Traditional and Complementary Medicine practitioners (Limited information):

(a) Traditional and complementary medicine is a health practice with strong historical and cultural roots, with global acceptability and applicability. The World Health Organisation acknowledges the contribution of Traditional and complementary medicine to health, wellness, people-centred health care and universal health coverage and seeks to bring traditional medicine into mainstream health care, appropriately, effectively and safely.

(b) According to the World Health Organisation, almost half the citizens in many industrialized countries now regularly use some form of Traditional and complementary medicine. For instance; its usage is estimated at: 42% in Unites States; 48% in Australia; 49%in France; and 70% in Canada while in many developing countries usage is estimated at: 71%in Chile; 40% in Colombia; and up to 80% in many African countries.

(c) However, although Parliament enacted the Traditional and Complementary Medicine Act, 2019 and assented to by the President on 28th May 2020 to regulate this sub-sector, there are still gaps largely in the formal education and training where most practitioners get their knowledge and skills largely from the informal sector.

3.2.2 Health Skillset Gap:

26. The skillsets listed above are in the technical, undergraduate, specialised and fellowship category. While government has progressed well in training, the technical and undergraduate categories, big gaps still exist in the training of both specialised and fellowship categories.

27. Thus, there is need to identify, and train persons in those varied and multi-level skills so as to close the appalling gaps in our health care system. This will require a number of intermediate and long-term interventions to develop a robust and committed health workforce.

3.2.3 Enrolment and Admissions:

28. According to the World Health Organisation standards, a country should have five (5) Health Workers (HWs) for every one thousand (1,000) people. Using the current estimated population of forty- f i v e (45,000,000) Million Ugandans, the country needs to admit forty- f i v e 45,000 thousand students to the various Health Training Institutions (HTIs). However, all our Health Training Institutions (tertiary institutions and universities) can only admit 20,000 students. This implies a deficit of 25,000 students. This deficit implies that the country lacks the adequate skills and numbers required for delivery of Health services.

29. The deficit of 25,000 students to the various Health Training Institutions is due to the: high cost of training; limited capacity of both facilities and trainers; lack of scholarships; lack of specialised health training programmes; lack of education and training for health policy; weak coordination arrangements, and the inadequate qualifications frame work.

3.2.4 Training

30. Currently, there are high numbers of students on some programmes in the 201 tertiary institutions and 18 universities (2023). However, to meet all our health education and training needs, the country requires over 250 additional Health Training Institutions distributed across the country to absorb about 180,000 students per year.

31. The country needs more than 50 training institutions offering specialised programmes as listed in Table 1. This implies building more training institutions, rehabilitating and equipping the old

ones to offer quality health education. The health training institutions also require recruitment and deployment of enough qualified technical staff with the varied competences.

3.2.5 Internship

32. Eligible students in health education and training programmes are expected to undergo Internship for specific period under supervision in an accredited Health Centre. The issue of concern is that, there is inadequate and insufficient training for health profession students during the internship.

33. The inadequate and insufficient internship is caused by lack of a well-structured internship program brought about by; unclear roles of the multiple stakeholders involved in training and implementation of the internship program; lack of compliance to the set standards by the HTIs, inadequate number and capacity of supervisors, inadequate number of internship training centres, inadequate tools and equipment; and poor welfare for the interns and the supervisors and the ever increasing number of interns that was affecting the quality.

34. National Referral Hospital (1500 beds), Regional Referral Hospital bed capacity between 300 and 600 beds and General Hospitals between 100 and 150 beds and within all these facilities, there are only 58 accredited internship training centres. On average 2,000 interns are produced per year, and all have to be attached for internship training in the limited available internship training centres.

35. Additionally, the supervisors are fewer to handle the increasing number of health professional interns. For example, every intern training centre, there should be at least a supervisor for every rotation (Medical, surgical, Obstetrics & Gynecology and pediatrics).

36. Uganda has not taken up yet the Country Coordination and Facilitation mechanism, proposed by the WHO and the Global Health Workforce Alliance. This is a multi-sectoral mechanism that brings together Ministries of Health, Education, Public Service, Local Governments as well as other relevant stakeholders to forecast and plan the training of the health workforce according to defined needs.

37. With the ever-growing number of institutions training health workers, the rate of production of technical staff in the various cadres is on the increase for doctors, nurses, midwives, clinical officers and pharmacists. However, due to limitations in funding for new positions in the public sector the rate of absorption is not keeping up with the production leading to unemployment and fertile ground for migration to greener pastures.

38. There is a large stock of qualified and licensed health professionals ready and available for employment. Their number rose from 90,412 in 2017 to 101,350 in 2018 (27). Out of those, more than 6,000 are doctors, more than 47,000 are nurses and more than 18,000 are midwives, according to the registry of the Uganda Medical and Dental Practitioners Council. If the existing stock was to be absorbed into the workforce, the ratio of doctors, nurses and midwives per 1,000 inhabitants would rise correspondingly from 0.60 to 2.9. Although this is clearly a much higher figure, it is still below the WHO target of 4.45.

3.2.6 Health Workforce Migration

39. Out-migration of health professionals enlarges the health workforce gap. Out-migration of health professionals to other countries and to other sectors is perceived as one of the main issues that impact health services negatively. This is because it has resulted in the loss of senior and specialised experts and increased the workload of those left behind, in the lower cadres.12

40. A study by the African Centre for Global Health and Social Transformation (ACHEST) and the Uganda Medical and Dental Practitioners Council for the years 2010-2015 estimated the net loss

of doctors due to migration at 10% of those who enter the market annually. However, this rate may be higher, because the estimation is based only on the letters of good standing issued by the Medical and Dental Practitioners Council.

41. Uganda pays these training costs. When a health worker emigrates, this lowers the recipient country's health workforce training costs, because it needs to train fewer health workers. On the other hand, Uganda is not only a source but also a destination country that receives health workers from other countries. According to the Medical and Dental Practitioners Council, in 2017, 19.6% of registered and licensed medical doctors were born elsewhere.

42. Ugandan health workers have several reasons to migrate abroad or to leave the public health sector for another job. Inadequate wages, job insecurity and lack of basic working standards play an important role. There is also the fear of unemployment, which may lead to employment in fields other than health; a phenomenon described as —brain wastell. Those who migrate, apart from better remuneration and work conditions, are also anticipating safer and better living conditions. Families and governments often even encourage migration, seeking for remittances and flow of foreign currency at home.

3.2.7 Demographic and Epidemiological Context

43. Uganda's population is: (i) young and rapidly growing, generating sustained demand for health services and health workers; (ii) increasingly urbanising, while still characterised by significant rural and hard-to-reach populations; and (iii) facing a dual disease burden comprising communicable diseases, emerging non-communicable diseases, maternal and child health challenges, and public health emergencies. This implies that education and training for health must produce adequate numbers, appropriate skills mixes, and geographically responsive cadres, rather than focusing solely on academic expansion or prestige programmes.

3.2.8 Financing and Public Resource Context

44. Public financing for health and education is: (i) constrained by competing national priorities; (ii) subject to public finance management and accountability requirements; and (iii) insufficient to absorb inefficiencies arising from duplication, misaligned training, or unregulated expansion. Learners and households bear a significant share of training costs, heightening the risk of: exposure to invalid qualifications; and inequitable access to quality training. This implies that policy standards and guidelines must support efficient use of public and private resources, protect learners' investments, and prevent waste arising from non-compliant provision.

3.3 Policy and Legal Frameworks

3.3.1 Uganda Vision 2040

45. This policy is aligned to Uganda's Vision 2040, which envisages a transformed Ugandan society from a peasant to a modern and prosperous country, through the implementation of six sequenced, five-year National Development Plans (NDPs). The first National Development Plan (NDPI) was from (April 2010/2011-2014/2015), the second National Development Plan (NDPII) was from 2015/2016 – 2019/2020 and now the third National Development Plan (NDPIII) was from 2020/2021 – 2024/2025 and this will continue up to 2040.

46. Uganda Vision 2040 (under paragraph 1.4 (a) p.5) emphasizes the factors that define a country_s productivity level. These include: Institutions; Innovation; Infrastructure; Microeconomic environment; Health and primary education; Higher education and training; goods market efficiency; Financial market development; Technological readiness; Market size; Labour market

efficiency; and business sophistication.

3.3.2 The Third National Development Plan (NDP) III - 2020/2021 – 2024/2025

47. The NDP III (2020/21-2024/25) focuses on sustainable industrialization for inclusive growth, employment and sustainable wealth creation. The NDPIII recognizes that our country has a comparative advantage in education for health training in the Great Lakes Region.

48. Specifically, NDP III under the human capital development emphasizes among other things: strengthening education curriculum to including for professional training for health for nursing, medicine, clinical practice and revision to the systems and professions in this regard. The effort is to bring Uganda to embrace modern and recent trends in professional education and training for health.

3.3.3 The National Health Policy, 2010

49. The second National Health Policy of July 2010 prescribes a number of interventions that promote health including professionalism, integrity and ethics. The policy has interventions to strengthen enforcement of professional standards and developing effective ways of increasing health workers accountability towards citizens.

50. The policy recognises the critical role of human resource in health in terms of numbers, skill mix and quality in the delivery of effective health care. In addition, the inadequate numbers and professional mix graduating from training institutions make it difficult to meet the human resource needs for the delivery of the minimum health care package. The policy calls for strengthening of human resources through attraction, proper motivation, remuneration, development of human resources relevant to the country‘s needs and the promotion of professionalism among all the health workers.

3.3.4 The National Employment Policy, 2011

51. The Employment Policy, 2011 provides the promotion of Youth Employment, job-placement, volunteer schemes and internship to enable young acquire the requisite job training and hands on experience before joining the world of work. The interventions are well aligned to the proposed interventions in the Education and Training for Health Policy especially the Internship component.

3.3.5 The National Youth Policy, 2001

52. The policy prescribes interventions that promote and support training and capacity building, vocational training and establishment of internship and rotation to enable the youth acquire a range of skills and essential tools and these are aligned to the Education and Training for Health Policy.

3.3.6 Medical and Dental Practitioners Act, Cap 272, 1998

53. The Medical Practitioners and Dental Surgeons Act prohibit unlicensed persons from practicing medicine, dentistry, or surgery. However, Section 36 allows the practise of any system of therapeutics by persons recognized to be duly trained in such practice by the community to which they belong, provided the practice is limited to that person and that community.

54. Section 17 (2) provides that —a person applying for registration shall satisfy the council that he or she has acquired experience by satisfactorily serving a full-time internship in a hospital approved by the councill.

3.3.7 The Nurses and Midwives Act, Cap 274, 1996

55. Section 3 of the Act; provides functions of the council and the key functions are to: regulate the standards of nursing and midwifery in the country; regulate the conduct of nurses and midwives and to exercise disciplinary control over them; approve courses of study for nurses and midwives; supervise and regulate the training of nurses and midwives. These functions are well aligned to the interventions in the National Education and Training for Health Policy.

3.3.8 The Pharmacy and Drugs Act, Cap 280, 1971

56. Under Section 6 (1) An application for a certificate of registration as a member of the society shall be made by delivering or sending to the secretary of the council — (a) the application; (b) the affidavit supporting the application; (c) the certificate or other document which the applicant submits as evidence of his or her qualifications, professional skill and experience; (d) an entrance fee of sixty shillings; (e) a certificate showing that he or she has passed an examination after a period of practical training.

3.3.9 The Allied Health Professionals ACT. (1996)

The Act established the council is responsible for regulating allied health professionals in the country by setting professional standards, overseeing conduct and exercising disciplinary control, approving courses of study and the qualifications awarded, supervising and regulating training institutes, overseeing the registration of professionals and publication of their names in the Gazette, advising the Government on related matters, and exercising general supervision over the professions, in addition to performing any other functions assigned under the Act.

3.3.10 Traditional and Complementary Medicine Act, 2019.

57. The Parliament of Uganda enacted the Traditional Medicine and Complementary Medicines Act. The objective of the Act is to define and standardize the concept and provide acceptable standards of traditional and complementary medicine practice in collaboration with modern medicine sectors. The Act seeks to establish a council responsible for the regulation of traditional and complementary medicine practitioners, defining their roles registering and issuing them with licenses, with sufficient representation from the practitioners.

3.3.11 Guidelines for Traditional/Herbal Medicines for Human and Veterinary Use

58. Under paragraph 2.15 on Training, It is desirable that personnel involved in production and Quality Control should have appropriate training in relevant fields such as pharmaceutical technology, taxonomic botany, phytochemistry, pharmacognosy, hygiene, microbiology, and related 689 expertise (such as traditional use of herbal medicines).

4.0 PROBLEM STATEMENT

59. Education for Health is defined as the process of developing, transmitting and acquiring behaviour, skills, knowledge, attitudes and values in an environment guided by a curriculum to support the provision of services which promote a state of complete physical, mental and social wellbeing of people.

60. In the Ugandan context there has been a concern of inadequate quantity and quality of education for health. This is caused by: Inadequate quality of health trainees due to inadequate variety of specialized health consultants; low motivation of clinical preceptors and consultants; lack of uniform standards in examination (bachelor's degree and above) and academic entry into professional training (e.g., Nurses) as well as an outdated curriculum in a sphere of inadequate mentorship and professional guidance. There are inadequate training materials and poorly equipped training facilities. Overall, the number of professional health trainers is limited and so is the investment in continuous capacity development. In addition, there is a lack of harmonised standards in admissions; unclear structured career guidance and growth as well as inadequate trainee welfare.

61. These challenges have all contributed to a poor health system that has generated low health outcomes that curtail socio-economic transformation. There is therefore a critical need to strengthen the policy framework to help the country attain optimal quantity and quality of education for health.

5.0 POLICY JUSTIFICATION

62. The policy will address the imperfections in the Markets for Education and Health Care. The Market imperfections may include: the presence of externalities from education and training for health; because trainees as recipients of education, are not responsible for deciding how much education and training they will obtain. This responsibility falls to their parents, who also bear the costs of education. Since the benefits of education accrue primarily to the trainees who receive it, the level of spending on education depends critically on the degree of parental altruism; because loans to obtain education are not backed by tangible collateral, they are often difficult to obtain private credit, and the presence of fixed costs in educational production.

63. This policy will rationalize the health professional training framework and provide guidance and strategic direction on meeting appropriately, the professional conduct of education for health. This policy has been designed to achieve the following objectives: to attain adequate quality of health trainees; to provide adequate training materials and equipment; to increase the quantity and quality of professional health trainers; to enhance continuous capacity development; to improve the quality of health training facilities and profession; and to increase enrolment of specialised health trainees.

64. With the implementation of this policy, government will strengthen the health systems with health workforce with sufficient numbers, and equitably distributed health staff that is competent, responsive, motivated and productive. It will help the country stride towards that achievement of a Universal Health Coverage (UHC) and the United Nations Sustainable Development Goals (SDGs), as well as the African Union Agenda 2063 Goal 2 which focuses on well-educated citizens and skill revolution underpinned by Science, Technology and Innovation. In order to achieve this, the policy will cover the following areas: admission, training, qualifications, internship and CPDs.

6.0 POLICY DIRECTION

65. The National Education and Training for Health Policy provides a framework that guides the actions of all stakeholders involved in the realm of health training so as to achieve an effective and globally competitive health workforce.

6.1 The Policy Vision

66. The policy vision is: —A competitive health workforce for a Healthy and Productive Population‖.

6.2 The Policy Mission

67. The policy mission is: "To transform the Uganda health workforce by providing; quality, sustainable and equitable health education and training which is responsive to the requirements of the labour market".

6.3 The Policy Goal

68. The policy goal is "To attain optimal quantity and quality of education and training for health‖.

6.4 The Policy Objectives

69. The policy objectives are to:
(a) Attain adequate quality and quantity of health trainees;
(b) Increase enrolment of specialized health trainees;
(c) Increase the quantity and quality of professional health trainers;
(d) Improve the quality of health training facilities;
(e) Strengthen internship, clinical rotation and practice; and
(f) To implement continuous capacity development in health sector.

6.5 The Policy Scope and Relationship with Sector Policies

70. Levels of Education and Training for Health: Education and Training for health falls under two levels namely, the lower and upper levels. The lower level can be attained from a Technical and Vocational Education and Training (TVET) provider and excludes degree and higher- l e v e l programmes delivered by higher education institutions, but provides trainees with occupational or work-related knowledge and skills at the level of a diploma. The upper level can be attained from a university or Other Degree Awarding institution which offers degrees and other post graduate qualifications respectively.

71. Relationship of Education and training for health with the TVET policy and Higher Education policy: This policy is in line, and should be read together with the TVET policy, 2019 and Higher Education policy. Notwithstanding the provisions of this policy, the laws regulating the provision of TVET, and Universities and Other Degree Awarding Institutions, and any other laws made thereafter for the purposes of this policy, shall be the laws applicable for Education and Training for Health.

6.6 Key aspects of Education and Training for Health

72. This policy provides a comprehensive, end-to-end governance framework for Education and Training for Health (ETH), covering the entire lifecycle of health professional formation—from entry

into training through qualification, supervised practice, and lifelong professional development. The scope is deliberately holistic to ensure coherence, quality, safety, and accountability across all stages, actors, and environments involved in preparing the health workforce.

73. Each aspect covered by the policy is described below, with emphasis on its operational intent, regulatory significance, and public interest rationale.

(a) Recruitment and Admissions / Entry: This aspect governs how learners enter health education and training pathways. It: establishes transparent, merit-based, and equitable admission criteria; aligns entry requirements with programme level, UQF descriptors, and professional expectations and regulates admissions numbers in line with approved institutional capacity, staffing, and clinical placement availability.

(b) Training, Assessment, and Certification: This aspect covers the core educational process through which learners acquire and demonstrate competence. It: governs curriculum design, teaching methodologies, and assessment systems; ensures training is competency-based, outcomes-oriented, and aligned with UQF and professional standards; and regulates certification to ensure that awards accurately reflect demonstrated competence and lawful completion of training.

(c) Clinical Practice, Rotation, and Internship: This aspect governs practice-based learning and transition to independent practice. It: regulates clinical rotations, internships, residencies, and other supervised practice arrangements; ensures placements occur only at approved and designated sites with adequate supervision and case mix; and defines scope of practice, supervision requirements, and learner protections during clinical exposure.

(d) Continuous Professional Development and Growth: This aspect addresses lifelong learning and professional currency. It: establishes expectations for continuous professional development (CPD) across health cadres; links CPD to evolving clinical standards, technologies, and population health needs; and supports career progression, specialisation, and re-licensure requirements.

(e) Trainers of Health Trainees (Tutors, Instructors, Preceptors, Lecturers, and Consultants): This aspect governs the human capital responsible for training the health workforce. It: sets standards for qualification, registration, pedagogical competence, and clinical currency of trainers; regulates appointment, supervision roles, workloads, and performance management; and ensures ethical conduct, learner protection, and accountability.

(f) Training Facilities, Equipment, and Materials: This aspect governs the physical and technological environment in which training occurs. It: sets minimum standards for classrooms, laboratories, skills labs, simulation centres, and clinical facilities; regulates availability and safety of equipment, consumables, and learning materials; and ensures compliance with health, safety, infection prevention, and environmental standards.

6.7 Policy Outcomes

74. The effective implementation of the Education and Training for Health (ETH) policy is expected to deliver transformational outcomes at individual, institutional, sectoral, and national levels. These outcomes are mutually reinforcing and reflect the policy‘s intent to link education quality, health system performance, and national development objectives within a single, coherent framework.

75. The outcomes anticipated from effective implementation of the policy include:

(a) Improved health outcomes: The policy is a population health intervention. By strengthening how health professionals are recruited, trained, assessed, supervised, and continuously developed, the policy directly contributes to improved health outcomes. The pathways to impact include:

(i) Production of competent, ethical, and practice-ready health professionals across all cadres. (ii) Improved clinical decision-making, patient safety, and quality of care through competency-based training and supervised practice. (iii) Better alignment of training outputs with disease burden, service delivery priorities, and community health needs and (iv) Reduced clinical errors, preventable morbidity, and mortality through strengthened clinical training and professional regulation.

(b) Strengthened health systems: The policy is designed not only to produce individual professionals, but to strengthen the health system as a whole. The system-level benefits of the policy include: (i) Improved health workforce availability, distribution, and skills mix, informed by coordinated workforce planning. (ii) Stronger linkages between education institutions, training hospitals, professional councils, and service delivery entities. (iii) Enhanced governance, regulation, and accountability across the health training ecosystem, reducing fragmentation and duplication; and (iv) Greater resilience of the health system through better-prepared personnel capable of responding to public health emergencies, emerging diseases, and technological change.

(c) Accelerated human capital development, economic growth and development: Beyond the health sector, the policy contributes to broader national development goals by strengthening human capital and supporting economic growth. Human capital and economic impacts (i) Development of a skilled, employable, and adaptable health workforce that contributes productively to the economy. (ii) Reduced unemployment and underemployment among health graduates through labour-market-aligned training. (iii) Increased productivity and reduced health-related economic losses due to improved population health. (iv) Enhanced attractiveness of the country‘s health training and professional qualifications globally, supporting mobility and competitiveness; and (iv) Long-term fiscal benefits through more efficient use of public training investments and reduced costs associated with poor-quality training or unsafe practice.

6.8 The Guiding Principles

76. The principles articulate the normative foundation and decision-making compass of Education and Training for Health. They define the values, priorities, and operating assumptions that inform policy design, implementation, regulation, and enforcement across the entire health education and training ecosystem. The principles are not aspirational statements; they are binding interpretive anchors that guide how standards are applied, how discretion is exercised, and how trade-offs are resolved in practice.

77. The implementation of the policy will be guided by the following key principles:

(a) Equity, Access, and Fairness: The policy promotes equitable access to quality health education and training. This implies: Admissions, placements, and progression are governed by transparent, merit-based criteria; Learners are protected from exploitation, discrimination, and exposure to invalid qualifications; and special attention is given to underserved regions and populations. Fairness— refers to the equal application of rules to all members of society. Thus, equity refers to differences that are unnecessary or reducible and are unfair and unjust. The principle of inclusivity refers to the ideals by which government can model respect for one another, regardless of their ethnicity, religion, sex, social class, ability or disability, and all the other characteristics that make us different from one another. This policy will uphold both equity and inclusivity.

(b) Public Interest and Patient Safety First: The policy is grounded in the primacy of public interest and patient safety. This implies: All education, training, and clinical learning arrangements must prioritise safe, ethical, and competent care; No training objective, institutional interest, or commercial consideration may override patient safety; and regulatory decisions shall err on the side of protecting learners, patients, and the public.

(c) Competency, Quality, and Fitness for Purpose: The policy is anchored in competency-based, quality-assured education and training. This implies: Training outcomes must be defined in terms of demonstrable competence, not time spent or content covered; Institutions, programmes, trainers, and sites must be fit for purpose before approval or expansion; and Quality assurance is continuous, evidence-based, and enforceable.

(d) Health-System and Labour-Market Responsiveness: Education and training must be responsive to national health system needs and labour-market realities. This implies: Programme design, admissions, and capacity decisions are informed by workforce planning and service delivery priorities; Emphasis is placed on appropriate skills mix, geographic distribution, and emerging health needs; and Training supply is aligned with demand, avoiding oversupply or critical shortages.

(e) Clear Mandates, Regulatory Coherence, and Coordination: The policy is guided by clarity of roles and coordinated regulation. This implies: Each actor (MoES, MoH, regulators, councils, institutions) operates strictly within its statutory mandate; Duplication, overlap, and conflicting directives are actively prevented; and Joint mechanisms are used where responsibilities intersect.

(f) Ethics, Professionalism, and Integrity: Ethical conduct and professional integrity are central to the policy. This implies: Ethics and professionalism are embedded throughout curricula and clinical training; Conflicts of interest are declared and managed at institutional and regulatory levels; and zero tolerance for fraud, misrepresentation, or abuse of learners or patients.

(g) Institutional Accountability and Transparency: The policy emphasises clear accountability and transparency. This Implies: Institutions and regulators are accountable for decisions, outcomes, and use of resources; Approvals, classifications, and enforcement actions are documented and auditable; and public information is provided to protect learners and stakeholders.

(h) Evidence-Based Decision-Making and Continuous Improvement: The policy is driven by data, monitoring, evaluation, and learning. This implies: Decisions on approvals, capacity, and sanctions are based on verified evidence; Monitoring and evaluation systems inform policy refinement and improvement; and Feedback loops translate evidence into corrective action.

(i) Integration Across the Education–Training–Practice Continuum: The policy recognises health professional formation as a continuum, not isolated stages. This implies: Coherence is ensured between pre-service education, clinical training, internship, licensure, and Continuous Professional Development; Transitions between stages are regulated and supported; and Qualification frameworks and professional requirements are aligned.

(j) Sustainability and Efficient Use of Resources: The policy promotes sustainable and efficient use of public and private resources. This implies: Training expansion is capacity-aware and fiscally responsible; Duplication and waste are minimised through coordination and standards; and Institutions are encouraged to plan for long-term viability.

(k) Environmental Sustainability: This principle means the responsibility to conserve natural resources and protect the global ecosystems to support health and wellbeing, now and in the future. The policy will be implemented in a manner that protects; preserves and conserves the environment in all its processes and interventions.

(l) Innovation: This principle promotes smart, future-oriented regulation and policies designed to encourage innovation activities that can deliver socially and environmentally beneficial progress. Under this principle, government will support innovation and creativity for education and health services delivery and transformation.

(m) Public Private Partnerships: Participation— means the involvement of all stakeholders.

Government will work with all the stakeholders (both state and non-state actors) in the implementation of the education and training for health policy. This enhances complementarity and capacity building of the different stakeholders.

(n) Human Rights based Approach: To ensure inclusivity the policy's implementation adopts human rights principles of: equality, non-discrimination and empowerment and participation of vulnerable groups, aware, able and enabled to defend their fundamental human rights in access to services and enjoyment of justice and self-determination.

(o) Decency: The decency principle — means development and implementation of rules without harming people. Government will ensure that there are mechanisms that guarantee occupational health and safety for all students and workers during training and work. This shall include social protection, provision of Personal Protective Equipment (PPEs), first-aid kits (in the event of accidents occurring) and options for provision of student and workers compensation.

(p) Accountability Transparency and Efficiency: Accountability — refers to the extent to which all the actors are responsible to society for their actions. Transparency — refers to the clarity and openness in decision-making. Efficiency —refers to the use of the resources without waste, delay, corruption, or undue burden on future generations. Implementation of the policy will be underpinned by accountability, transparency and efficiency at all levels.

7.0 POLICY OBJECTIVES AND INTERVENTIONS

78. Under this part, a Framework of identifying the potential interventions to support realisation of the policy objectives. An intervention is a statement of the actions that government might take to address the strategic priorities and resolve the policy constraints. It narrows the focus from a broad strategic priority and begins to define specific activities. It focuses on WHO needs to do WHAT and HOW it will get done.

79. Aligning the Education and training for health policy objectives and interventions to the strategic priorities ensures that Ministry focuses on the big picture objectives that address the root causes of failings in Education and Training for markets. The policy is as specific as possible, to help guide the actors to design solutions, pulling from the lessons learned in practice before this policy.

80. This part introduces the metrics for how the actors especially the Ministry of Education and Sports and the Ministry of Health will judge the implementation of these particular policy interventions. This creates a clear, measurable definition of Education and training for health policy success during the delivery and implementation.

81. In view of the above, the Education and training for health policy aims at achieving six (6) core objectives aligned to four broad categories namely; (i) Student admission (entry), (ii) Students Training, (iii) Internship, and (iv) Continuous Capacity Building and post graduate training and upgrading. Government proposes to implement specific interventions and measures to realise the objectives as detailed below.

7.1 Policy Objective 1: To attain adequate quality and quantity of health trainees.

82. In order to achieve the above policy objective, Government will ensure that there is adequate numbers and quality of education for health trainees. The strategic interventions under this policy objective include to:

(a) Improve health trainer to student‘s ratio;

(b) Improve preceptor/ mentor to student‘s ratio;

(c) Diversify and increase the number of specialized and super specialized health trainers;

(d) Enhance motivation for clinical preceptors and consultants;

(e) Enhance the capacity to have adequate health trainers;

(f) Increase numbers and capacity of training facilities for specialized health skill set;

(g) Provide adequate clinical instructional materials and equipment in training facilities;

(h) Introduce standardized assessment and examinations for all undergraduate health trainees;

(i) Standardize and regularly review curricula for education for health training;

(j) Improve mentorship and professional guidance;

(k) Ensure that health trainers obtain regular and periodical exposure to clinical practice

(l) Streamline and set standards for admitting foreign students in health professions

(m) Set entry requirements for education and training for health

(n) Streamline training, qualifications and certification of traditional and Complementary Medicine practitioners

7.2 Policy Objective 2: To increase enrolment of specialised health trainees

83. To achieve the above policy objective, Government will support the training and development of specialised health professionals through implementing the following strategic interventions:

(a) Develop and regularly update curricula for health professionals‘ training institutions;

(b) Improve academic entry requirements into professional training institutions;

(c) Standardize admission, assessment, and registration procedures;

(d) Develop the qualifications framework for education for health training;

(e) Rationalize the cost of education for health training;

(f) Review the career growth pathways and guidance;

(g) Directly sponsor post-graduate and other specialised health professional cadre training.

(h) Increase number of health trainers and a diversity of specialized health consultants

(i) Improve both mentorship and professional career guidance

(j) Attract, promote and support entrepreneurs to invest in education for health training

(k) Review and develop the minimum policy standards and guidelines for post graduate training

7.3 Policy Objective 3: To increase the quantity and quality of professional health trainers.

84. To achieve the above policy objective, Government will progressively increase the quantity and quality of the tutors and lecturers, clinical consultants and instructors, preceptors and mentors. This will involve implementing the following Strategic Interventions:

(a) Increase the number of tutors and lecturers, consultants and instructors, preceptors and mentors;

(b) Improve the quality of health tutors and lecturers, consultants and instructors, preceptors and mentors;

(c) Improve supervision, management, Monitoring and Evaluation, reporting and feedback on education for health and training;

(d) Enhance the motivation of clinical preceptors and consultants;

(e) Improve the working condition in the rural and hard to reach areas;

(f) Strengthen regulation of private training institutions; and

(g) Provide a Framework for training and mentoring Traditional and Complementary Medicine Practitioner Trainers.

7.4 Policy Objective 4: To improve the quality of health training facilities.

85. In order to achieve the above policy objective, Government will enhance the capacity of health training facilities to ensure provision of quality hands-on training services. Government will:

(a) Develop and operationalise the Health Safety Standard Operating Protocols; including the Personal Protective Equipment (PPE);

(b) Develop and operationalise Bio-safety Standard Operating Protocols;

(c) Provide adequate security in and around the Health Training facilities;

(d) Increase the numbers and expand capacity of health facilities for specialized health training

(e) Provide Health training equipment and the necessary materials (skills, laboratories, Information and Communication Technologies (ICT) , libraries among others

(f) Establish the Health Training Management Information System (HTMIS)

(g) Support the development of a critical mass of skilled professionals in the field of anatomy to provide the required foundational training in anatomy for medical courses;

(h) Create and enforce an enabling policy, legal and institutional regime to govern all processes relating to the sourcing, usage, management, storage and interment of cadavers that are used in anatomical teaching and practice;

(i) Strengthen regulation on the usage of bio-medical (skeleton, cadavers etc.), chemical and other training materials in medical training;

(j) Develop and enhance regulatory and legal frameworks that improve the quality of public and private health facilities;

(k) Streamline stakeholders‘ mandates and roles in education and health training;

(l) Promote ethical codes of practice and standardize regulation of professional practice;

(m) Strengthen the regulation of private training institutions;

(n) Construct new and renovate the existing health training facilities.

(o) Develop standards on attaching training institutions to hospitals/Health facilities.

(p) Promote extra-curricular activities in health training institutions

7.5 Policy Objective 5: To strengthen internship, rotation and clinical practice.

86. In order to achieve the above policy objective, Government will ensure that the health training facilities have the capacity to train and mentor all the interns. Government will:

(a) Develop and implement a standard internship management framework;

(b) Develop standards and guidelines for clinical teaching and learning;

(c) Develop and enforce a standard framework for health training rotation;

(d) Develop a framework on the adaptation to the changing health training technologies including Artificial Intelligence;

(e) Develop standards for private health care and education service providers;

(f) Develop and implement national standards and guidelines for medical internship;

(g) Review the scope of leadership and management of medical internship;

(h) Ensure efficiency in the selection, deployment and management of interns;

(i) Ensure that students are supported throughout their training (internship, and clinical practice) by their respective sponsors (Government for Government sponsored or Private for private).

(j) Develop and implement a plan to improve the welfare for medical interns;

(k) Develop standards and guidelines for the accreditation of internship training centres;

(l) Establish pre-internship examinations for the internship programme;

(m) Develop an accreditation system and criteria for workplaces offering internship, rotation and clinical practice;

(n) Develop standards for joint monitoring and supervision of internship and their centres;

7.6 Policy Objective 6: To enhance professional continuous capacity development.

87. In order to achieve the above policy objective, Government will support all efforts aimed at building the capacity of health workers by prioritising the following strategic interventions:

(a) Enhance research and education for health trainees and trainers;

(b) Develop change management systems for health education development;

(c) Develop workload standards and rationalize workload of trainers accordingly;

(d) Enhance the levels of motivation for health trainees and trainers;

(e) Develop the health training and staff retention strategy;

(f) Build the capacity of the trainees and trainers to cope up with the changing technologies and disease dynamics;

(g) Ensure equitable distribution of the training institutions and service facilities;

(h) Establish Health Training Coordinating Centres;

(i) Establish new and revamp the existing in-service training Centres;

(j) Identify and train mentors and preceptors; and

(k) Develop the capacity needs assessment standards and guidelines manual and enforce it.

8.0 CROSS CUTTING ISSUES HEALTH PROFESSIONS EDUCATION

88. Cross-cutting issues are topics that are identified as important and that affect and cut across most or all aspects of policy development. These topics should therefore be integrated and mainstreamed throughout all stages of development from policy design, to implementation, evaluation and learning.

89. To mainstream an issue means to adopt the lenses that focus on important topics throughout the whole policy cycle management process. Mainstreaming cross cutting issues requires political leadership and institutional commitment. The critical enabling factors for this to happen are: supportive policy frameworks and strategies; the commitment of necessary financial and human resources; performance incentives and accountability; and a learning culture. Thus, the mainstreaming process requires special attention, innovation, flexibility and adaptation; the progressive creation of new norms and standards as awareness is created and understanding of the issues is developed.

90. This policy will ensure that all key cross-cutting issues that pertain to education and health training development are embedded in its implementation. The identified cross-cutting issues include the following among others.

8.1 Gender, Persons with Disabilities (PwDs) and Equity in Health Professions Education

91. This policy will be implemented through strategies that advance gender equity and equality.

(a) Gender mainstreaming is a public policy perspective and practice of always assessing and including the concerns, experiences and the different implications for people of different genders in any planned policy action, including legislation and programmes, in all areas and levels so that

women and men benefit equally and inequality is not perpetuated.15 Therefore, Government will deliberately ensure that men and women have equal access to health training services, and equally participate in health training.

(b) Government will deliberately include Persons with Disabilities (PwD) and special needs in all relevant and appropriate health training opportunities including specific attention to particular PwD needs and access to funding for training where possible.

(c) For equity and inclusion, Government will address inclusive development by ensuring equity, inclusiveness, non-discrimination, protection of the marginalised and equitable distribution of the health training facilities in all parts of the country.

8.2 Environment and Climate Change Adaptation in Health Professions Education

92. In the implementation of this policy, Government will, ensure that the priority interventions do not undermine its efforts on environment and Natural Resource Conservation. It will achieve this by:

(a) Promoting environment protection while contributing to the national strategy of mitigating the negative effects of climate change;

(b) Ensuring that all health training facilities practice safe disposal of medical wastes and any other training devices and,

(c) It will protect and progressively work to address the adverse effects of climate change to uphold the tranquility of Uganda‘s natural resource base.

8.3 Occupational Health, and Safety in Health Professions Education

93. This policy puts in place mechanisms that guarantee occupational health and safety for all the actors in education for health and training. Government will:

(a) Promulgate and enforce rigorously the occupational health and safety regulations;

(b) Develop awareness of occupational health and safety hazards among all the trainees, workers and employers;

(c) Prevent, reduce, or control exposure using Personal Protective Equipment (PPE), administrative controls, or other primary prevention measures such as training or even biological measures such as immunization. This will include provision of first-aid kits as well as compensation in case of exposure to bodily harm as the case may be.

(d) Introduce and maintain effective control and evaluation measures, and

(e) Government will provide a safe working environment for workers in accordance with the provisions of the Occupational Safety and Health Act, 2006.

8.4 Human Rights in Health Education and Training

94. The policy recognises the inseparable linkages between human rights and public health and considers human rights as crucial to health policy, research, and advocacy. Thus, students are required to see health training through the lens of universal dignity, community empowerment, and social justice.

95. The policy respects the ethical responsibilities of health professions to respect human rights and

the legal implementation of human rights obligations to frame public health policy. Thus, it notes the importance of mainstreaming human rights in health education as inter alia; to develop legal competencies for human rights; to examine how human rights violations shape the lived reality of health, especially for the most marginalised persons; and to enable students to translate key human rights norms and principles into action-oriented health policies, programmes, and practices.

96. Government through this policy will in view of the above:

(a) Empower health professionals to place human rights at the centre of their work, because human rights education can facilitate a future of health with justice;

(b) Incorporate Human Rights in Health Education and health professional studies because of the linkages between health and human rights to broaden the operationalisation of human rights and engagement in human rights learning and practice;

(c) Mainstream Human Rights in Health Education through a wide range of health and human rights courses in our health training institutions and universities. These courses cover a wide breadth of topics, including courses that focus on a specific set of rights (such as sexual and reproductive rights); the health-related human rights of specific groups (including the rights of children and adolescents); the promotion and protection of health and human rights; and the intersections of human rights with related disciplines (drawing from complementary teaching on bioethics, law, and social justice);

(d) Standardise Human Rights in Health Education. On account of the increasing incorporation of human rights into health education, there is a need for standardized curricula— to harmonise the teaching materials and methods in health and human rights. The standardization will provide a unified understanding of the global norms to defend individual rights and hold Government accountable for rights realisation; and

(e) The policy will ensure that all the stakeholders' fundamental human rights are protected in line with the provisions of the Constitution of the Republic of Uganda, 1995. In addition, the policy protects the intellectual property in line with the Acts of Parliament enacted pursuant to Article 189 (1) of the Constitution of the Republic of Uganda, 1995, which when read together with the Sixth Schedule of the Constitution makes copyrights, patents, trademarks and all forms of intellectual property the responsibility of the government. Under the proviso, government has the responsibility to establish a mechanism for protecting intellectual property and hence the enactment of the intellectual property laws.

8.5 HIV/AIDS and Other Epidemic Outbreaks in Health Professions Education

97. The implementation of the Policy will ensure that pre- and in-service training for all health workers includes aspects related to safeguarding the trainees and the population against spread of HIV and AIDS and other infectious diseases.

98. Government will sustain its efforts in the prevention and control of disease outbreaks and pandemics such as Ebola and Covid-19. Guidelines, standard operating procedures shall be developed in accordance with the Public Health Act, 2022.

8.6 Governance, Leadership and Management in in Health Professions Education

99. In the implementation of this policy, Government will adhere to ethos of good governance and offer political and technical leadership at all levels. All the Government structures will be linked to the institutional set-ups of both the Ministry of Health and Education which will expeditiously

issue the standards, guidelines and procedures on desirable changes as may be necessary to support effective implementation.

8.7 Public Private Partnerships in Health Professions Education

100. In order to attract and promote health care services entrepreneurs, Government will partner with the private sector. The justification of this partnership is to take advantage of the expertise and swiftness of the private sector in education for better health outcomes. The partnership will be at all levels of implementation including construction of training facilities, support training of students, internship and clinical placements as well as other collaborations for science and innovations and upgrading among others.

8.8 Technology and Innovations in Health Professions Education

101. Although some institutions have been early and prolific adopters of technology, academic health centres, Health Professions Education (HPE) institutions, have been reluctant to change course, preferring to remain largely dependent on traditional methods requiring face-to-face, hands-on learning in the clinical setting to prepare graduates to enter the workforce.

102. The National Education and Training for Health Policy will leverage the use of technologies in Health Professional Education to better support patients, practitioners, faculty, and students. The policy:

(a) Embraces the “new normal” by carrying forward online teaching methods that have increased efficiency while maintaining or improving student engagement and learning. Blended courses that are carefully designed to optimize the benefits of online and in-person formats may offer the best of both worlds;

(b) Directs the Health Education and Training Institutions to prepare their staff, the courses, and classrooms for flexible delivery. The Health Education and Training institutions should ensure that staff members have the technology, training, and instructional design and technical support needed to develop courses that can easily pivot from in-person to online delivery;

(c) Requires the Health Education and Training Institutions to address the potential for inequities in education and health care delivery. The Health Education and Training Institutions must do more to ensure all of their students have adequate access to technology. While the increased use of telehealth and other forms of technology- has the potential to enable access to medical services for many, it may disadvantage some vulnerable people, such as the poor;

(d) Requires Government to incentivize health care providers to motivate them to find the innovative solutions that extend the reach of telehealth and community health support to vulnerable members of the population;

(e) Requires the establishment of systematic, on-going evaluation to assess and monitor new uses of technology to inform continuous improvements. Like the health system as a whole, Health Professions Education and training should continuously improve based on evidence. Quality improvement principles including small, incremental tests of change and establishing measures to assess processes and outcomes can support a continuously learning health care education;

(f) Expand the development of repositories of online resources within and across disciplines. Educators in and outside of the health professions have long recognized the value of shared online resources. Open education repositories have the potential to save faculty valuable time, allowing them to focus on facilitating learning rather than developing e-learning content.

103. The policy requires investment in Health Information Technology (HIT) leadership, training and development of the existing workforce, and students as well as the creation of new roles such as data scientists and clinical informaticists in Health Professions Education to increase efficiency in operations and increase the coverage through digitalisation.

9.0 POLICY IMPLEMENTATION ARRANGEMENTS

9.1 Conditions for Successful Implementation of Education and Training for Health Policy

104. Public policies aim to achieve clearly stated objectives. Policy makers should pay as much attention to implementation as to policy formulation.

105. Policies frequently fail if responsibility is shared among too many players. This is important considering that the implementation of the Education and Training for Health Policy will be multisectoral and multi-stakeholder involving a wide range of institutions, bodies and other actors. This is because where many Ministries, Departments and Agencies (MDAs) are involved; the complexity of coordination may overwhelm the original policy intent. Therefore, in view of this, it is necessary that this policy is implemented by just few MDAs. For the other actors, it is recommended that their needs and demands should be recognised and factored into the implementation architecture by the lead MDAs.

106. The Ministry of Education and Sports (MoES) and the Ministry of Health have the primary responsibility and accountability for successful implementation of this policy. The two Ministries will coordinate and collaborate with the various stakeholders to ensure the successful implementation of the Education and Training for Health Policy. The policy will be implemented through a programme approach under the Human Capital Development Programme, involving the actors in: other MDAs; the private sector; civil society; development partners; the academia and relevant research institutions among others.

107. A clear chain of accountability. One Agency must have the responsibility for the success of this policy and a capacity to intervene when implementation runs into difficulties supported by other MDAs. However, this should be preceded by ample time and adequate preparation and planning of approximately between 12- 14 months.

108. Selection of relevant policy instruments to dictate the mode of implementation. The policy instruments can either be from the coercive or non-coercive categories of implementation instruments. Since there are many instruments open to Government to ensure effective and successful implementation, it is essential that the key policy instruments are identified early in the planning process of implementation.

109. Acknowledge the political dimension to implementation. This policy will be implemented under the Human Capital Development Programme of NDP III. Implementation will be guided by the 5-year Education and Training for Health Implementation Plan for FY 2022/24- 2028/29 which has been developed and aligned to NDP III and NDP IV.

9.2 Roles and Responsibilities of the Key Stakeholders

110. The respective roles and responsibilities of the various stakeholders in the implementation of this Policy are as follows:

9.2.1 Ministry of Education and Sports

(a) The Ministry of Education and Sports together with the Ministry of Health will provide the overall regulation and guidance on this policy's implementation;

(b) The Ministry of Education and Sports will provide the technical support, regulation and promotion of quality professional education and training for health in the country;

(c) The Ministry of Education and Sports will promote professionalism beyond education and training for national integration into other sectoral development, personal development and transformation;

(d) The Ministry of Education will set the standards for curricula, implementation and enforcement of the minimum standards as well quality assurance for education and training for health;

(e) The Ministry of Education and Sports will engage the education development partners in key aspects like resource mobilisation and budgeting, strategic planning, regulation; advise other ministries on matters related to education and training for Health; and

(f) The Ministry of Education and Sports will develop a Management Information System (MIS) with an interface through which other systems within the Ministry of Education and the rest of the Government can be integrated to facilitate smooth knowledge and information sharing.

9.2.2 Ministry of Health

(a) The Ministry of Health together with the Ministry of Education and Sports provide overall regulation and guidance on the provision of education and training for health services

(b) The Ministry of Health will dialogue with the Development Partners in key aspects like resource mobilisation and budgeting, strategic planning, regulation, advising other MDAs on provision of education and training for health services;

(c) The Ministry of Health will be responsible for the overall Management of the Medical Internship Programme; and

(d) The Ministry of Health will support capacity building including the provision of critical training equipment.

9.2.3 The Ministry of Public Service

(a) The Ministry of Public Service will support systems that formalize the profession of education and training for health;

(b) The Ministry of Public Service will provide, sustain, manage, and oversee the systems, structures and procedures for education and training for health with the service;

(c) The Ministry of Public Service will regulate the human resource within the training institutions responsible for education and training for health; and

(d) The Ministry of Public Service will provide structures to accommodate adequate and relevant workforces for education and training for health respectively.

9.2.4 Ministry of Finance, Planning and Economic Development

(a) The Ministry of Finance, Planning and Economic Development will support mobilisation of

resources to finance education and training for health policy implementation;

(b) The Ministry of Finance, Planning and Economic Development may undertake value for money audits for the investments due to this policy during the implementation process to advance the policy aspirations; and

(c) The Ministry of Finance, Planning and Economic Development will ensure the efficient allocation of the funds and accountability for such resources to achieve the policy outcomes

9.2.5 Ministry of Gender, Labour and Social Development

(a) Promote expansion of social protection and equity in service provision (including persons with disabilities).

(b) Promote skills development and labour productivity while promoting gender equality in both education and at the workplace settings.

(c) Avail standard messages pertaining to social protection of vulnerable groups, equal opportunities and Gender Mainstreaming for inclusion in the education and training content for health workers.

(d) Provide standard OSH guidelines for adoption by training institutions on one side and for inclusion in the education and training content for health workers and shall conduct inspection of workplaces from time to time to ensure adherence to OSH standards.

(e) Support dissemination of Guidelines for Regulation of Local/Traditional/Herbal Medicines for human and veterinary use and contribute to its revision from time to time during policy implementation.

(f) Avail standard messages pertaining to needs of special interest groups for inclusion in the education and training content for health workers to support mainstreaming during training, internship and practice.

(g) Avail the principles of labour productivity and industrial relations for inclusion in the education and training content for health workers.

(h) Mobilise and empower parents, households and communities to support/interest children to appreciate and undertake courses in Health Sector to increase numbers.

9.2.6 The National Planning Authority

(a) The National Planning Authority will ensure the mainstreaming of education and training for health into the National planning frameworks and processes; and

(b) The National Planning Authority will facilitate the workings of the Human Capital Development Programme to report on education and training for health and address any emerging policy challenges from the national planning perspective (including through thematic evaluations).

9.2.7 Uganda Bureau of Statistics

(a) The Uganda Bureau of Statistics (UBOS) will promote the principles of good science and sound statistical thinking and reasoning relevant to health professionals discipline variants. It will advise on graduate or health sciences statistics education, and alignment with the modern-day focus across disciplines in education and training for health.

(b) The Uganda Bureau of Statistics (UBOS) will jointly work with the Ministry of Education and Sports and the Ministry of Health to collect and disseminate statistics on education and training for health.

9.2.8 Development Partners and Non-State Actors

(a) The Development Partners and other Non-State Actors will mobilise financial resources to support the implementation of the policy provisions; and

(b) The Development Partners and other Non-State Actors will upon request Provide technical assistance during the policy implementation process.

9.2.9 Local Governments/Authorities/Municipalities

(a) The Local Governments, Authorities, or Municipalities will ensure their education department is supported to contribute to oversight roles at the places where installations and institutions are located for education and training for health are secure;

(b) The Local Governments, Authorities, or Municipalities will ensure strong linkages and partnerships with other government programmes in the Local Government, Authority, or Municipality;

(c) The Local Governments, Authorities, or Municipalities will involve stakeholders in community discussions and decision-making processes relating to education and training for health; and

(d) The Local Governments, Authorities, or Municipalities will organize activities and events, dialogues, festivals, awards, elders meeting, clan leaders, cultural compilations to promote objectives of this education and training for health policy.

9.2.10 Civil Society Organizations (CSOs, NGOs, CBOs, and FBOs):

(a) Civil Society Organisations (CSOs) will comply with the standards and regulations set under this policy;

(b) CSOs will ensure quality and quantity in the products and services produced;
(c) Civil Society Organisations will take advantage of the funding opportunities for the implementation of interventions that advance the objectives of this policy;

(d) CSOs will advocate for professionalism in education and training for health at all levels; and

(e) Civil Society Organisations will; carry out research, develop an inventory, and make clear documentation on education and training for health for posterity.

9.2.11 The Private Sector

(a) The Partner sector will work with government to ensure efficiency in education and training for health professional development; and

(b) The Partner sector will support, participate in training and research, and share best practices in the various aspects of the education and training for health professionals.

9.3 Coordination Mechanisms for Policy Implementation

111. The Ministry of Education and Sports will take the lead and coordinate all stakeholders outlined under paragraph 8.2 above in respect to; strategy formulation, review and implementation of

actionable plans, strategies, regulations and enforcement of laws and regulations in respect to education and training for health.

112. The policy coordination structure will be as follows:

(a) The Minister will establish a National Inter-Ministerial Committee to provide guidance and leadership on Health Training. At the Human Capital Development Programme level, the Minister will strengthen a Technical Working Group composed of technical officers from the relevant Ministries, Departments and Agencies, Development Partners and representatives of Civil Society Organisations.

(b) The policy coordination structure should be decentralised to bring on board the various institutions across the country in accordance with the Local Governments Act, 1997.

(c) The policy coordination structure will work hand-in hand with the relevant regulators, Professional Councils, Uganda Health Professions Assessment Board and other Health Professional Associations in the private sector, the academia and research organisations.

(d) The Diploma Awarding Health Training Institutions will be regulated by the body responsible for TVET while the Degree Awarding Health Training Institutions will be regulated by the body responsible for Higher Education.

113. The policy coordination structure established in paragraphs above will:

(a) Coordinate and strengthen partnerships and collaboration amongst the different state and non-state actors to ensure they are in line with Government commitments under NDP III Human Capital Development Programme;

(b) Conduct performance assessment and reviews of activities implemented to realize the strategic objectives of the education and training for health policy;

(c) Identify, discuss and make decisions on actions that need to be implemented to respond to needs, issues or challenges that may arise during policy implementation;

(d) Mobilize resources to ensure implementation of this policy;

(e) Guide Public Private Partnerships to enhance health professional's development.

(f) Work with Private Sector, Non-State Actors, researchers, and the media.

(g) Report against the requirements of the Government Annual Performance Report, Sector Reviews and Budget performance reports as well as the Auditor General Report on performance. Aspects of this policy implementation will be part of annual sector reviews.

10.0 FINANCING ARRANGEMENTS

114. Whereas there are financial barriers due to many funding requirements and political priorities, Government must develop innovative ways to finance education and training for health programmes. This implies that government must develop a sustainable funding strategy with funds targeting the priority skills in education and training for health and the country's most critical development needs. This is important because if Government machinery does not enable the translation of policy decisions into action, even the best-designed policy will fail.

115. Notwithstanding the vast resource requirements required for implementation, Government will, put in place budgetary arrangements and mechanisms to mobilise resources to meet the requisite financing needs for the implementation of this policy.

116. Government will pursue several resources mobilisation measures to complement the national budget resource allocation to various stakeholders for the implementing various aspects of the policy. These measures will include mobilisation of technical and financial assistance from development partners and international and domestic financing agencies and institutions.

117. Education and Training for Health Policy will be financed using the following measures:

(a) Funds appropriated from the consolidated fund on an annual basis to fund expenditure by the government through the stakeholders implementing the education and training for health policy;

(b) Leveraging private equity funds (for instance those that support public private partnerships);

(c) Domestic revenue mobilisation including collection of Non-Tax Revenue; as well as

(d) Overseas Development Aid (ODA) which includes all official development assistance provided by foreign official agencies that can be classified as concessional, irrespective of whether the assistance is provided in the form of grants or soft loans. ODA includes everything from grants, concessional loans, debt relief, humanitarian aid, development research, and administration costs within donor countries.

118. In the implementation of education and training for health policy, the private entities are encouraged to collaborate through business partnerships and other entrepreneurial relationships with the private sector to support the common goal of developing a more diverse health-care workforce for the country.

11.0 POLICY MONITORING, REVIEW AND EVALUATION

119. Policy monitoring refers to the process of detecting how the policy is doing. To monitor a policy, some data about the policy must be obtained. A good implementation plan will suggest some ways in which on-going data about the policy can be generated in the regular course of policy maintenance, for example, from records, documents, feedback from clients, diary entries of staff, ratings by peers, tests, observation, and physical evidence.

120. Policy monitoring and evaluation will: (a) support policy making and strategic planning by improving the links between the policy interventions and their outcomes and impact; (b) enhance accountability and provide legitimacy for the use of public resources; and (c) it will promote learning and enhance policies' efficiency and effectiveness.

121. This policy will be implemented through a programme approach under the Human Capital Development Programme as stated in the National Development Plan. An implementation strategy for this policy has been developed with a clear Monitoring and Evaluation framework detailing the proposed policy outputs, outcomes as well as key performance/results indicators (KPIs). This will be used in the performance appraisal of activities, assessment, evaluation, and reporting on the policy implementation performance.

122. In support of a robust policy monitoring and evaluation system, Government will focus on

three main pillars: (i) Building an institutional framework by putting in place the right policy and organisational measures to support the performance of this policy; (ii) Promoting the use of evidence and policy monitoring and evaluation, by investing in policy making processes and supporting stakeholder engagement; and (iii) Promoting the quality of policy monitoring and evaluation, for instance through developing standards and guidelines, investing in capacity building, and ex post review and control mechanisms.

123. Data from policy monitoring will be recorded as part of the Education for Health Management Information System to ease (by automation) the periodically analysis, performance reporting and communication of the results to all stakeholders.

124. All the Ministries Departments and Agencies, Local Governments and the Non-State Actors and stakeholders with a role in the implementation of this policy, will be required to conduct their own monitoring and report on their complementary interventions under this policy.

12.0 POLICY COMMUNICATION ARRANGEMENTS

125. Effective policy communication is not just about the strength or quality of arguments. Effective communication requires the suppliers of evidence to see the world from the perspective of their audience and understand the policy process in which they engage. In communicating public policy changes it is important to be transparent and honest. This means; providing accurate and relevant information, explaining the rationale and benefits of policy changes, acknowledging the challenges and uncertainties, and avoiding jargon and spin. Being transparent and honest builds trust and credibility and reduces confusion and anxiety.

126. Government will in line with its National Communication Strategy of 2011, ensure that this policy is understood and supported by stakeholders at all levels. The strategy emphasises that policy and Communication should be integrated; communication should be built into policy formulation, analysis and implementation and not merely added as an afterthought.

127. Government will ensure that all concerned parties are adequately informed of the policy' s vision, mission, strategic objectives, and its desired outcomes. The policy will be published and widely disseminated to all stakeholders. The Ministries in charge of Health and Education will communicate this policy through sustained dialogue and events such as: talk shows, use of mass media (Frequency Modulation (FM) Radios and Television stations), advertorials and pin-up posters, and national newspapers, bulletins and journals, as well as social media platforms.

128. Government will support the staff at the national and district levels and the Non-State Actors to popularise this policy through conferences and workshops, to provide information and obtain feedback from the beneficiaries on the policy performance.

129. Government will through partnerships with various stakeholders at all levels support knowledge exchanges for sharing both traditional knowledge and international best practices so as to inspire innovations and new developments that advance human capital development through education and training for health professions. Accordingly, both Global and Regional best practices in professional education and training for health and other forms of capacity building will be communicated to provide learning points and references to inspire continuous reform.

The Repulic of Uganda

MINISTRY OF EDUCATION AND SPORTS

THE NATIONAL EDUCATION AND TRAINING FOR HEALTH POLICY

IMPLEMENTATION STANDARDS

2026

FOREWARD

The Government of Uganda recognises that a competent, ethical, and well-trained health workforce is indispensable to effective health service delivery, patient safety, and national development.

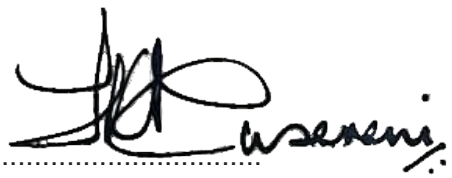
Education and training for health therefore constitute a shared national responsibility spanning the education and health sectors, and require coherent policy direction, strong regulation, and close coordination between institutions and stakeholders.

The National Education and Training for Health Policy, 2025 was adopted by Cabinet to provide a unified national framework for the development of health professionals across the education and training of health professionals continuum including internship and fellowship. The Policy responds to long-standing systemic challenges in the sector, including fragmented regulatory mandates, uneven training quality, weak linkage and coordination between education and service delivery, and misalignment between training outputs and national health system and workforce needs.

These Policy Implementation Standards are jointly issued by the Minister responsible for Education and the Minister responsible for Health to operationalise the National Education and Training for Health Policy, 2025. The Standards prescribe binding minimum requirements governing institutions, programmes, trainers, clinical training sites, governance arrangements, quality assurance mechanisms, financing, and accountability across all pathways of education and training for health, in both public and private sectors. The Standards translate policy intent into enforceable obligations applicable to all public and private entities involved in education and training for health.

The Standards establish a harmonised regulatory framework that clarifies the complementary roles of the Ministry responsible for Education, the Ministry responsible for Health, the Technical and Vocational Education and Training Council, the National Council for Higher Education, and the various Professional Councils. They are anchored in the Uganda Qualifications Framework, aligned with the International Standard Classification of Education 2011, and informed by relevant World Health Organisation guidance and other health international bodies, thereby ensuring coherence between academic quality assurance, occupational competence, professional regulation, and patient safety.

All institutions, training hospitals, internship centres, Professional Councils, and other stakeholders involved in education and training for health are required to comply fully with these Standards. Their effective implementation is essential to safeguarding quality, equity, and accountability in health education and training, and to producing a skilled, practice-ready health workforce capable of meeting Uganda's present and future health needs.



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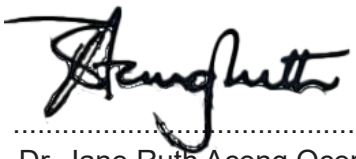
Janet K. Museveni
First Lady and Minister of Education and Sports



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Dr. Jane Ruth Aceng Ocero
Hon. Minister of Health

APPROVAL AND ADOPTION

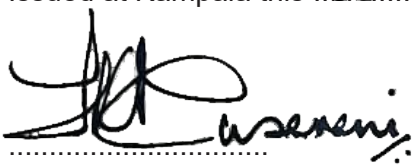
These Implementation Standards are issued pursuant to the National Education and Training for Health Policy, 2025, and are hereby approved and adopted by the Government of the Republic of Uganda for the purpose of operationalising education and training for health across all public and private institutions.

These Standards are issued under the joint authority of the Ministry of Education and Sports and, the Ministry of Health with the approval of Cabinet, and shall be binding on all institutions, authorities, bodies, and persons involved in education and training for health in Uganda.

Cabinet Minute No.: 328(CT2025) — Date of Cabinet Approval: 06th October 2025

MINISTERIAL SIGNING AND ISSUANCE

Issued at Kampala this ..26th.... day of .....Feb..... 2026.



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Janet K. Museveni
First Lady and Minister of Education and Sports

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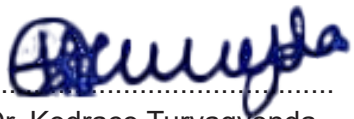
Dr. Jane Ruth Aceng Ocero
Hon. Minister of Health

Acknowledged by:



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Dr. Kedrace Turyagyenda
Permanent Secretary,Ministry of Education and Sports

.....
Dr. Diana Atwine
Permanent Secretary, Ministry of Health

List of Acronyms

CPD: Continuous Professional Development

ETH: Education and Training for Health

HTI: Health Training Institution

HTIs: Health Training Institutions

IPC: Infection Prevention and Control

IQA: Internal Quality Assurance

ISCED: International Standard Classification of Education

KCCA: Kampala Capital City Authority

MER: Monitoring Evaluation and Reporting

MoES: Ministry of Education and Sports

MoH: Ministry of Health

NCHE: National Council for Higher Education

NETH: National Education and Training for Health

OSCE: Objective Structured Clinical Examination

PPE: Personal Protective Equipment

PPPs: Public-Private Partnerships

SHO: Senior House Officer

TVET: Technical and Vocational Education and Training

UHEQF: Uganda Higher Education Qualifications Framework

UQF: Uganda Qualifications Framework

WHO: World Health Organization

S.1 Introduction

S1.1 These Standards provide binding operational requirements for the implementation of the National Education and Training for Health (NETH) Policy, 2025.

S1.2 The Standards shall apply to all public and private Health Training Institutions (HTIs); universities, colleges, training hospitals, clinical placement sites, professional councils, assessment bodies, and any other entity involved in health education and training.

S1.3 These Standards shall be read together with:

(a) The National Education and Training for Health Policy, 2025;

(b) The Technical and Vocational Education and Training (TVET) Policy, 2019;

(c) The Technical and Vocational Education and Training (TVET), Act, No.3 of 2025;

(d) The Universities and Other Tertiary Institutions Act, Cap. 262;

(e) Relevant Professional Councils Acts: The Medical and Dental Practitioners Act, Cap. 300; The Nurses and Midwives Act, Cap. 301; The Allied Health Professionals Act, Cap 296; The Traditional and Complementary Medicine Act, Cap. 304, and The Pharmacy and Drugs Act, Cap. 309

(f) The TVET qualifications and quality assurance frameworks and

(g) The Uganda Higher Education Qualifications Framework (UHEQF).

(h) The Uganda Qualifications Framework (UQF).

S2 Legal Standards

S.2.1 All Education and Training for Health activities shall be conducted within a harmonised legal and regulatory framework, avoiding duplication of mandates among: Ministry of Education and Sports (MoES); Ministry of Health (MoH); The TVET Council; The National Council for Higher Education (NCHE); Health Professional Councils; and Assessment boards.

S.2.2 Conditions for Offering Health Training Programmes:

(a) No institution shall offer health education or training programmes unless it satisfies all three complementary regulatory requirements, is explicitly aligned with the; Uganda Qualifications Framework (UQF), International Standard Classification of Education (ISCED 2011), and Uganda's health professional regulatory regime.

(b) Together safeguard legality, quality, and professional relevance within the national health workforce ecosystem.

S2.2.1 Licensing by the Appropriate Authority – Institutional Legality and Capacity:

(a) Licensing constitutes the foundational legal authorisation to operate as an education or training

provider in Uganda. It confirms that an institution meets minimum statutory requirements relating to governance, physical infrastructure, staffing, safety, and institutional capacity, as prescribed by the relevant law. Licensing establishes the institution's lawful existence and eligibility to seek programme-level accreditation but does not, in itself, confer authority to offer specific health training programmes.

(b) Under the Uganda Qualifications Framework (UQF), licensing is a prerequisite for participation in the national qualifications system and ensures that only legally established institutions may deliver programmes mapped to recognised qualification levels. This aligns with ISCED 2011, which presupposes that education and training provision occurs within formally recognised and regulated institutions.

S2.2.2 Accreditation by the TVET Council, NCHE, or Both (as Applicable):

(a) Accreditation is the primary quality assurance mechanism for health training programmes and shall be undertaken by the regulator whose mandate corresponds to the qualification level and educational orientation of the programme, consistent with the UQF–ISCED 2011 alignment.

(i) The TVET Council shall accredit health programmes mapped to UQF Levels 3–6, corresponding to ISCED Levels 3–5, including certificate, craft, technician, and diploma qualifications oriented toward occupational competence and applied clinical skills.

(ii) The National Council for Higher Education (NCHE) shall shall accredit health programmes mapped to UQF Levels 7–10, corresponding to ISCED Levels 6–8, including bachelor's, postgraduate diploma, master's, and doctoral programmes in health sciences and related professions.

(iii) Where institutions offer articulated or hybrid pathways linking TVET and higher education (e.g., diploma-to-degree progression), coordinated or dual accreditation shall apply to ensure vertical and horizontal coherence within the UQF.

(b) Accreditation assures curriculum integrity, learning outcomes, staffing adequacy, assessment standards, and alignment with national qualification levels.

S2.2.3 Recognition by Professional Council for Clinical and Practice Relevance

(a) In addition to accreditation, all health training programmes with clinical or professional practice implications shall be recognised by the relevant Professional Council established under Ugandan law, including but not limited to: Uganda Medical and Dental Practitioners Council; Uganda Nurses and Midwives Council; Allied Health Professionals Council; Pharmacy Council of Uganda and any other health professional regulatory body established by Law

(b) Such recognition confirms that the programme meets profession-specific standards for clinical competence, ethics, scope of practice, internship, and licensure. This requirement operationalises the statutory mandates of professional councils to protect public health and ensure safe practice, and determines graduates' eligibility for registration, licensing, and lawful professional practice.

(c) Professional Council recognition does not replace academic Uganda Qualifications Framework aligned to either TVET or Higher Education Qualifications Framework accreditation but functions as a practice-gatekeeping mechanism, safeguarding public health and maintaining professional standards consistent with international norms separating academic quality assurance from professional regulation.

S2.2.4 Rationale

(a) This provision establishes a coherent, three-tier regulatory architecture consistent with international and national frameworks in which: Licensing – establishes institutional legality and capacity; Accreditation (TVET Council / NCHE) – assures qualification level, quality, and alignment with UQF and ISCED 2011; and Professional Council Recognition – ensures clinical relevance, professional standards, and patient safety under the health laws.

(b) This tripartite approach together, prevents; unregulated provision, eliminates regulatory overlap, eliminates unqualified providers, eliminates duplication of mandates, protects learners and patients, and ensures that health training institutions contribute effectively to national health system and workforce needs while remaining aligned with global education and qualification standards.

S.2.3 Alignment of Health Education and Training Qualifications

(a) All health education and training qualifications shall be designed, delivered, assessed, and awarded in full alignment with the; Technical and Vocational Education and Training (TVET) qualifications framework, Higher Education qualifications framework, Uganda Qualifications Framework (UQF), and recognised international standards, to ensure coherence, quality, portability, and professional relevance across the health workforce continuum.

(i) Alignment with TVET Qualifications: Health training qualifications offered at, technician (certificate and diploma) levels shall conform to the TVET qualifications framework, including approved occupational standards, competency-based curricula, assessment and certification systems, and progression pathways. Such qualifications shall be mapped to the relevant UQF levels and corresponding ISCED 2011 levels, ensuring that TVET health graduates acquire measurable occupational competencies, clinical skills, and employability outcomes, while retaining opportunities for articulation into higher education.

(ii) Alignment with Higher Education Qualifications: All health education and training qualifications offered by universities and degree-awarding institutions shall comply with the higher education qualifications framework as regulated by the National Council for Higher Education. This includes alignment with nationally approved qualification descriptors for undergraduate and postgraduate awards, defined learning outcomes, credit systems, research and practicum requirements, and quality assurance standards. All higher education health qualifications shall be mapped to appropriate UQF levels and ISCED 2011 classifications, ensuring national consistency and international comparability.

(iii) Alignment with the Uganda Qualifications Framework (UQF): The UQF shall serve as the integrating and harmonising framework for all health education and training qualifications, regardless of provider or pathway. All TVET and higher education health qualifications shall be levelled, classified, and quality-assured within the UQF to enable: (a) clear progression and articulation between TVET and higher education pathways; (b) recognition of prior learning and credit transfer; (c) comparability of qualifications across institutions and subsectors; and; (d) coherence with labour market and health workforce planning needs.

(iv) Alignment with Recognised International Standards: Health education and training qualifications shall be benchmarked against recognised international standards and classification systems, including ISCED 2011, relevant World Health Organization (WHO) guidelines, and internationally accepted professional education norms applicable to specific health disciplines. This alignment supports cross-border recognition, regional and global mobility of health professionals, international benchmarking of curricula and competencies, and Uganda's participation in regional and global health labour markets.

(b) Rationale: This integrated alignment framework ensures that health education and training

qualifications in Uganda are internally coherent, nationally standardised, and internationally credible. It prevents fragmentation between TVET and higher education, strengthens articulation pathways, safeguards quality and patient safety, and ensures that graduates possess qualifications that are recognised for employment, further education, and professional practice both nationally and internationally.

S3 Institutional Standards

S3.1 Classification of Health Training Institutions (HTIs)

(a) Health Training Institutions (HTIs) shall be formally classified into the following categories to ensure clear institutional mandates, appropriate regulatory oversight, and alignment of training functions with national health workforce needs. This classification recognises the differentiated roles of institutions across the education, training, and professional practice continuum. HTIs shall be formally classified as: Universities and University Constituent Colleges; Tertiary Health Training Institutions; Specialised Health Institutes and Fellowship Training; and Internship Centres.

(i) Universities and University Constituent Colleges:

(1) Universities and University Constituent Colleges shall comprise degree-awarding institutions legally established and regulated under the higher education framework. These institutions shall be authorised to offer undergraduate and postgraduate health sciences and professional degree programmes, including medicine, dentistry, pharmacy, nursing, public health, biomedical sciences, and allied disciplines.

(2) Their core mandate shall include advanced academic instruction, research, innovation, and specialised clinical training, with programmes accredited by the National Council for Higher Education and recognised by the relevant Professional Councils for professional practice. Universities shall operate within the Uganda Qualifications Framework at UQF Levels 7–10 (ISCED Levels 6–8) and shall serve as primary centres for health research, specialist training, and academic leadership in the health sector.

(ii) Tertiary Health Training Institutions

(1) Tertiary Health Training Institutions shall include non-university institutions that provide certificate, diploma, and other sub-degree health training programmes aimed at producing mid-level health workers and technicians. These institutions shall operate under the TVET framework or other applicable tertiary education laws and shall deliver competency-based and practice-oriented training aligned to national occupational and health service standards.

(2) Such institutions shall be accredited by the TVET Council or other designated authority, mapped to UQF Levels 3 – 6 (ISCED Levels 3–5), and recognised by the relevant Professional Councils where programmes have clinical or practice implications. Tertiary HTIs shall play a critical role in expanding access, strengthening service delivery capacity, and supporting regional and community health systems.

(iii) Specialised Health Institutes and Fellowship Training Centres

(1) Specialised Health Institutes and Fellowship Training Centres shall include institutions or units, whether stand-alone or affiliated to universities, teaching hospitals, or national referral facilities, that provide advanced specialist, sub-specialist, and fellowship-level training in defined health

disciplines.

(2) These institutions shall focus on high-level clinical competence, research-informed practice, and advanced professional development, often beyond initial degree qualifications. Fellowship and specialist training shall be governed by standards set by the relevant Professional Councils, specialist colleges, or statutory bodies, in collaboration with NCHE where academic awards are involved. Such training shall be aligned to upper UQF Levels 8–9 and relevant international specialist training benchmarks.

(iv) Internship Centres

(1) Internship Centres shall comprise accredited health facilities authorised to provide structured, supervised pre-qualification practical training required for professional registration and licensure. These centres shall not award academic qualifications but shall serve as mandatory practice settings for students of health training programmes and graduates of health training programmes.

(2) Internship Centres shall be approved by the Ministry responsible for health in collaboration with the relevant Professional Councils and Uganda Pharmacy Board shall meet prescribed standards for clinical exposure, supervision, case mix, and learning support. Their role is to consolidate clinical competence, professional ethics, and readiness for independent practice in accordance with national health laws and standards.

(b) Regulatory Rationale: This formal classification establishes a differentiated and coherent health training ecosystem, clarifying institutional roles across academic education, technical training, specialist development, and clinical practice. It supports effective regulation, avoids mandate overlap, enhances quality assurance, and ensures that each category of HTI contributes optimally to national health workforce development, patient safety, and health system performance.

S3.2 Institutional Requirements for Health Training Institutions (HTIs)

(a) Each Health Training Institution (HTI) shall meet the following minimum institutional requirements to ensure legal compliance, effective governance, quality education and training, and safe clinical practice, in line with national education, health, and environmental standards.

(i) Defined Legal Status: Each HTI shall possess a clearly defined legal status established under the relevant laws of Uganda. HTIs shall operate as: Public Institutions, Private Not-For-Profit entities, or Private For-Profit Institutions. The legal status shall be evidenced through lawful incorporation or establishment instruments and shall determine the institution's ownership structure, accountability arrangements, regulatory obligations, and eligibility for public funding or partnerships. Clear legal status ensures institutional legitimacy, regulatory oversight, and enforceable responsibility for academic and clinical outcomes.

(ii) Approved Institutional Mandate: Each HTI shall operate within an approved institutional mandate that specifies its scope of training, qualification levels, professional focus, and target health workforce outcomes. The mandate shall be consistent with the institution's legal status, its licensing and accreditation approvals, and national health and education priorities. Institutions shall not offer programmes or engage in activities outside their approved mandate, thereby safeguarding system differentiation, quality assurance, and alignment with national health workforce planning.

(iii) Functional Governance and Management Organs: Each HTI shall establish and maintain functional governance and management organs appropriate to its category and legal status. These shall include a governing council or board with defined fiduciary and policy oversight responsibilities, an academic governing body responsible for academic standards and quality

assurance, and an executive management structure responsible for day-to-day administration. Clear separation of governance and management functions shall be maintained to ensure accountability, transparency, academic integrity, and effective decision-making.

(iv) Adequate Academic, Clinical, Administrative, and Co-curricular Infrastructure:

(1) Each HTI shall maintain adequate and fit-for-purpose infrastructure to support its approved mandate and programmes. This shall include: (i) academic facilities such as lecture rooms, laboratories, libraries, skills laboratories, and digital learning systems; (ii) clinical training facilities or formalised access to accredited health facilities for practicum and internship; (iii) administrative facilities to support governance, student services, records management, and quality assurance; and (iv) appropriate co-curricular, recreational, and sports facilities to support student welfare, holistic development, and well-being.

(2) Infrastructure adequacy shall be assessed relative to student numbers, programme requirements, and applicable accreditation standards.

(v) Structures for Managing Biomedical Materials and Medical Waste: Each HTI shall establish clear and functional structures for the safe management of biomedical materials and medical waste generated through training, laboratory work, and clinical practice. These structures shall comply with applicable health, safety, and environmental laws and guidelines and shall include policies, trained personnel, designated facilities, and partnerships with licensed waste management service providers where necessary. Effective biomedical waste management is essential to protect students, staff, patients, the public, and the environment, and constitutes a core component of institutional quality and regulatory compliance.

(b) Rationale: The institutional requirements provide a minimum governance and operational baseline for all Health Training Institutions. They ensure that HTIs are legally established, purpose-driven, well-governed, adequately resourced, and compliant with public health and environmental safety standards. Collectively, they strengthen quality assurance, protect learners and patients, and support a credible, accountable, and sustainable health training system.

S3.3 Compliance with Approved Scope, Level, and Cadre Authorisation

S3.3.1 No institution shall operate, offer programmes, or enroll learners outside its approved scope, qualification level, or authorised professional cadre, as determined by its licensing, accreditation, and professional recognition approvals.

S3.3.2 Meaning and Application

(a) Approved scope refers to the specific fields or disciplines of health education and training an institution is authorised to deliver, as defined in its institutional mandate and regulatory approvals.

(b) Approved level refers to the qualification levels—whether certificate, diploma, degree, or postgraduate — mapped to the Uganda Qualifications Framework and corresponding international classifications, for which the institution is accredited.

(c) Authorised cadre refers to the specific health professional categories or occupational roles for which the institution is permitted to train learners, as recognised by the relevant Professional Councils.

S3.3.3 Institutions shall not introduce new programmes, upgrade qualification levels, expand into additional cadres, or alter programme orientation without prior approval from the competent regulatory authorities.

S3.3.4 Regulatory Oversight and Enforcement:

(a) Operating outside approved authorisation constitutes a material regulatory breach and undermines quality assurance, professional standards, and patient safety. Regulators shall enforce this provision through routine inspections, accreditation reviews, and sanctions, which may include suspension of programmes, withdrawal of accreditation, nullification of qualifications awarded, or other remedies provided by law.

(b) Policy Rationale: This provision safeguards system differentiation, prevents mandate creep, protects learners from unrecognised qualifications, and ensures that health training provision remains aligned with national health workforce planning, professional standards, and public interest considerations.

S3.3.5 Enforcement for Non-Compliance with Approved Scope, Level, or Cadre

(a) Prohibition and Offence

(i) An institution that offers health education or training programmes outside its approved scope, qualification level, or authorised cadre commits a regulatory offence.

(ii) Any programme, enrolment, assessment, or award made in contravention of this provision shall be unlawful and void for regulatory and professional recognition purposes.

(b) Regulatory Powers of Enforcement Authorities

(i) The relevant regulatory authorities, including the TVET Council, the National Council for Higher Education (NCHE), and the applicable Professional Councils, shall have concurrent and coordinated powers to enforce compliance within their respective mandates.

(ii) For the avoidance of doubt: accreditation authorities shall enforce compliance relating to qualification level and programme scope; and Professional Councils shall enforce compliance relating to authorised cadres and clinical practice relevance.

(c) Administrative Sanctions

Without prejudice to any other sanction provided by law, a regulatory authority may impose one or more of the following administrative measures where non-compliance is established:

(i) Written compliance directive, requiring immediate cessation of unauthorised activities and submission of a corrective action plan within a specified period;

(ii) Suspension of programme accreditation for the affected programme(s) and /or the institutional operations;

(iii) Withdrawal or cancellation of accreditation where non-compliance is persistent or deliberate;

(iv) Prohibition of student admissions into the unauthorised programme or cadre; and

(v) public notification of the institution's non-compliance status to protect the prospective learners and the public.

(d) Protection of Learners

(i) Where learners have been admitted into unauthorised programmes, the enforcing authority shall require the institution to: facilitate transfer of affected learners to properly authorised institutions or programmes; or bear the cost of remediation or re-training as may be directed by the regulator.

(ii) No learner shall be penalised for regulatory non-compliance attributable to an institution.

(e) Financial and Civil Liability

(i) An institution that knowingly operates outside its approved authorisation shall be liable to administrative fines as may be prescribed by regulations.

(ii) The institution shall bear civil liability for losses suffered by learners arising from the award of unrecognised or invalid qualifications.

(f) Criminal Liability (Where Applicable)

(i) Where unauthorised operation involves fraudulent representation, falsification of approvals, or deliberate misrepresentation to learners or the public, responsible officers of the institution may be subject to criminal prosecution under applicable laws.

(ii) Conviction under this clause shall not preclude the imposition of administrative sanctions.

(g) Right to Be Heard and Appeals

(i) No sanction shall be imposed without affording the institution due process, including written notice of the alleged breach and an opportunity to be heard.

(ii) An institution aggrieved by a decision under this section may appeal to the prescribed appellate body or court in accordance with the law.

(h) Inter-Agency Coordination

(i) Regulatory authorities shall establish information-sharing and joint inspection mechanisms to detect and prevent unauthorised programme expansion or cadre training.

(ii) Decisions affecting institutional authorisation shall be communicated to all relevant regulators to ensure regulatory coherence and enforcement consistency.

These enforcement and sanctions clauses: deter mandate creep and unauthorised programme expansion; protect learners from invalid qualifications; uphold professional standards and patient safety; reinforce differentiation between TVET, higher education, and professional regulation; and provide proportionate, legally defensible remedies consistent with principles of administrative justice.

S4 Governance and Composition of Governing Bodies of HTIs

All Health Training Institutions (HTIs) shall establish governing bodies constituted in accordance with the applicable laws and regulatory instruments, and structured to provide strategic oversight, fiduciary accountability, and academic integrity, while ensuring strong linkage between; policy, training, professional standards, and health service delivery.

S4.1 Required Representation: The governing body of each HTI shall include, at a minimum, representation from the following constituencies:

(a) Health Professions: Representation from the health professions shall include persons with recognised professional standing and experience in regulated health disciplines relevant to the institution's mandate. Such representation ensures that institutional strategy, programme development, and resource allocation are informed by current professional standards, ethical requirements, scope-of-practice considerations, and patient safety imperatives. Health professional members shall provide oversight on the clinical relevance of training and alignment with national health workforce needs.

(b) Academia: Academic representation shall include individuals with appropriate scholarly qualifications and experience in education and training for health. This representation safeguards academic standards, curriculum integrity, research quality, and assessment rigor, and ensures that the institution's academic policies, quality assurance systems, and teaching and learning practices remain consistent with national and international educational standards.

(c) Employers and Service Delivery Entities: Representation from employers and health service delivery entities shall include individuals drawn from public or private health facilities, health agencies, or related service providers. This representation strengthens the linkage between training and labour market needs, service delivery realities, and employability outcomes, and ensures that institutional decisions are responsive to evolving health system demands, technological changes, and workforce deployment priorities.

S.4.2 Governance Principles and Regulatory Rationale

(a) This multi-stakeholder composition promotes balanced, competent, and accountable governance by integrating professional expertise, academic judgment, and service delivery perspectives within institutional oversight structures. Also, it enhances policy coherence, improves training relevance, reduces skills mismatches, and strengthens public confidence in health training institutions.

(b) Governing bodies constituted in this manner support evidence-informed decision-making, protect the public interest, and ensure that HTIs remain aligned with legal mandates, professional standards, and national health priorities.

S4.3 Functions and Responsibilities of Governance Bodies in Institutions

The governance bodies of Health Training Institutions (HTIs) shall exercise strategic oversight, fiduciary responsibility, and accountability for the institution, and shall, at a minimum, perform the following functions:

(a) Approval of Institutional Strategies and Academic Plans: Governance bodies shall approve the institution's strategic plans, academic development plans, and investment priorities, ensuring that these are consistent with the institution's legal mandate, approved scope, and national

health workforce and education policies. This includes approval of new academic initiatives, programme rationalisation, infrastructure development plans, and partnerships, subject to regulatory requirements. Strategic approval ensures coherence, sustainability, and alignment with national priorities.

(b) Oversight of Quality Assurance and Regulatory Compliance: Governance bodies shall oversee the establishment and effective functioning of internal quality assurance systems, and shall ensure compliance with all applicable laws, accreditation conditions, professional council requirements, and regulatory standards. This oversight includes monitoring academic standards, assessment integrity, clinical training quality, and institutional performance against approved benchmarks. Governance bodies shall require regular reporting on quality assurance outcomes and corrective actions.

(c) Ensuring Institutional Accountability: Governance bodies shall ensure accountability for academic, financial, and administrative performance. This includes oversight of financial management, risk management, audit processes, and performance management of senior management. Governance bodies shall act in the public interest, safeguard institutional assets, and ensure transparency and responsible stewardship of resources.

(d) Oversight of Human Resource Management in Line with TVET HRM Standards: Where applicable, governance bodies shall ensure that human resource management systems of the institution comply with the TVET Human Resource Management (HRM) standards issued by the TVET Council, including standards relating to recruitment, qualifications, deployment, performance appraisal, professional development, and retention of instructors, trainers, and support staff. This function shall be exercised at the policy and oversight level and shall not extend to day-to-day operational management, which remains the responsibility of executive management.

(e) Resource Mobilisation through Training with Production: Governance bodies shall approve and oversee strategies for resource mobilisation, including income-generating activities linked to training-with-production models. Such activities shall be pedagogically sound, aligned with approved programmes, compliant with applicable laws, and structured to enhance practical training while contributing to institutional sustainability. Governance bodies shall ensure that revenues generated are transparently managed and reinvested in training quality, infrastructure, and learner support.

(f) Governance Rationale: These functions collectively ensure that governance bodies provide effective strategic direction without encroaching on management functions, uphold academic and professional standards, ensure compliance with regulatory frameworks, and promote institutional sustainability. By integrating quality assurance, HRM oversight, and responsible resource mobilisation, governance bodies strengthen the credibility, relevance, and resilience of Health Training Institutions.

S4.4 Conflict-of-Interest and Fit-and-Proper-Persons Framework

S4.4.1 Purpose and Application

(a) This framework establishes minimum standards to ensure that members of governing bodies of Health Training Institutions (HTIs) act with integrity, independence, competence, and accountability.

(b) The framework shall apply to all chairpersons, members, and co-opted members of HTI governing bodies, whether serving in a public, private not-for-profit, or private for-profit institution.

S4.4.2 Fit-and-Proper-Persons Requirements

(a) General Eligibility: A person shall be eligible for appointment to the governing body of a Health Training Institution (HTI) only if that person:

(i) possesses appropriate professional qualifications, academic standing, or sectoral experience relevant to the institution's mandate;

(ii) has demonstrable experience in governance, leadership, regulation, education, health service delivery, or public administration;

(iii) is of sound mind and good repute; and

(iv) meets the ethical and integrity standards prescribed under applicable laws.

(b) Integrity and Character: A person shall be deemed not fit and proper if that person:

(i) has been convicted of an offence involving fraud, dishonesty, corruption, abuse of office, or professional misconduct, unless such conviction has been lawfully set aside;

(ii) has been removed from office for gross misconduct or abuse of authority in a public or regulated institution;

(iii) is an undischarged bankrupt or has been declared insolvent under applicable law; or

(iv) has been sanctioned by a Professional Council or regulatory authority in a manner that materially impairs suitability for governance responsibilities.

(c) Competence and Capacity: Governing body members shall collectively possess competencies in: health professions and clinical practice; academic governance and quality assurance; finance, audit, and risk management; legal and regulatory compliance; and strategic planning and institutional oversight.

(d) Conflict-of-Interest Standards: A conflict of interest arises where a governing body member has a direct or indirect personal, professional, financial, or institutional interest that may improperly influence, or be perceived to influence, the impartial discharge of their duties.

(e) Disclosure Obligations

(i) Every member shall, upon appointment and annually thereafter, submit a written declaration of interests, including: employment or consultancy relationships; shareholding or ownership interests; board memberships or advisory roles; and any other interests that may conflict with HTI responsibilities.

(ii) Declarations shall be updated promptly upon any material change in circumstances.

(f) Management of Conflicts

(i) A member who has a conflict of interest in any matter before the governing body shall: disclose the nature of the conflict in full; recuse themselves from deliberations and decision-making on the matter; and not seek to influence the outcome, directly or indirectly.

(ii) All disclosures and recusals shall be recorded in the minutes of the governing body.

(g) Prohibited Conduct: A governing body member shall not:

(i) Use their position to obtain personal or institutional advantage;

(ii) Participate in decisions relating to contracts, recruitment, admissions, accreditation, or partnerships where they have a material interest; or

(iii) Receive gifts, inducements, or benefits that could compromise independence or integrity.

(h) Oversight, Enforcement, and Sanctions

(i) Oversight Mechanisms

(1) Each HTI shall establish a Governance and Ethics Committee responsible for monitoring compliance with this framework.

(2) Regulatory authorities may require submission of declarations of interest and may review governance practices during inspections or accreditation reviews.

(ii) Breach and Sanctions

(1) A breach of the fit-and-proper or conflict-of-interest requirements constitutes grounds for removal from office.

(2) Additional sanctions may include: written reprimand; suspension from the governing body; and referral to a Professional Council or law enforcement agency where applicable.

(3) Institutional failure to enforce this framework may attract regulatory sanctions against the HTI.

(i) Due Process and Appeals

(a) Procedural Fairness: No adverse action shall be taken against a governing body member without: (i) written notice of the alleged breach; and (ii) an opportunity to be heard in accordance with principles of natural justice.

(b) Right of Appeal: A person aggrieved by a decision under this framework may appeal to the prescribed authority or court in accordance with applicable law.

(j) Policy and Governance Rationale: This framework strengthens institutional integrity, public trust, and regulatory credibility by ensuring that HTI governing bodies are composed of competent individuals free from disabling conflicts of interest. It aligns HTI governance with best practice in public sector oversight, higher education governance, and health sector regulation, and directly supports quality training, patient safety, and accountability.

S4.5 Formal Affiliation Agreements with Training Hospitals and Placement Sites

All Training Institutions offering health education and training programmes with clinical or practicum components shall enter into formal, written affiliation agreements with accredited clinical training hospitals and approved placement sites as a condition for programme approval, accreditation, and continued operation.

S4.5.1 Purpose of Affiliation Agreements: Formal affiliation agreements shall ensure that clinical training is structured, supervised, safe, and educationally sound, and that learners acquire the practical competencies required for professional practice. Such agreements establish clear institutional responsibility, protect learners and patients, and ensure that clinical training capacity is aligned

with approved student enrolments and programme requirements.

S4.5.2 Scope of Affiliated Clinical Sites: Affiliation agreements may be entered into with national and regional referral hospitals, general hospitals, health centres, specialised clinics, private-not-for-profit facilities, private health facilities, and other approved service delivery sites, provided that such sites meet the standards prescribed by the relevant Professional Councils and the Ministry of health.

S4.5.3 Minimum Content of Affiliation Agreements: Each affiliation agreement shall, at a minimum, specify:

(a) The roles and responsibilities of the Training Institution and the clinical training site, including supervision, assessment, and learner support;

(b) The number of learners to be placed, duration of placements, and student–supervisor ratios;

(c) Arrangements for clinical supervision, mentorship, and evaluation by qualified and licensed health professionals;

(d) Provisions on patient safety, ethical practice, confidentiality, and infection prevention and control;

(e) Liability, insurance, and indemnity arrangements for learners and supervisors;

(f) Mechanisms for quality assurance, monitoring, and reporting on clinical training outcomes; and

(g) Procedures for dispute resolution, review, renewal, and termination of the agreement.

S4.5.4 Regulatory Oversight and Approval: Affiliation agreements shall be subject to review and approval by the relevant accreditation and professional regulatory authorities as part of programme accreditation and periodic quality assurance reviews. Institutions shall not place learners in clinical settings that are not formally affiliated and approved.

S4.5.5 Policy Rationale: This requirement ensures that clinical training is planned, accountable, and quality-assured, prevents ad hoc or overcrowded placements, and aligns training provision with service delivery capacity. It strengthens collaboration between training institutions and the health system, enhances learner competence, safeguards patient welfare, and supports the production of a skilled and practice-ready health workforce.

S4.5 Use of Government and Public Hospitals as Training Sites

Government and public hospitals shall serve as designated clinical training sites for public health training institutions as part of the State's obligation to support health workforce development and ensure the sustainability of the national health system.

(a) Policy Basis and Obligation: As publicly funded service delivery institutions, Government and public hospitals have a public interest mandate that extends beyond service provision to include training, mentorship, and professional development of the health workforce. The use of public hospitals as training sites shall therefore be recognised as an integral component of national health and education policy and workforce planning.

(b) Scope of Training: Public hospitals shall provide structured training opportunities for learners from public health training institutions, including universities, tertiary health training institutions, and specialised training programmes, in accordance with their approved mandates and capacity. Training shall cover clinical rotations, practicum placements, internships, and supervised

experiential learning required for qualification, registration, or licensure.

(c) Conditions and Standards: The use of Government and public hospitals as training sites shall be subject to the following conditions:

(a) The existence of formal affiliation agreements between the training institution and the hospital;

(b) adherence to standards prescribed by the relevant Professional Councils, the Ministry responsible for health, and accreditation authorities;

(c) availability of qualified and licensed personnel to provide supervision and mentorship; and

(d) safeguards for patient safety, ethical practice, infection prevention and control, and service continuity.

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S4.6 Institutional Responsibilities: Public hospitals shall designate appropriate units and supervisors for training purposes and integrate training activities into service delivery in a manner that does not compromise patient care. Training institutions shall ensure that learners are adequately prepared, insured, and supervised, and that placement numbers are consistent with the hospital's training capacity.

(a) Rationale: This provision strengthens the linkage between education and service delivery, optimises the use of public health infrastructure, and ensures that graduates are trained in real-world service environments reflective of national health system realities. It also promotes equity in access to training sites, reduces dependence on ad hoc arrangements, and supports the production of competent, practice-ready health professionals in the public interest.

(b) Designation and Oversight of Internship Centres: Internship centres shall be formally designated training facilities approved for the provision of structured, supervised post-qualification practical training, and shall be designated through a coordinated regulatory process involving the education and health authorities.

(c) Approval and Designation: Internship centres shall be designated only upon approval by the National Council for Higher Education (NCHE) and/or the TVET Council, as applicable, based on the level and type of qualification for which internship training is required. Such approval shall confirm that the centre meets the minimum standards for training capacity, supervision, case mix, infrastructure, and learning support necessary to host interns in accordance with approved curricula and qualification requirements.

(d) Supervision by the Ministry of Health: The Ministry of Health shall exercise sectoral supervision over designated internship centres to ensure that internship training is integrated within health service delivery and complies with national health policies, service standards, and patient safety requirements. This supervision shall include monitoring of clinical environments, infection prevention and control, ethical practice, and the adequacy of clinical supervision.

(e) Coordination with Professional Councils: Designation and supervision of internship centres shall be undertaken in coordination with the relevant Professional Councils, which shall define profession-specific internship requirements, supervision ratios, logbooks, assessment standards, and eligibility for registration and licensure. Professional Councils shall recognise internship centres designated under this framework for purposes of professional practice.

(f) No institution or health facility shall host interns for regulated health professions unless it has been formally designated as an internship centre under this provision. Internship training undertaken outside designated centres shall not be recognised for academic completion, professional

registration, or licensure.

(g) This framework ensures that internship training is quality-assured, safe, and professionally relevant, while avoiding fragmentation between education regulation and health service oversight. It clarifies institutional responsibilities, protects interns and patients, and strengthens accountability across the health training and service delivery continuum.

S4.7 University Responsibilities for Internship Coordination and Completion

Universities offering health education and training programmes shall formally communicate to the Ministry of Education and Sports and Ministry of Health, the details of all health trainees eligible and due for internship and shall retain institutional responsibility for the successful completion of such internship training.

(a) Notification and Coordination with the Ministry of Health: Universities shall submit timely and accurate information to the Ministry of Health on all health trainees scheduled for internship, including programme type, sponsorship type (Government or private), professional cadre, qualification level, and expected internship period. This communication shall support national internship planning, placement allocation, supervision arrangements, and workforce deployment, and shall be undertaken in accordance with timelines and formats prescribed by the Ministry of Health in consultation with relevant regulators.

(b) Institutional Responsibility for Internship Completion: Notwithstanding placement in external internship centres, universities shall remain academically and administratively responsible for ensuring that their trainees complete internship requirements as prescribed by the approved curriculum, accreditation conditions, and Professional Council standards. This responsibility shall include monitoring internship progress, verifying supervision and assessment, addressing interruptions or deficiencies, and certifying completion as a condition for award of the qualification or recommendation for professional registration.

(c) Coordination with Internship Centres and Professional Councils: Universities shall maintain active coordination with designated internship centres and relevant Professional Councils to ensure that internship training meets required standards for clinical exposure, supervision, ethics, and competence. Universities shall ensure that trainees are properly prepared, insured, and supported during internship, and that internship outcomes are documented and validated.

(d) This provision ensures continuity of academic accountability across the education–practice interface, prevents fragmentation of responsibility, and strengthens coordination between universities and the health sector. It supports effective internship planning, protects trainees and patients, and ensures that internship training contributes meaningfully to professional competence and licensure readiness.

(e) Ministry of health: The Government of Uganda through the ministry of health shall continue to support health trainees on government sponsorship in meeting their welfare and subsistence needs (accommodation, transport, and basic living expenses) during medical internship until completion.

S4.8 Parent and Guardian Responsibilities for Internship and Completion

Parents and guardians of privately sponsored health trainees shall continue to support these health trainees in meeting their reasonable personal welfare and subsistence needs (accommodation, transport, and basic living expenses) during medical internship until completion, particularly where such costs/ facilities are not fully covered by Government or institutional arrangements.

Parents and guardians of health trainees shall play a supportive and complementary role in facilitating successful internship placement and completion, in accordance with institutional requirements and national policies, without assuming functions reserved for training institutions, regulators, or the State.

(a) Scope of Responsibilities

(i) Financial and Welfare Support: Parents and guardians shall, where applicable, support trainees in meeting reasonable personal welfare and subsistence needs during internship, including accommodation, transport, and basic living expenses, particularly where such costs are not fully covered by government or institutional arrangements.

(ii) Compliance with Internship Requirements: Parents and guardians shall encourage and support trainees to comply with internship schedules, codes of conduct, ethical standards, and institutional or Professional Council requirements, and to complete internship training within the prescribed period.

(iii) Facilitation of Communication and Documentation: Parents and guardians shall support timely communication between the trainee and the training institution, including submission of required documentation related to internship commencement, continuation, deferment, or completion, where such support is reasonably required.

(iv) Support for Continuity and Completion: Where internship completion is disrupted due to illness, family circumstances, or other legitimate reasons, parents and guardians shall cooperate with training institutions and relevant authorities to facilitate lawful deferment, resumption, or completion of internship training.

(b) Limits of Responsibility: Nothing in this provision shall be construed to transfer to parents or guardians:

(i) Responsibility for placement allocation, supervision, assessment, or certification of internship training;

(ii) liability for institutional or regulatory failures; or

(iii) obligations reserved for the Ministry of Health, training institutions, internship centres, or Professional Councils.

(c) This provision recognises parents and guardians as key stakeholders in learner success while clearly delineating their role as supportive rather than regulatory or managerial. It promotes shared responsibility, learner welfare, and timely completion of internship training, without undermining institutional accountability or statutory mandates.

S4.9 Internship Management for Graduates Trained Abroad

For students who have completed health education and training programmes outside Uganda and are seeking internship placement within the country, the National Council for Higher Education (NCHE) and the relevant Professional Councils shall jointly assign such students to accredited training institutions for the purpose of managing internship training.

(a) Regulatory Basis and Joint Authority: NCHE and the relevant Professional Councils shall exercise coordinated authority to ensure that foreign qualifications are appropriately assessed, recognised, and integrated into Uganda's education and professional practice frameworks. This joint assignment function ensures that internship placement is anchored in both academic

equivalence and professional competence requirements.

(b) Assignment to Accredited Institution: Students trained abroad shall be attached to accredited and authorised local institutions—including universities, tertiary health training institutions, or designated internship centres—that are approved to supervise and manage internship training in the relevant professional cadre. The assigned institution shall assume responsibility for academic oversight, coordination with internship centres, and verification of internship completion.

(c) Scope of Institutional Responsibility: The accredited institution assigned under this provision shall:

(i) Orient the student to national internship requirements, professional standards, and ethical obligations;

(ii) ensure placement in a designated and approved internship centre;

(iii) monitor internship progress, supervision, and assessment in accordance with Professional Council standards; and

(iv) certify completion of internship requirements for purposes of registration or licensure.

(d) Safeguards and Standards: Internship assignment and management shall be conditional upon:

(i) Verification of the student's foreign qualifications and transcripts;

(ii) determination of equivalence to relevant UQF levels and professional standards; and

(iii) compliance with any additional requirements, bridging, or remedial training prescribed by NCHE or the Professional Council.

(e) This framework ensures that graduates trained abroad are fairly, consistently, and safely integrated into Uganda's health system, while safeguarding academic standards, professional competence, and patient safety. It prevents ad hoc placements, clarifies institutional accountability, and upholds public confidence in the regulation of foreign-trained health professionals.

S4.10 Senior House Officers and Fellows

S4.10.1 Senior House Officers (SHOs):

(a) Senior House Officers shall be qualified medical or health professionals who have completed initial professional training and internship and are undertaking structured post-internship clinical training as part of career progression toward specialist or advanced professional practice.

(b) Senior House Officers (SHOs) shall:

(i) Be registered and licensed by the relevant Professional Council;

(ii) Be appointed to accredited health facilities approved for postgraduate or advanced clinical training;

(iii) Provide supervised clinical services while receiving structured training, mentorship, and assessment; and

(iv) Operate under defined scopes of responsibility consistent with their level of competence and

training objectives.

(c) Senior House Officer positions shall serve as a transitional training stage, strengthening clinical competence, decision-making capacity, and readiness for specialist training, while contributing to service delivery under supervision.

S4.10.2 Fellows

(a) Fellows shall be fully qualified and registered specialists or senior professionals undertaking advanced subspecialty or fellowship training beyond primary specialist qualification. Fellowship training shall be highly structured, competency-based, and aligned with nationally and internationally recognised specialist standards.

(b) Fellowship programmes shall:

(i) Be conducted in accredited specialised health institutes, teaching hospitals, or fellowship training centres;

(ii) Be regulated by the relevant Professional Councils, specialist colleges, or statutory bodies, in collaboration with NCHE where academic awards are involved;

(iii) Focus on advanced clinical expertise, leadership, research, innovation, and specialised service delivery; and

(iv) Be aligned to higher UQF levels and relevant international professional benchmarks.

S4.10.3 Regulatory Oversight and Accountability:

(a) Senior House Officers and Fellows shall be appointed, supervised, and assessed in accordance with the:

(i) Standards set by the Ministry of Health for service delivery environments;

(ii) Training requirements and codes of practice prescribed by Professional Councils; and

(iii) The Institutional Policies of accredited training centres.

(b) Neither SHOs nor Fellows shall practice independently beyond their authorised scope, and all clinical activities shall be subject to supervision, performance review, and ethical oversight.

(c) Rationale: Formal recognition of Senior House Officers and Fellows ensures a clear and coherent postgraduate training pathway, strengthens specialist and subspecialist capacity, and supports continuity between education, training, and service delivery. It enhances quality of care, safeguards patient safety, and ensures that advanced clinical training is properly regulated, accountable, and aligned with national health system needs.

S5 Education and Training Standards

All health education and training programmes shall be designed, delivered, assessed, and reviewed in accordance with the following standards, to ensure relevance, quality, and responsiveness to national and global health needs.

S5.1Education and Training Standards for Health Programmes

(i) Education and training standards for health programmes establish the minimum requirements that govern the design, delivery, assessment, and continuous improvement of health education and training in the country. These standards ensure that all health programmes produce graduates who are competent, ethical, and fit for professional practice, while remaining responsive to national health priorities, labour market needs, and international obligations.

(ii) Anchored in the Uganda Qualifications Framework, informed by World Health Organisation (WHO) and recognised international health bodies guidance and operationalised through Professional Council competency and licensure requirements, the standards provide a coherent framework that links education to service delivery, protects public safety, and supports the development of a skilled, adaptable, and practice-ready health workforce.

S5.1.1 Competency-based

(i) All health education and training programmes shall be competency-based, with clearly defined learning outcomes that specify the knowledge, skills, attitudes, and professional behaviours required for safe and effective practice. Programmes shall emphasise demonstrable competence through practical training, clinical exposure, skills laboratories, and structured assessment, rather than time-based progression alone.

(ii) Competency standards shall be derived from national occupational standards, professional council requirements, and internationally recognised benchmarks. The Education and Training Operational Standards are aligned with — World Health Organisation (WHO) education and training guidance, Uganda Qualification Framework (UQF) learning-outcomes/level-descriptor logic, and Professional Council competency and practice-gatekeeping frameworks. Thus, all health education and training programmes shall be:

(a) Aligned with WHO standards— transformative education and quality assurance: Programmes should be organised around demonstrable competencies that improve population health outcomes and link education to health-system needs, supported by strong accreditation and regulation.

(b) Aligned with Uganda Qualification Framework (UQF) — learning outcomes + level descriptors: Competency-based design operationalises UQF's core logic: qualifications are defined by learning outcomes and differentiated by progressively higher complexity, responsibility, and autonomy at each level. This requires programmes to (a) state outcomes clearly, (b) assess outcomes validly (skills + applied competence, not theory alone), and (c) certify achievement at the appropriate UQF level and

(c) Shall be aligned with Professional Councils — entry-to-practice competence; licensure gatekeeping: Competency-based programmes are the only defensible basis for professional recognition because Professional Councils regulate standards of training and practice, and enforce internship/registration as proof of competence for licensure and safe practice (e.g., internship completion evidence for medical/dental registration; statutory nursing/midwifery regulation; allied health regulation).

S5.1.2 Labour-Market Responsive

(i) Programmes shall be responsive to labour market demands, informed by health workforce planning data, service delivery needs, and employer feedback from both public and private health sectors. Curriculum design and enrolment levels shall take into account employment trends, skills shortages, geographic distribution of health workers, and emerging roles within

the health system. This responsiveness ensures graduate employability, efficient use of training resources, and alignment with national development priorities.

(ii) Alignment with WHO — fit-for-purpose workforce; education–employment link: WHO guidance emphasises aligning education pipelines with health labour market needs to reduce mismatches between training output and service delivery realities.

(iii) Alignment with UQF alignment — qualifications as signals to employers; progression/portability: A labour-market responsive programme uses UQF descriptors to make qualifications transparent to employers, supports credit transfer/RPL, and ensures that competence claims at each level are credible for recruitment and deployment decisions.

(iv) Professional Council alignment — scope-of-practice and cadre readiness: Professional Councils' standards and licensing requirements effectively define whether graduates are practice-ready for a given cadre/scope. Labour-market responsiveness therefore requires continuous employer/service-delivery feedback into curricula, clinical placement design, and competence assessment—so graduates meet real job tasks and regulatory expectations.

S5.1.3 Comprehensive and integrated

(i) Health education and training programmes shall be comprehensive and integrated, combining theoretical instruction, practical skills development, clinical training, ethics, communication, digital health competencies, and inter-professional education. Integration shall occur across disciplines, levels of training, and service delivery contexts to promote holistic understanding of health systems and collaborative practice. Programmes shall also support articulation across TVET, higher education, and professional training pathways.

(ii) WHO alignment — interprofessional education; system-oriented training:

WHO's education guidance promotes integration across disciplines and training settings (classroom–skills lab–clinical environment), strengthening teamwork and service delivery performance.

(iii) UQF alignment — coherent outcomes across knowledge, skills, responsibility/ autonomy: "Comprehensive and integrated" means the programme's outcomes must cover UQF dimensions at the relevant level: knowledge, skills, and competence / responsibility/autonomy—including professional behaviours and ethics—assessed across integrated learning experiences.

(iv) Professional Council alignment — competence spans technical + ethical + professional conduct: Professional competence is not purely technical: councils enforce ethical practice, professionalism, supervised practice/internship, and continuing competence expectations. Integrated programmes therefore must embed ethics, patient safety, communication, and supervised clinical practice as assessable requirements—not optional add-ons.

S5.1.4 Alignment to national health priorities, disease burden and international health needs.

(i) All programmes shall be aligned with national health priorities and disease burden profiles, including prevalent communicable and non-communicable diseases, maternal and child health, mental health, and emerging public health threats. Alignment shall be informed by national health policies, strategic plans, and epidemiological data, while also reflecting international health obligations and global health standards, such as those set by the World Health Organization. This ensures that graduates are equipped to address both domestic health challenges and participate in regional and global health responses.

(ii) WHO alignment — population health needs and global health obligations:

WHO guidance explicitly frames health professional education as socially accountable and responsive to population health needs, including evolving threats and international health expectations.

(iii) UQF alignment — outcomes remain level-valid while context adapts:
Alignment to disease burden is achieved by updating curricula and clinical exposure without drifting from the UQF level descriptor (i.e., ensuring complexity, responsibility, and autonomy remain appropriate to the qualification level).

(iv) Professional Council alignment (public protection mandate): Professional Councils exist fundamentally to protect the public by regulating training and practice; therefore, programme content and clinical competencies must reflect prevailing disease patterns and patient safety risks, as a condition for recognition and practice eligibility.

S5.1.5 To make the alignment enforceable, every programme shall demonstrate:

(i) Competency Framework Mapping: programme outcomes mapped to UQF level descriptor elements and the relevant Professional Council competency/registration requirements.

(ii) Assessment Blueprint: Objective Structured Clinical Examination (OSCE)/skills assessments, workplace-based assessments, logbooks, and theory examinations aligned to the outcomes (with pass/fail competence thresholds).

(iii) Labour-market evidence pack: workforce needs analysis + employer/service-delivery feedback + placement capacity analysis informing admissions and curriculum updates.

(iv) Disease-burden alignment statement: curriculum and clinical rotation plan explicitly mapped to national priorities and major burden conditions, reviewed periodically.

S5.1.6 Objective Structured Clinical Examination

(i) The Objective Structured Clinical Examination (OSCE) / Objective Structured Practical Examination (OSPE) is a structured, standardised method of assessing clinical competence in health education and training programmes. It is designed to evaluate a learner's ability to apply knowledge, clinical skills, professional behaviours, communication, and decision-making in simulated or controlled clinical scenarios. OSCEs / OSPE consist of a series of timed stations, each focused on specific competencies such as history taking, physical examination, procedural skills, clinical reasoning, patient counselling, infection prevention, and ethical practice. Learners rotate through the stations and are assessed using predefined checklists or rating scales to ensure objectivity, reliability, and fairness.

(ii) Within health training systems, the OSCE / OSPE is recognised as a best-practice assessment tool because it aligns closely with competency-based education and professional standards. It allows institutions and regulators to verify that learners can perform essential clinical tasks safely and consistently before progression, internship, or licensure. OSCEs / OSPE are commonly used by universities, training institutions, and Professional Councils as part of summative and formative assessment, and they support patient safety by ensuring that graduates demonstrate minimum clinical competence under standardised conditions prior to

S6 Trainers, Clinical Instructors, Preceptors/Consultants' Standards

For avoidance of doubt, educator eligibility under this Standard shall be interpreted and

enforced in accordance with (i) WHO guidance on quality health workforce education and educator competence, including nurse educator core competencies and transformative education standards; (ii) the national qualifications framework approach to level descriptors (knowledge, skills, autonomy/responsibility) to ensure level-appropriate staffing; and (iii) applicable professional council licensing and CPD requirements as conditions for lawful practice, supervision, assessment, and renewal of annual practising licences.

S6.1 Qualifications, Licensing, and Professional Development of Trainers and Clinical Educators
All trainers, tutors, clinical instructors, and preceptors engaged in education and training programmes shall meet the following minimum standards, which are intended to safeguard academic integrity, professional competence, and learner protection across both academic and clinical learning environments:

S6.1.1 Recognised Academic and Professional Qualifications

All trainers, tutors, clinical instructors, and preceptors shall possess recognised academic and professional qualifications relevant to the level and field of training they deliver. Academic qualifications shall be aligned with the Uganda National Qualifications Framework (UNQF) and internationally recognised standards, ensuring subject-matter mastery and appropriate depth of theoretical knowledge. Professional qualifications shall demonstrate competence in the relevant occupation or discipline, thereby ensuring that teaching and supervision are grounded in current professional practice and industry standards.

S6.1.2 Valid Practising Licence from the Relevant Professional Body

Where applicable, all trainers, tutors, clinical instructors, and preceptors shall hold a valid and current practising licence issued by the relevant statutory professional body. Licensing confirms legal authorisation to practise, adherence to professional codes of conduct, and accountability to regulatory oversight mechanisms. This requirement ensures that learners are trained and supervised by professionals who are in good standing and whose practice reflects current ethical, safety, and competency standards of the profession.

S6.1.3 Pedagogical or Clinical Teaching Preparation

In addition to subject-matter and professional competence, all trainers, tutors, clinical instructors, and preceptors shall have undertaken formal pedagogical or clinical teaching preparation. This preparation may include training in instructional methods, curriculum delivery, learner assessment, mentorship, supervision, and adult learning principles. For clinical instructors and preceptors, such preparation shall also cover clinical supervision, patient safety, ethical decision-making, and competency-based assessment in practice settings. This requirement recognises that effective teaching and supervision require specialised instructional skills beyond professional expertise alone.

S6.1.4 Continuous Professional Development (CPD)

All trainers, tutors, clinical instructors, and preceptors shall participate in Continuous Professional Development (CPD) as prescribed by the relevant professional bodies, regulatory authorities, and training institutions. CPD shall encompass both professional practice updates and teaching-related development, including advances in knowledge, skills, technology, pedagogy, and clinical practice. Regular participation in CPD ensures that educators remain current, competent, and responsive to evolving professional standards, labour-market needs, and educational innovations, thereby sustaining the quality and relevance of education and training programmes over time.

S6.2 Preceptors and Consultants: Minimum Standards for Clinical Teaching and Supervision

These standards recognise that preceptors and consultants exercise dual authority as clinicians and educators. Accordingly, they must be simultaneously competent practitioners, legally authorised professionals, and trained clinical teachers who remain current through structured and verifiable professional development. Enforcing these standards strengthens patient safety, enhances training quality, ensures consistency across clinical training sites, and aligns national health education systems with international best practice.

Preceptors and consultants play a critical role in bridging theoretical instruction and real-world clinical practice. Given their direct responsibility for patient safety, trainee supervision, and competency assessment in workplace-based learning environments, all preceptors and consultants shall meet the following minimum standards:

S6.2.1 Recognised Academic and Professional Qualifications

All preceptors and consultants shall possess recognised academic and professional qualifications relevant to the discipline, scope, and level of clinical training they supervise. Academic qualifications shall be appropriate to the level of trainees under supervision and aligned with national qualifications frameworks and internationally recognised standards. Professional qualifications shall demonstrate advanced competence and expertise in the relevant field of practice, ensuring that trainees are supervised by clinicians with sufficient depth of knowledge, clinical judgment, and experiential authority to guide complex decision-making and professional formation.

S6.2.2 Valid Practising Licence Issued by the Relevant Professional Body

All preceptors and consultants shall hold a valid and current practising licence issued by the relevant statutory professional body and shall be in good standing at the time of appointment and throughout the period of supervision. Licensing constitutes legal authorisation to practise and supervise clinical care, confirms adherence to professional codes of ethics and standards, and ensures accountability to disciplinary and regulatory mechanisms. No individual whose licence is expired, suspended, or restricted shall serve as a preceptor or consultant for clinical training purposes.

S6.2.3 Mandatory Structured Orientation in Clinical Teaching and Supervision

All preceptors and consultants shall undertake a mandatory, structured orientation in clinical teaching and supervision prior to assuming responsibility for trainees. This orientation shall be designed to equip clinicians with core competencies in clinical education, including: principles of adult and experiential learning; competency-based clinical training; supervision and mentorship; workplace-based assessment; documentation of clinical performance; patient safety and ethical considerations in training settings; and management of underperforming trainees. The orientation shall be formally documented and periodically refreshed to ensure consistent, standardised, and high-quality clinical teaching across all accredited training sites.

S6.2.4 Continuous Professional Development (CPD)

All preceptors and consultants shall participate in Continuous Professional Development (CPD) as prescribed by relevant professional bodies, regulatory authorities, and training institutions. CPD shall encompass both clinical practice updates and clinical education competencies, including advances in diagnostics, treatment protocols, technology, supervision methods, assessment tools, and professional ethics. Participation in CPD shall be a condition for continued recognition as a preceptor or consultant and shall be demonstrably linked to licence renewal, institutional credentialing, and maintenance of clinical teaching privileges.

S6.3 Trainer-to-Student and Preceptor-to-Intern Ratios

Appropriate trainer-to-student and preceptor-to-intern ratios are a core determinant of training quality, patient safety, and competency acquisition in health education and training programmes. Accordingly, all education and training institutions and accredited clinical training sites shall comply with the following standards:

S6.3.1 General Principle

Trainer-to-student and preceptor-to-intern ratios shall be discipline-specific, context-appropriate, and aligned with nationally prescribed minimum standards issued by the Ministry responsible for Health and Education, the TVET Council, the National Council for Higher Education (NCHE) (where applicable), and the relevant professional councils.

These ratios shall apply across classroom teaching, skills laboratories, and clinical training environments, and shall be used as mandatory benchmarks for programme accreditation, internship approval, and institutional inspection.

S6.3.2 Medicine, Dentistry, and Pharmacy

Given the high-risk, high-complexity nature of clinical decision-making in these professions, ratios shall ensure intensive supervision, direct observation, and timely feedback.

(1) Trainer-to-Student Ratios (Institutional / Academic Training):

(a) Medicine and Dentistry: typically, not exceeding 1:10–15 in clinical teaching settings and 1:20–25 in classroom-based instruction.

(b) Pharmacy: typically, not exceeding 1:15–20 in laboratory and clinical settings and 1:25–30 in classroom-based instruction.

(2) Preceptor-to-Intern Ratios (Internship / Clinical Practice):

(a) Medicine and Dentistry: not exceeding 1:3–5 interns per preceptor/consultant in clinical departments to ensure close supervision, patient safety, and valid competency assessment.

(b) Pharmacy: not exceeding 1:5–8 interns per preceptor, depending on practice setting (hospital, community, regulatory, or industrial).

These ratios reflect the need for sustained, hands-on supervision, case discussion, and workplace-based assessment in professions where errors carry significant clinical and legal consequences.

S6.3.2 Nursing, Midwifery and Allied Health Professional

For nursing, midwifery and allied health professional programmes, ratios shall reflect the centrality of bedside care, procedural competence, and continuous patient interaction, while recognising the team-based nature of service delivery.

(1) Trainer-to-Student Ratios (Institutional / Skills-Based Training): (a) Classroom instruction: typically, not exceeding 1:30–40 students per trainer and (b) Skills laboratories and simulation: not exceeding 1:10–15 students per trainer.

(2) Preceptor-to-Student / Intern Ratios (Clinical Practice): Clinical placements and internships: not exceeding 1:6–10 students or interns per preceptor, depending on ward acuity, case mix, and level of training.

(3) For allied health professional the ratio shall not exceed 1:5–8 interns per preceptor, depending on practice setting (hospital, community, regulatory, or industrial).

These ratios are intended to ensure adequate supervision, reinforcement of professional values, patient safety, and attainment of required clinical competencies.

S6.2.3 National Prescribing Authority and Enforceability

The specific numerical ratios applicable at any given time shall be those formally prescribed by national authorities and professional councils, and may be periodically revised to reflect changes in service delivery models, technology, enrolment pressures, and international best practice. Institutions shall not admit students, deploy interns, or seek programme accreditation unless they can demonstrate compliance with the applicable minimum ratios.

S6.2.4 Compliance and Quality Assurance

Compliance with trainer-to-student and preceptor-to-intern ratios shall be a condition for: Programme accreditation and re-accreditation; Approval and designation of internship and clinical training centres; Student enrolment ceilings and internship intake numbers; and Ongoing institutional and site inspections.

Failure to meet prescribed ratios shall constitute a material breach of training standards and shall attract corrective measures, including enrolment caps, suspension of clinical placements, or withdrawal of accreditation, as determined by the relevant regulatory authorities.

S6.2.5 Cross-Cutting Regulatory Provisions

(1) Binding Nature of Ratios:

The ratios set out in this Schedule constitute minimum national standards. No institution or clinical training site shall admit students, deploy interns, or conduct clinical training unless these ratios are met and demonstrably sustained.

(2) Alignment with WHO Clinical Education Norms

These ratios are informed by WHO guidance on:
(i) Quality and transformative education for health professionals;
(ii) Safe clinical learning environments;
(iii) Nurse educator and clinical educator competency standards; and
(iv) The requirement for adequate supervision to protect patients and learners.
WHO guidance consistently emphasises lower ratios in clinical and skills-based settings and allows higher ratios in classroom settings, a principle reflected throughout this Schedule.

(3) Alignment with Professional Council Internship Guidelines

The internship ratios reflect prevailing professional council expectations that:
(i) Interns must be supervised by licensed practitioners in good standing;
(ii) Supervisors must have manageable numbers of interns to allow direct observation, mentoring, assessment, and sign-off of competencies; and

(iii) Internship approval is contingent upon adequate supervisory capacity.

(4) Application Across Settings

Ratios shall apply to: Public and private universities and training institutions; Government and private hospitals; Accredited health centres and community practice sites; and any other facility designated as a clinical training or internship centre.

(5) Review and Revision

The responsible Ministry, in consultation with the TVET Council, the Ministry of Health, NCHE (where applicable), and professional councils, may revise this Schedule by Statutory Instrument to reflect changes in service delivery models, technology, enrolment patterns, or updated WHO and professional standards.

(6) Enforcement and Sanctions

Non-compliance with this Schedule shall constitute a material breach of accreditation and internship approval conditions and may result in: Enrolment Caps or Intake Suspension; Withdrawal of Internship Centre Designation; Programme Accreditation Sanctions; or any Other Lawful Regulatory Action.

S7 Clinical Training, Internship, and Residency Standards

(a) Clinical training, internship, and residency constitute the core experiential components of health professional education and are critical to the production of competent, ethical, and practice-ready health workers. These phases of training shall therefore be governed by clear, enforceable standards that ensure patient safety, educational quality, professional accountability, and national workforce relevance.

(b) Purpose and Scope: Clinical training, internship, and residency standards are established to ensure that all learners acquire the requisite competencies, professional values, and clinical judgment through structured, supervised, and assessed workplace-based learning. These standards apply to all accredited institutions, designated training sites, and supervising personnel involved in undergraduate clinical placements, internships, and postgraduate residency or fellowship programmes across public and private sectors.

(c) Accreditation and Designation of Training Sites: All facilities used for clinical training, internship, or residency shall be formally accredited and designated by the responsible authorities in consultation with the relevant professional councils. Designation shall be based on demonstrable capacity in terms of service scope, patient case-mix, infrastructure, equipment, staffing levels, and supervisory competence. No clinical training, internship, or residency shall be conducted in a facility that has not been duly approved for that specific level and discipline of training.

(d) Structured and Competency-Based Training: Clinical training, internship, and residency programmes shall be competency-based, structured, and outcomes-oriented. Each programme shall have clearly defined learning objectives, competency frameworks, rotation schedules, supervision arrangements, and assessment methods consistent with national qualifications frameworks and professional council standards. Training shall progressively increase learner responsibility and autonomy in line with demonstrated competence, while maintaining appropriate levels of supervision at all times.

(e) Supervision and Preceptorship: All learners shall be supervised by qualified, licensed, and accredited preceptors, consultants, or supervisors in accordance with nationally prescribed trainer-to-student and preceptor-to-intern ratios. Supervisors shall provide direct clinical oversight, mentorship, formative feedback, and summative assessment, and shall remain accountable for patient safety and the integrity of competency sign-off. Institutions shall ensure that supervisory loads are manageable and do not compromise service delivery or training quality.

(f) Internship and Residency Governance: Internship and residency programmes shall be centrally coordinated, transparently allocated, and equitably distributed in accordance with national health workforce planning priorities. Clear governance arrangements shall define the roles and responsibilities of training institutions, host facilities, professional councils, and Ministries responsible for health and education. Internship and residency placements shall be subject to formal approval, monitoring, and periodic review to ensure compliance with standards.

(g) Assessment, Documentation, and Certification: All clinical training, internship, and residency programmes shall employ valid, reliable, and standardised assessment methods, including workplace-based assessments, logbooks, portfolios, and objective structured clinical examinations where applicable. Institutions and training sites shall maintain accurate records of attendance, supervision, competencies achieved, and assessment outcomes. Successful completion of internship or residency shall be certified only after all prescribed competencies and minimum training requirements have been satisfactorily met.

(h) Learner Protection and Patient Safety: Clinical training, internship, and residency shall be conducted in a manner that safeguards both learners and patients. Learners shall practise only within their level of training and competence, under appropriate supervision, and in accordance with professional ethical standards. Training institutions and host facilities shall provide safe working conditions, adequate indemnity arrangements where applicable, and mechanisms for reporting and addressing adverse events, harassment, or exploitation.

(i) Continuous Quality Assurance and Improvement: Clinical training, internship, and residency programmes shall be subject to ongoing quality assurance through inspections, audits, learner feedback, supervisor evaluations, and outcome monitoring. Regulatory authorities and professional councils shall use these mechanisms to identify gaps, enforce corrective actions, and promote continuous improvement in training quality and relevance.

(j) Compliance and Sanctions: Compliance with clinical training, internship, and residency standards shall be a mandatory condition for programme accreditation, internship centre designation, and residency approval. Failure to comply shall attract proportionate regulatory sanctions, which may include enrolment caps, suspension of placements, withdrawal of designation, or other lawful measures as determined by the relevant authorities.

(k) These standards recognise clinical training, internship, and residency as high-stakes phases of professional formation where education, service delivery, and public safety intersect. Clear regulation of these phases ensures that health professionals entering independent practice are competent, ethical, and fit for purpose, while protecting patients, learners, and the integrity of the national health system.

S7.1 Clinical and Field Training Standards

(a) The principle is that training follows regulation: clinical learning occurs only in regulated and accredited health facilities, while field training is grounded in local government designation and community relevance.

(b) These provisions ensure consistency, safety, and accountability across institutional and

community-based training environments.

(c) Clinical and field training constitute essential components of health education and training, enabling learners to apply theoretical knowledge, develop practical competencies, and acquire professional values in real-world service settings.

(d) To safeguard training quality, learner welfare, and public safety, all clinical and field training shall comply with the following standards:

S7.1.1 Structured, Supervised, and Assessed Training: All clinical and field training shall be formally structured, adequately supervised, and rigorously assessed in accordance with approved training plans and competency frameworks. Training shall be guided by clearly defined learning objectives, rotation schedules, scopes of practice, and expected competencies appropriate to the level of training. Supervision shall be provided by qualified and licensed preceptors or supervisors, and learner performance shall be assessed using standardised and validated tools, including logbooks, portfolios, workplace-based assessments, and other approved instruments to ensure consistency, fairness, and reliability across training sites.

S7.1.2 Approved and Regulated Clinical Training Sites: All clinical training shall take place exclusively in health facilities regulated by the Ministry of Health and formally accredited by the TVET Council and/or the National Council for Higher Education (NCHE), as applicable, with the explicit approval of the relevant professional bodies. Accreditation and approval shall be based on the facility's demonstrated capacity in terms of service scope, infrastructure, staffing, patient volume, case mix, and supervisory competence. No institution or learner shall conduct clinical training in a facility that has not been duly approved for that specific cadre and level of training.

S7.1.3 Designation of Field Training and Community Practice Sites: All field training shall take place in community-based sites formally designated by City, District, Municipal, or Kampala Capital City Authority (KCCA) authorities, upon request by the respective health training institutions. Such designation shall confirm that the site is suitable for learning, provides relevant exposure to community health practice, and has the necessary supervisory arrangements. Field training sites may include health units, community programmes, public health projects, outreach initiatives, and other approved community settings aligned with national and local health priorities.

S7.1.4 Coordination and Accountability: The Ministry of Health shall be responsible for coordinating clinical and field placements, ensuring that learners are appropriately allocated, supervised, and assessed. Formal agreements or memoranda of understanding shall define the roles and responsibilities of training institutions, host facilities, local authorities, and supervisors. These arrangements shall provide clear lines of accountability for learner supervision, assessment, safety, and reporting.

S7.1.5 Quality Assurance and Compliance: Clinical and field training shall be subject to ongoing quality assurance through inspections, supervision reports, learner feedback, and regulatory audits by the Ministry of Health, TVET Council, NCHE and relevant professional bodies. Compliance with these standards shall be a mandatory condition for programme accreditation, continuation of clinical placement approvals, and recognition of training outcomes. Non-compliance shall attract corrective measures or sanctions in accordance with applicable laws and regulations.

S7.1.6 Clinical and field training shall be structured, supervised and assessed using standardised tools. All clinical training shall take place in health facilities regulated by Ministry of Health, and accredited by the TVET Council and /or NCHE, with the approval of respective professional bodies.

S7.1.7 All field training shall take place in community sites designated by City / District / Municipal/

KCCA authorities at the request of respective health training institutions.

S7.1.8 All health trainees eligible for internship shall be provisionally licensed by the respective professional body to undertake the internship.

S7.1.9 The placement of trainees to their respective internship sites shall be undertaken by the Ministry of Health.

S7.1.10 Internship training shall be structured, supervised and assessed using standardised tools.

S7.2 Internship Standards

(a) Internship represents a transitional but critical phase between academic training and independent professional practice.

(b) Internship standards are therefore established to ensure that interns acquire supervised, hands-on experience, consolidate professional competencies, and internalise ethical and professional norms while safeguarding patient safety and public trust.

S7.2.1 Purpose and Scope:

(a) Internship shall be a mandatory, structured, and supervised period of workplace-based training required for professional registration and licensure.

(b) These standards apply to all internship programmes across health professions, including medicine, dentistry, pharmacy, nursing and midwifery conducted in both public and private sectors

S7.2.2 Designation and Accreditation of Internship Centres:

(a) All internship training shall take place only in formally designated and accredited internship centres approved by the Ministry of Health, the relevant regulatory and quality assurance authorities, and the respective professional councils.

(b) Approval shall be based on the centre's capacity to provide adequate clinical exposure, supervision, infrastructure, case mix, and learning support.

(c) No facility shall host interns unless it has been duly approved for the specific profession and level of internship.

S7.2.3 Structured and Competency-Based Internship Programmes:

(a) Internship programmes shall be competency-based and guided by approved internship curricula, rotation schedules, and learning outcomes issued or endorsed by the relevant professional councils.

(b) Each intern shall follow a clearly defined training plan that specifies duration, rotations, scope of practice, supervision arrangements, and assessment requirements.

(c) Intern responsibility shall progressively increase in line with demonstrated competence, while ensuring appropriate supervision at all times.

S7.2.4 Supervision, Preceptorship, and Ratios:

(a) All interns shall be supervised by qualified, licensed, and accredited preceptors or consultants who are in good standing with their professional councils.

(b) Supervision shall be continuous, accessible, and proportionate to the clinical risk involved. Internship centres shall comply with nationally prescribed preceptor-to-intern ratios, which shall be used as binding benchmarks for internship approval, intern deployment, and intake numbers.

(c) Preceptors shall be responsible for mentorship, clinical oversight, feedback, and competency sign-off.

S7.2.5 Assessment, Documentation, and Certification:

(a) Intern performance shall be assessed using standardised and validated assessment tools, including logbooks, workplace-based assessments, portfolios, and end-of-rotation evaluations. Internship centres shall maintain accurate and auditable records of attendance, competencies achieved, supervision provided, and assessment outcomes.

(b) Certification of internship completion shall be issued only after all prescribed competencies, rotations, and minimum training requirements have been satisfactorily completed and verified by the relevant authorities.

S7.2.6 Intern Welfare, Rights, and Responsibilities:

(a) Internship shall be conducted in a manner that protects intern welfare and dignity. Internship centres and training institutions shall ensure reasonable working conditions, access to supervision and support, occupational safety, and mechanisms for reporting grievances, harassment, or unsafe practices.

(b) Interns shall adhere to professional codes of conduct, institutional policies, and ethical standards, and shall practise only within their authorised scope and level of competence.

S7.2.7 Governance, Coordination, and Allocation:

(a) Internship programmes shall be centrally coordinated in accordance with national health workforce planning priorities to ensure equitable distribution of interns and optimal use of training capacity.

(b) Clear governance arrangements shall define the roles and responsibilities of training institutions, internship centres, professional councils, and Ministries responsible for health and education.

(c) Allocation, deployment, and completion of internship shall be transparent, predictable, and subject to monitoring.

S7.2.8 Quality Assurance, Monitoring, and Review:

(a) Internship programmes and centres shall be subject to continuous quality assurance through inspections, audits, supervisor evaluations, and intern feedback.

(b) Regulatory authorities and professional councils shall use these mechanisms to ensure compliance, identify gaps, and promote continuous improvement.

(c) Internship standards and requirements may be periodically reviewed to reflect evolving professional practice, service delivery needs, and international best practice.

S7.2.9 Compliance and Sanctions:

(a) Compliance with internship standards shall be a mandatory condition for internship centre designation, programme approval, and recognition of internship outcomes for licensure.

(b) Non-compliance shall attract proportionate regulatory sanctions, including reduction of intern intake, suspension of internship approvals, withdrawal of centre designation, or other lawful measures as may be prescribed.

S7.2.10 Internship standards formalise the balance between learning and service delivery during a high-risk transition period. By mandating structured supervision, clear assessment, and institutional accountability, these standards protect patients, support interns, and ensure that only competent and ethically grounded professionals enter independent practice.

S7.2.11 All health trainees shall be required to have successfully undertaken their internship as a pre-condition to their graduation and subsequent licensing to practice.

S7.3 Residency Training Standards

(a) Residency standards recognise specialist training as a high-stakes investment in clinical leadership and health system performance. By embedding structured supervision, competency-based progression, research integration, and strong governance, these standards ensure that specialists are safe, competent, ethical, and responsive to national health priorities.

(b) Residency training constitutes an advanced, postgraduate phase of professional formation in which practitioners develop specialist competence, clinical leadership, and independent decision-making capacity under supervised conditions. Residency standards are therefore established to ensure high-quality specialist training, patient safety, academic rigor, and alignment with national health system needs.

S7.3.1 Purpose and Scope:

(a) Residency training shall be a structured, competency-based postgraduate programme leading to specialist or consultant-level qualification and recognition by the relevant professional councils.

(b) These standards apply to all residency and specialist training programmes conducted by accredited universities, teaching hospitals, and designated training centres in both public and private sectors.

(c) Residency training shall apply to post-graduate health students seeking specialist training at Masters' level in respective fields.

S7.3.2 Accreditation and Designation of Residency Training Centres:

(a) Residency training shall be conducted only in formally accredited and designated residency training centres approved by the relevant authorities in consultation with professional councils.

(b) Accreditation shall be based on demonstrated capacity in terms of specialist service scope, patient volume and case mix, infrastructure, equipment, staffing, research environment, and supervisory expertise.

(c) No institution or facility shall admit residents unless it has been duly approved for that specific specialty and level of training.

S7.3.3 Structured, Competency-Based Residency Programmes:

(a) Residency programmes shall be competency-based and guided by nationally approved curricula and specialty training frameworks.

(b) Each programme shall define learning outcomes, competencies, rotation structures, duration, assessment methods, and progression requirements.

(c) Training shall progressively grant residents increased clinical responsibility and autonomy in line with demonstrated competence, while ensuring appropriate supervision commensurate with patient risk and case complexity.

S7.3.4 Supervision, Mentorship, and Staff Requirements:

(a) Residents shall be supervised and mentored by qualified consultants or specialists who are licensed, in good standing with their professional councils, and formally accredited as trainers.

(b) Supervisors shall provide direct clinical oversight, academic guidance, mentorship, and assessment. Residency training centres shall comply with nationally prescribed consultant-to-resident ratios, ensuring that supervisory workloads remain manageable and that training quality and patient safety are not compromised.

S7.3.5 Integration of Service, Education, and Research:

(a) Residency training shall integrate clinical service delivery, structured education, and research.

(b) Residents shall participate in supervised service provision aligned with training objectives, engage in formal teaching sessions, and undertake research, audit, or quality improvement projects as prescribed by the programme.

(c) This integration ensures the development of clinical expertise, scholarly competence, and system-level thinking required of specialists.

S7.2.6 Assessment, Progression, and Certification:

(a) Resident performance shall be assessed using standardised, transparent, and reliable assessment tools, including workplace-based assessments, logbooks, portfolios, examinations, and periodic competency reviews.

(b) Progression through residency shall be contingent upon satisfactory performance and attainment of prescribed competencies.

(c) Certification of completion shall be issued only after all training, assessment, and research requirements have been successfully fulfilled and verified.

S7.3.7. Resident Welfare, Rights, and Professional Conduct:

(a) Residency training shall be conducted in a manner that safeguards resident welfare, dignity, and professional development.

(b) Training centres shall ensure reasonable working hours, access to supervision and support, occupational safety, and mechanisms for reporting grievances, harassment, or unsafe practices.

(c) Residents shall comply with professional codes of conduct, ethical standards, and institutional

policies, and shall practise within their authorised scope and level of competence.

S7.3.8. Governance, Coordination, and National Planning:

(a) Residency programmes shall be governed through clear institutional and national arrangements that define the roles and responsibilities of universities, training centres, professional councils, and Ministries responsible for health and education.

(b) Residency intake, specialty distribution, and training capacity shall be aligned with national health workforce planning priorities to ensure equitable access and responsiveness to population health needs.

S7.3.9. Quality Assurance, Monitoring, and Continuous Improvement:

(a) Residency programmes and training centres shall be subject to continuous quality assurance through accreditation reviews, inspections, supervisor and resident evaluations, examination outcomes, and graduate performance tracking.

(b) Regulatory authorities and professional councils shall use these mechanisms to ensure compliance, address gaps, and promote continuous improvement in specialist training.

(c) Residency training shall be supervised and assessed using standardised tools.

S7.3.10 Compliance and Sanctions:

(a) Compliance with residency training standards shall be a mandatory condition for programme accreditation, centre designation, and recognition of specialist qualifications.

(b) Residency training shall be undertaken at least two years after completion of under-graduate health training and upon proof of registration with the relevant professional body as well as evidence of active practice.

(c) Residency training programs shall be developed by respective health training institutions and accredited / approved by the NCHE.

(d) Non-compliance shall attract proportionate regulatory sanctions, including reduction of resident intake, suspension of programmes, withdrawal of accreditation, or other lawful measures as may be prescribed.

S7.4 Fellowship Standards

(a) Fellowship training represents the highest level of post-residency or post-specialist professional development— Super Specialists, aimed at producing sub-specialists, clinical leaders, academic experts, and innovators capable of advancing clinical practice, research, and health system performance.

(b) The training of Super Specialists shall be undertaken through Fellowship. Fellowship standards are therefore established to ensure rigor, patient safety, scholarly excellence, and national relevance.

(c) Fellowship standards recognise advanced specialist training as a strategic national investment in clinical excellence, innovation, and leadership.

(d) By embedding structured supervision, advanced competencies, research integration, and strong

governance, these standards ensure that fellows contribute meaningfully to improved health outcomes, specialist capacity, and the sustainability of the health system.

S7.4.1. Purpose and Scope

(a) Fellowship programmes shall provide advanced, focused, and competency-based training beyond residency or primary specialist qualification in defined sub-specialty or advanced practice areas.

(b) These standards apply to all fellowship programmes conducted by accredited universities, teaching hospitals, centres of excellence, and specialist institutions in both public and private sectors.

S7.4.2. Accreditation and Designation of Fellowship Training Centres

(a) Fellowship training shall be conducted only in formally accredited and designated fellowship training centres approved by the relevant authorities in consultation with professional councils.

(b) Accreditation shall be based on demonstrated capacity in advanced clinical services, specialised infrastructure and equipment, sufficient patient volumes and case complexity, highly qualified faculty, and a robust academic and research environment.

(c) All Fellowship (super-specialised) training programmes shall be approved and managed by respective regulatory professional bodies.

(d) No institution or facility shall admit fellows unless it has been duly approved for that specific fellowship area.

S7.4.3. Entry Requirements and Selection

(a) Admission to fellowship programmes shall be restricted to candidates who have successfully completed an accredited residency or specialist training programme and are fully registered and licensed with the relevant professional council.

(b) Fellowship training shall be strictly undertaken by post-Masters' health trainees under the supervision of respective professional bodies to produce Super Specialists.

(c) Selection processes shall be transparent, merit-based, and aligned with national health workforce priorities, ensuring that fellows possess the foundational competence, professional maturity, and ethical standing required for advanced practice.

S7.4.4. Structured and Competency-Based Fellowship Programmes

(a) Fellowship programmes shall be structured, outcomes-oriented, and competency-based, with clearly defined learning objectives, advanced competencies, scope of practice, training duration, and progression criteria.

(b) Training shall focus on mastery of complex clinical procedures, advanced diagnostic and therapeutic decision-making, leadership, teaching, research, and innovation within the sub-specialty.

(c) Fellows shall assume progressively higher levels of autonomy consistent with demonstrated competence, while remaining under appropriate supervision.

S7.4.5. Supervision, Mentorship, and Faculty Requirements

(a) Fellows shall be supervised and mentored by senior specialists or consultants with recognised expertise in the fellowship area and in good standing with their professional councils.

(b) Supervisors shall be formally accredited as fellowship trainers and shall provide advanced clinical oversight, academic mentorship, and professional guidance.

(c) Fellowship training centres shall comply with nationally prescribed trainer-to-fellow ratios to ensure intensive supervision, high-quality mentorship, and patient safety.

S7.4.6. Integration of Advanced Practice, Teaching, and Research

(a) Fellowship training shall integrate advanced clinical practice with teaching, research, and health system leadership.

(b) Fellows shall participate in specialist service delivery, contribute to undergraduate and postgraduate teaching under supervision, and undertake substantive research, innovation, quality improvement, or policy-relevant projects aligned with national priorities.

(c) This integration ensures the development of sub-specialists who are not only clinically excellent but also capable of advancing knowledge and training future professionals.

S7.4.7. Assessment, Progression, and Certification

(a) Fellow performance shall be assessed using rigorous and standardised assessment methods, including advanced workplace-based assessments, procedure logs, portfolios, research outputs, and formal evaluations.

(b) Progression and completion shall be contingent upon demonstrated attainment of all prescribed competencies and training requirements.

(c) Certification of fellowship completion shall be issued only after successful verification by the training institution and recognition by the relevant professional council.

S7.4.8. Fellow Welfare, Professional Conduct, and Accountability

(a) Fellowship training shall be conducted in a manner that safeguards fellow welfare, professional integrity, and ethical practice.

(b) Training centres shall ensure safe working conditions, access to supervision and mentorship, and mechanisms for addressing grievances or professional concerns.

(c) Fellows shall adhere to professional codes of conduct, ethical standards, and institutional policies, and shall practise strictly within the approved scope of fellowship training.

S7.4.9. Governance, National Planning, and Recognition

(a) Fellowship programmes shall operate within clear governance frameworks that define the roles and responsibilities of universities, training centres, professional councils, and Ministries responsible for health and education.

(b) Fellowship intake and sub-specialty focus shall be aligned with national and regional health workforce needs.

(c) Recognition of fellowship qualifications shall be subject to approval by the relevant professional councils and integrated into national specialist registers where applicable.

S7.4.10. Quality Assurance, Monitoring, and Continuous Improvement

(a) Fellowship programmes and training centres shall be subject to continuous quality assurance through accreditation reviews, inspections, trainee and faculty evaluations, research output monitoring, and graduate outcome tracking.

(b) Regulatory authorities and professional councils shall use these mechanisms to ensure compliance, address gaps, and promote continuous improvement in advanced specialist training.

S7.4.11. Compliance and Sanctions

(a) Compliance with fellowship standards shall be a mandatory condition for programme accreditation, centre designation, and recognition of fellowship qualifications.

(b) Non-compliance shall attract proportionate regulatory sanctions, including suspension of fellowship intake, withdrawal of programme approval, or other lawful measures as may be prescribed.

S8 Occupational Safety Standards

(a) Occupational safety standards are established to protect learners, trainers, health workers, patients, and the public from preventable harm arising from education, training, and service delivery environments.

(b) All institutions, training sites, and host facilities involved in health education and training shall ensure safe, healthy, and dignified working and learning conditions in accordance with applicable laws, regulations, and professional standards.

(c) Universities, Tertiary Health Training Institutions, Specialised Health Institutes, Fellowship Training Centers, Internship Centres, and Clinical Sites shall comply with occupational safety and health standards; infection prevention and control standards; as well as, provision of insurance and indemnity coverage for trainees and trainers during clinical practice.

(d) Occupational safety standards recognise that health education and training occur in inherently high-risk environments. By embedding safety, prevention, and accountability into all stages of training, these standards protect learners and patients, reduce avoidable harm, and reinforce a culture of professionalism, ethics, and quality within the health system.

S8. 1. Scope and Application

(a) Occupational safety standards shall apply to all settings in which education, training, internship, residency, and fellowship activities take place, including classrooms, laboratories, skills and simulation centres, health facilities, community and field training sites, and research environments.

(b) These standards shall apply to students, interns, residents, fellows, trainers, preceptors, supervisors, and support staff.

S8.2. Safe Physical and Working Environment

(a) All training and service environments shall be maintained in a condition that minimises physical, biological, chemical, ergonomic, and psychosocial hazards.

(b) Facilities shall ensure adequate lighting, ventilation, sanitation, waste management, fire safety, electrical safety, and structural integrity.

(c) Equipment and tools used for training and service delivery shall be safe, functional, regularly maintained, and appropriate for their intended use.

S8.3. Infection Prevention and Control (IPC)

(a) Institutions and training sites shall implement and enforce comprehensive infection prevention and control measures consistent with national health guidelines. These shall include hand hygiene facilities, appropriate use of personal protective equipment (PPE), safe injection practices, sterilization and disinfection protocols, healthcare (Infectious; Cytotoxic; Pathological; Sharps; Chemical; Radioactive; Non-hazardous) waste management, and procedures for managing exposure to infectious agents.

(b) Learners and staff shall receive training in Infection Prevention and Control (IPC) prior to and during placement in clinical and field settings.

S8.4. Occupational Health and Safety Training

(a) All learners and staff shall receive mandatory orientation and periodic refresher training on occupational health and safety relevant to their roles and training environments. This shall include hazard identification, safe work practices, emergency procedures, use of personal protective equipment (PPE), reporting of incidents, and protection of vulnerable groups.

(b) No learner shall be deployed to a clinical or field setting without prior safety orientation.

S8.5. Risk Assessment and Hazard Management

(a) Training institutions and host facilities shall conduct regular risk assessments of training environments and activities and shall implement appropriate mitigation measures.

(b) Identified hazards shall be documented, communicated to learners and staff, and addressed through engineering controls, administrative controls, safe work procedures, or provision of protective equipment.

S8.6. Incident Reporting and Response

(a) Clear and accessible mechanisms shall be established for reporting occupational injuries, exposures, accidents, harassment, or unsafe conditions.

(b) Institutions and training sites shall ensure timely investigation, documentation, and response to reported incidents, including provision of medical care, counselling, post-exposure prophylaxis where applicable, and corrective actions to prevent recurrence.

(c) Learners and staff shall not be penalised for reporting safety concerns in good faith.

S8.7. Learner Protection and Indemnity

(a) Training institutions and host facilities shall put in place measures to protect learners from undue

risk, exploitation, or unsafe workloads.

(b) Where applicable, appropriate insurance or indemnity arrangements shall be provided to cover occupational injuries, exposure incidents, or training-related risks.

(c) Learners shall practise only within their authorised scope and level of competence and under appropriate supervision.

S8.8. Psychosocial Safety and Dignity at Work

(a) Occupational safety standards shall include measures to safeguard mental health, dignity, and professional well-being.

(b) Institutions and training sites shall take reasonable steps to prevent harassment, discrimination, bullying, or abuse and shall provide mechanisms for confidential reporting, support, and redress.

(c) Reasonable working hours, rest periods, and access to support services shall be promoted, particularly for interns, residents, and fellows.

S8.9. Roles, Responsibilities, and Accountability

(a) Clear responsibilities for occupational safety shall be assigned to training institutions, host facilities, supervisors, and learners.

(b) Institutions shall designate responsible officers or committees to oversee occupational safety compliance, training, and reporting.

(c) Learners and staff shall comply with safety policies, use protective measures appropriately, and report hazards or incidents promptly.

S8.10. Monitoring, Compliance, and Enforcement

(a) Occupational safety compliance shall be subject to regular monitoring through inspections, audits, and reporting mechanisms by relevant regulatory authorities.

(b) Compliance with occupational safety standards shall be a mandatory condition for programme accreditation, training site designation, and continuation of clinical or field placements.

(c) Non-compliance shall attract corrective actions or sanctions as prescribed by law.

S8.11 Environmental Standards

The environment in which health education and training is conducted shall adhere to the following standards:

(a) All HTIs shall operate in a safe environment with adequate infrastructure and resources for use including PPEs, water, protocols for waste management etc.

(b) The physical facilities and space in which health training is conducted shall be in good operational conditions in line with the approved capacity as prescribed by the respective regulatory professional bodies, TVET council, NCHE;

(c) Any institution operating in an unsafe environment shall be subject to penalties / sanctions including, but not limited to, suspension or revocation of the training license until the unsafe

condition is rectified.

S8.12 Equipment and Training Materials Standards

The following standards shall apply to equipment and training materials in health education and training:

(a) HTIs shall have adequate training materials and equipment in line with the approved performance ratios.

(b) HTIs shall use equipment and training materials in line with technological advancement and current industrial standards.

(c) HTIs shall adhere to the standards set by Ministry of Health for sourcing, handling, transportation, storage, usage and interment of cadavers, skeletons and other biological materials.

(d) HTIs shall adhere to the standards set by respective regulatory agencies for sourcing, handling, transportation, storage, usage and disposal of chemical, physical and radioactive materials.

S8.13 Learner Welfare Standards

Trainees in HTIs shall be subject to the following standards:

(a) Health trainees, including interns, pursuing undergraduate (certificate, diploma and degree) programs shall be facilitated by their respective sponsors (private or government) to cover their welfare and living expenses.

(b) HTIs shall provide emergency care facilities including sickbays and first aid kits in all aspects of undertaking their training programs.

S8.14 Standards on Duration of Training and Evidence of Learning

The following standards shall apply to the duration for health training:

(a) HTIs shall comply with the duration of training prescribed by the approved curriculum for each programme.

(b) Government sponsorship shall strictly cover the training expenses for the beneficiary during the prescribed training duration of the program on which they are admitted.

(c) Trainers shall support student learning in all settings including hospitals and clinics.

(d) Trainers in universities and HTIs shall dedicate more of their time towards training in addition to clinical practice as part of the labour sharing model.

(e) Preceptors and consultants should dedicate more of their time towards patient care in addition to clinical training as part of their professional responsibility of mentorship.

(f) Trainees shall provide periodic attendance-to-duty (feedback) reports on their trainers concerning their clinical rotation to the Head of the HTIs/ Dean of the college for university education.

(g) Trainees and Medical Interns shall provide periodic attendance-to-duty (feedback) reports on their trainers, Preceptors and consultants to the Head of the Hospital or Placement site in relation to their clinical rotation/attachment.

(h) The Head of the HTIs/ Dean of the college for University and the Head of the Hospital or Placement site shall establish a platform for periodic feedback sharing.

(i) HTIs shall provide annual progress reports for all students enrolled in the different health training programs to the Ministry responsible for health education and training to guide planning and decision-making purposes.

(j) Universities shall provide annual enrollment reports for the pre-clinical and clinical students in the different health training programs that require internship to the Ministry responsible for health to guide planning and decision-making.

(k) HTIs shall maintain evidence of learning for individual trainees and ensure that every trainee is provided with and maintains Learning Logbooks.

S9 Ethical and Professional Standards

(a) Ethical and professional standards are foundational to health education and practice and are essential for protecting patients, learners, institutions, and the public.

(b) All persons involved in health education and training—including students, interns, residents, fellows, trainers, preceptors, and supervisors—shall adhere to the highest standards of ethical conduct, professionalism, and accountability.

(c) Ethical and professional standards ensure that health education and training are grounded in trust, accountability, and respect for human dignity. By embedding these standards across all levels of training and practice, the health system promotes patient safety, professional integrity, and public confidence in health professionals.

(d) The delivery of health education and training shall adhere to the following ethical and professional standards: Ethical practice and patient-rights protection; Grievance and disciplinary mechanisms; Trainees to undergo medical assessment to determine their fitness for training; Trainees who contract any unseen circumstance that renders them unfit for training after they have been admitted shall be reasonably accommodated and protected so as to ensure that they are supported to conclude their studies; and dress code and willingness to undertake assignment. The details are outlined below.

S9.1. Scope and Application

(a) Ethical and professional standards shall apply across all learning and service settings, including classrooms, laboratories, clinical facilities, community and field sites, research environments, and digital or simulation platforms.

(b) These standards shall govern conduct during training, assessment, service delivery, research, supervision, and professional interactions.

S9.2. Compliance with Professional Codes and Laws

(a) All learners and practitioners shall comply with applicable national laws, institutional policies, and codes of ethics and professional conduct issued by the relevant professional councils.

(b) Ethical conduct shall include respect for patient rights, confidentiality, informed consent, professional boundaries, honesty, and integrity in all professional activities.

(c) Breaches of ethical standards shall be subject to disciplinary action in accordance with institutional

procedures and professional regulatory frameworks.

S9.3. Patient Rights, Safety, and Dignity

(a) All training and service activities shall uphold the rights, safety, and dignity of patients and communities.

(b) Learners shall be clearly identified as trainees and shall participate in patient care only under appropriate supervision and within their authorised scope of practice.

(c) Patients shall be informed of the involvement of learners in their care and their right to refuse participation without prejudice.

S9.4. Professional Behaviour and Conduct

(a) All learners and staff shall demonstrate professional behaviour consistent with the values of the health professions, including respect, accountability, teamwork, cultural sensitivity, and non-discrimination.

(b) Professional conduct shall extend to interactions with patients, colleagues, supervisors, support staff, and communities, and to the responsible use of authority and trust inherent in health practice.

S9.5. Academic Integrity and Honesty

(a) Ethical and professional standards shall include strict adherence to academic integrity in learning, assessment, research, and publication.

(b) Plagiarism, falsification of records, misrepresentation of competencies, examination malpractice, or any form of academic dishonesty shall constitute serious misconduct and attract disciplinary sanctions.

S9.6. Conflict of Interest and Professional Boundaries

(a) All persons involved in training and supervision shall declare and appropriately manage conflicts of interest that may compromise objectivity, fairness, or patient welfare.

(b) Professional boundaries shall be maintained at all times, particularly in relationships involving power differentials, such as between supervisors and trainees or clinicians and patients. Exploitation, abuse, or harassment in any form is strictly prohibited.

S9.7. Ethical Research and Innovation

(a) Where training involves research, innovation, or quality improvement activities, all such activities shall comply with national research ethics guidelines and receive approval from recognised research ethics committees where required.

(b) Learners and supervisors shall respect principles of beneficence, non-maleficence, autonomy, and justice in all research-related activities.

S9.8. Reporting, Whistle-Blowing, and Protection from Retaliation

(a) Institutions and training sites shall establish clear, accessible mechanisms for reporting ethical breaches, professional misconduct, or unsafe practices.

(b) Learners and staff who report concerns in good faith shall be protected from retaliation, victimisation, or discrimination.

(c) Reported matters shall be investigated promptly, fairly, and confidentially.

S9.9. Education, Orientation, and Reinforcement of Ethics

(a) Ethical and professional standards shall be actively taught, reinforced, and assessed throughout all stages of training.

(b) Institutions shall provide orientation, ongoing education, and mentorship on ethics and professionalism and shall integrate ethical reasoning, reflective practice, and professionalism assessment into curricula and evaluations.

S9.10. Enforcement, Accountability, and Sanctions

(a) Compliance with ethical and professional standards shall be a mandatory condition for programme accreditation, training site designation, and professional recognition.

(b) Institutions and professional councils shall enforce these standards through appropriate disciplinary procedures.

(c) Sanctions for violations may include redress, suspension, termination of training, withdrawal of accreditation, or referral to professional regulatory bodies, as provided by law.

S10 Quality Assurance and Assessment Standards

S10. Quality Assurance and Assessment Standards

(a) Quality assurance and assessment standards are established to ensure that health education and training programmes consistently produce competent, ethical, and practice-ready professionals who meet nationally and internationally recognised standards.

(b) These standards apply across all phases of training, including pre-service education, clinical and field training, internship, residency, and fellowship.

(c) Quality assurance and assessment standards ensure that health education and training are not defined merely by time spent in training, but by demonstrable competence and professional readiness.

(d) By embedding rigorous internal and external quality assurance, standardised assessment, and accountability mechanisms, these standards protect learners, patients, employers, and the public, while strengthening trust in national qualifications and professional regulation.

S10.1. Purpose and Scope

(a) Quality assurance and assessment standards shall ensure the credibility, consistency, fairness, and integrity of education and training outcomes.

(b) They apply to all accredited institutions, training sites, programmes, assessors, and regulatory bodies involved in health education and professional formation.

S10.2. Internal Quality Assurance Systems

(a) All training institutions shall establish and maintain robust internal quality assurance (IQA) systems covering curriculum delivery, teaching and supervision, assessment practices, learner support, faculty development, infrastructure, and learning resources.

(b) IQA systems shall be documented, routinely implemented, and continuously reviewed to ensure alignment with approved curricula, professional standards, and national qualifications frameworks.

S10.3. External Quality Assurance and Accreditation

(a) Programmes and institutions shall be subject to external quality assurance through accreditation, re-accreditation, inspections, and audits conducted by the TVET Council the NCHE, (where applicable), and relevant professional councils.

(b) External quality assurance shall verify compliance with national standards, assess training outcomes, and provide independent assurance to government, employers, and the public.

S10.4. Standardised, Competency-Based Assessment

(a) Assessment of learners shall be competency-based, valid, reliable, transparent, and fair, and aligned with approved learning outcomes and professional competency frameworks.

(b) Assessment methods may include written examinations, practical and clinical examinations, workplace-based assessments, logbooks, portfolios, simulations, and Objective Structured Clinical Examinations (OSCEs), as appropriate to the level and discipline of training.

S10.5. Use of Standardised Assessment Tools

(a) All assessment shall utilise standardised and approved tools to ensure consistency across institutions and training sites.

(b) Assessment instruments, marking criteria, and grading systems shall be clearly defined, documented, and communicated to learners in advance.

(c) Moderation and benchmarking mechanisms shall be applied to safeguard comparability of assessment outcomes nationally.

S10.6. Assessment Governance and Integrity

(a) Clear governance arrangements shall define roles and responsibilities for assessment design, administration, marking, moderation, and approval of results.

(b) Institutions shall put in place safeguards to prevent examination malpractice, conflicts of interest, bias, or undue influence.

(c) Assessment records shall be securely maintained, auditable, and protected from tampering or misuse.

S10.7. Progression, Certification, and Recognition

(a) Learner progression, completion, and certification shall be based solely on demonstrated attainment of prescribed competencies and minimum training requirements.

(b) No learner shall progress to internship, residency, fellowship, or professional registration without satisfactory completion of all required assessments.

(c) Certification of training outcomes shall be recognised only if issued by duly accredited institutions and programmes.

S10.8. Feedback, Appeals, and Remediation

(a) Learners shall receive timely, constructive feedback on assessment outcomes to support learning and professional development.

(b) Institutions shall establish transparent mechanisms for appeals, review of results, and remediation of underperformance.

(c) Remedial support shall be structured, time-bound, and documented, with clear criteria for re-assessment.

S10.9. Continuous Quality Improvement

(a) Quality assurance and assessment systems shall support continuous improvement through systematic analysis of assessment results, learner performance trends, graduate outcomes, employer feedback, and regulatory findings.

(b) Institutions and regulators shall use this evidence to refine curricula, teaching methods, assessment tools, and supervision practices.

S10.10. Compliance, Monitoring, and Sanctions

(a) Compliance with quality assurance and assessment standards shall be a mandatory condition for programme accreditation, student enrolment, clinical placement approval, and recognition of qualifications.

(b) Regulatory authorities may impose corrective measures or sanctions for non-compliance, including enrolment caps, suspension of programmes, withdrawal of accreditation, or other lawful actions.

S11 Financing Standards

(a) Financing standards are established to ensure that health education and training programmes are adequately funded, fiscally sustainable, transparent, and accountable, and that financial arrangements support quality training outcomes, learner welfare, and patient safety. These standards apply to all institutions, training sites, and programmes involved in pre-service education, clinical and field training, internship, residency, and fellowship.

(b) Financing standards operationalise the principle that quality training requires assured funding. By linking financing to enrolment, capacity, supervision, and accountability, these standards protect learners and patients, prevent unfunded mandates, and ensure that health education and training systems remain credible, equitable, and sustainable.

(c) A diversified financing framework reduces dependence on a single funding source, enhances system resilience, and enables strategic expansion of health education and training. By clearly

defining and regulating permissible financing sources, these standards ensure that funding supports quality, equity, and national health workforce objectives without undermining public accountability or professional standards.

(d) Cross-Cutting Financing Principles: All financing sources for Education and Training for Health shall be governed by the following principles:

(i) Legality and Appropriation: Funds shall be mobilised and utilised in accordance with applicable laws and approved budgets.

(ii) Equity and Access: Financing mechanisms shall promote fair access to training opportunities, particularly for priority cadres and underserved populations.

(iii) Quality and Sustainability: Financing shall be sufficient to meet prescribed training standards and sustain programmes over time.

(iv) Transparency and Accountability: All funds shall be subject to financial controls, reporting, and audit.

S11.1. Adequacy and Predictability of Funding

(a) All approved health education and training programmes shall be supported by adequate and predictable financing commensurate with enrolment levels, training intensity, infrastructure requirements, supervision needs, and nationally prescribed trainer-to-learner ratios.

(b) Funding arrangements shall ensure continuity of training and shall not compromise programme quality, learner progression, or patient safety.

S11.2. Alignment with Approved Enrolment and Training Capacity

(a) Financing shall be explicitly linked to approved enrolment ceilings, internship and residency intake numbers, and accredited training capacity.

(b) Institutions and training sites shall not admit learners or deploy interns, residents, or fellows beyond levels for which adequate financial resources and supervisory capacity have been secured and approved by the relevant authorities.

S11.3. Sources of Financing

(a) Financing for health education and training may derive from a mix of public and private sources, including government subventions, training grants, cost-sharing arrangements, scholarships, development partner support, and lawful institutional revenues.

(b) All sources of financing shall be clearly identified, lawful, and consistent with national public finance and procurement laws.

S11.4. Budgeting and Financial Planning

(a) Institutions and host facilities shall prepare annual and medium-term budgets for education and training activities, clearly disaggregating costs for instruction, clinical supervision, infrastructure, equipment, learning materials, assessment, intern or resident support, and occupational safety measures.

(b) Financial plans shall be aligned with approved curricula, training schedules, and quality assurance

requirements.

S11.5. Financing of Clinical Training, Internship, and Residency

(a) Adequate funding shall be provided to support the costs associated with clinical training, internship, residency, and fellowship, including supervision, teaching time, assessment, consumables, protective equipment, and learner support.

(b) Where interns, residents, or fellows contribute to service delivery, financing arrangements shall recognise the dual training-service role while ensuring that training objectives are not subordinated to service demands.

S11.6. Learner Support and Welfare

(a) Financing standards shall ensure that learners, interns, residents, and fellows have access to essential support, including learning resources, supervision, occupational safety measures, and, where applicable, stipends or allowances as prescribed by government policy.

(b) Financial arrangements shall not expose learners to undue hardship, exploitation, or unsafe working conditions.

S11.7. Financial Accountability and Controls

(a) All funds allocated or utilised for health education and training shall be managed in accordance with applicable public finance management, procurement, and audit laws.

(b) Institutions and training sites shall maintain accurate financial records, internal controls, and audit trails to ensure that funds are used solely for approved training purposes and deliver value for money.

S11.8. Transparency and Reporting

(a) Institutions and training sites shall submit periodic financial reports to the relevant authorities detailing sources of funds, expenditures, and variances against approved budgets.

(b) Financial transparency shall be a condition for programme accreditation, continued approval of training sites, and access to public or donor funding.

S11.9. Sustainability and Cost-Effectiveness

(a) Financing arrangements shall promote long-term sustainability and cost-effectiveness, including efficient use of shared training infrastructure, rational deployment of supervisors, and avoidance of duplicative or unfunded programme expansion.

(b) Expansion of programmes, enrolment, or new specialties shall be approved only where sustainable financing has been demonstrated.

S11.10. Compliance, Monitoring, and Sanctions

(a) Compliance with financing standards shall be a mandatory condition for programme accreditation, training site designation, and learner intake approval.

(b) Failure to meet financing requirements, misuse of funds, or persistent underfunding that compromises training quality or safety shall attract corrective measures or sanctions, including

enrolment caps, suspension of programmes, withdrawal of accreditation, or other lawful actions.

S11.11. Financing Sources for Education and Training for Health

(a) Education and Training for Health shall be financed through a diversified and complementary mix of public, private, and partner funding sources to ensure adequacy, equity, sustainability, and alignment with national health workforce priorities.

(b) The following financing modalities shall be recognised and regulated:

(a) Government Budget Allocations

(i) Government budget allocations shall constitute the primary and anchor source of financing for Education and Training for Health, particularly for public institutions, internship, residency, and fellowship programmes, and nationally prioritised cadres. Such allocations shall be appropriated through the national budget process and shall cover, as applicable, tuition support, training infrastructure, teaching and supervision costs, clinical training expenses, learner welfare, and regulatory oversight.

(ii) Government financing shall be aligned with approved enrolment ceilings, training capacity, and national health workforce planning objectives.

(b) Scholarships and Bursaries

(i) Scholarships and bursaries shall provide targeted financial support to eligible learners to promote access, equity, and inclusion in health education and training. These may be funded by government, institutions, foundations, faith-based organisations, corporate entities, or other lawful sponsors.

(ii) Scholarship and bursary schemes shall be administered transparently, based on clear eligibility criteria, and may be linked to service obligations, priority disciplines, or underserved regions in accordance with national policy.

(c) Higher Education Students Financing Scheme

(i) The Higher Education Students Financing Scheme shall support eligible learners through student loans or financing arrangements to meet tuition and approved training-related costs in accredited health education and training programmes.

(ii) Access to this scheme shall be subject to eligibility criteria, institutional accreditation status, and programme approval. The scheme shall complement, rather than substitute, direct public investment in strategically critical health training programmes.

(d) Public–Private Partnerships (PPPs)

(i) Public–Private Partnerships may be utilised to mobilise additional resources for Education and Training for Health, particularly for infrastructure development, specialised training facilities, equipment, simulation centres, and service-linked training platforms.

(ii) All PPP arrangements shall comply with national PPP and public finance laws and shall ensure that public interest, training quality, affordability, and equity are safeguarded. PPPs shall not compromise regulatory oversight or academic and professional standards.

(e) Private Sponsorship

(i) Private sponsorship by individuals, families, employers, or organisations shall be permitted as a legitimate source of financing for health education and training. Such sponsorship shall be subject to institutional policies and regulatory safeguards to ensure that privately financed learners meet the same academic, professional, and ethical standards as other learners.

(ii) Private sponsorship shall not exempt institutions from compliance with approved enrolment limits, quality assurance requirements, or training standards.

(f) Development Partner Support

(i) Development partner support, including grants, technical assistance, and programme funding, may be utilised to strengthen Education and Training for Health, particularly in areas of capacity building, innovation, priority skills, research, and system reform.

(ii) All development partner funding shall be aligned with national policies, priorities, and regulatory frameworks and shall be transparently reported and coordinated through established government mechanisms to avoid fragmentation or duplication.

S11.12. Financing Mechanisms: Strategic Priorities

(a) All financing mechanisms for Education and Training for Health shall be designed, applied, and monitored in a manner that advances national health workforce objectives, addresses systemic gaps, and ensures sustainable skills development.

(b) Accordingly, financing mechanisms shall adhere to the following strategic priorities:

(a) Prioritisation of Critical Skill Shortages

(i) Financing mechanisms shall prioritise the training and deployment of health professionals in critical skill shortage areas as identified in the National Development Plan, the Health Sector Development Plan, and official workforce analyses issued by the Ministry responsible for Health.

(ii) Priority financing shall be directed towards disciplines, cadres, and sub-specialties where shortages pose significant risks to service delivery, health outcomes, or system resilience. Such prioritisation may include targeted scholarships, funded training slots, internship and residency positions, and incentives linked to service in high-need areas.

(b) Promotion of Equity and Regional Balance

(i) Financing mechanisms shall promote equitable access to health education and training and support balanced regional distribution of health professionals. This shall include measures to expand training opportunities for learners from underserved regions, marginalised communities, and priority populations, as well as financing arrangements that support training institutions and clinical sites in regions with limited capacity.

(ii) Where appropriate, financing may be linked to service obligations or placement in underserved areas, in accordance with national policy and legal frameworks.

(c) Support for Specialised and Super-Specialised Training

(i) Financing mechanisms shall provide dedicated support for specialised and super-specialised training, including residency, fellowship, and advanced professional programmes critical to tertiary and referral-level care, research, and health system leadership. Such financing shall

recognise the higher costs, longer duration, and advanced infrastructure and supervision requirements associated with specialist and sub-specialist training.

(ii) Investment in these areas shall be aligned with national referral system needs, centres of excellence, and long-term workforce development strategies.

S11.13. Financial Accountability and Sustainability

(a) All institutions providing education and training for health shall demonstrate sound financial accountability and long-term sustainability as a condition for accreditation, continued programme approval, and eligibility to receive public or regulated funding. Financial management shall support the delivery of quality training while safeguarding public resources and learner interests.

(b) Financial accountability and sustainability are integral to the credibility and resilience of education and training systems. By requiring institutions to manage resources transparently and plan for long-term viability, these standards protect learners, uphold public trust, and ensure that investments in health education and training deliver enduring national benefits.

S11.13.1. Financial Accountability

(a) Institutions shall establish and maintain robust financial management and control systems to ensure that all funds received or utilised for education and training purposes are managed lawfully, efficiently, and transparently.

(b) This shall include:

(i) Compliance with Public Finance and Accounting Laws: All public funds and regulated resources shall be managed in accordance with applicable public finance management, procurement, and audit laws.

(ii) Proper Financial Records and Controls: Institutions shall maintain accurate, complete, and auditable financial records, including budgets, expenditure reports, procurement documentation, and asset registers.

(iii) Separation of Funds: Funds earmarked for education and training activities shall be clearly identified and not diverted to unauthorised purposes.

(iv) Regular Reporting and Audit: Institutions shall submit periodic financial reports and shall be subject to internal and external audits as required by law or regulatory authorities.

S11.13.2. Financial Transparency

Institutions shall ensure transparency in financial decision-making and use of resources related to education and training. This shall include disclosure of major funding sources, tuition and fee structures, expenditure priorities, and any material financial risks that may affect training delivery or learner progression.

S11.13.3. Financial Sustainability

(a) Institutions shall demonstrate the ability to sustain education and training programmes over the medium and long term without compromising quality, learner welfare, or safety.

(b) This shall include:

(i) Viable Financing Plans: Evidence of realistic and approved budgets, medium-term financial projections, and diversified funding sources appropriate to programme scale and complexity.

(ii) Alignment with Approved Capacity: Financial resources shall be commensurate with approved enrolment levels, staffing requirements, infrastructure, and training obligations.

(iii) Risk Management: Identification and mitigation of financial risks, including over-dependence on a single funding source, unfunded expansion, or recurrent budget shortfalls.

S11.13.4. Value for Money and Efficient Use of Resources

Institutions shall ensure that financial resources are used efficiently and deliver value for money in support of training objectives. This includes cost-effective deployment of staff, shared use of facilities where appropriate, and avoidance of wasteful or duplicative expenditures.

S11.13.5. Regulatory Oversight and Consequences of Non-Compliance

Demonstration of financial accountability and sustainability shall be a mandatory requirement for programme accreditation, re-accreditation, and continued designation as a training institution or site. Failure to meet these standards may result in regulatory action, including conditional accreditation, enrolment caps, suspension of programmes, withdrawal of approval, or other lawful sanctions.

S12 Stakeholder Engagement Standards

(a) Stakeholder engagement standards are established to ensure that Education and Training for Health is inclusive, responsive, coordinated, and aligned with national health system needs.

(b) All institutions and authorities involved in health education and training shall engage relevant stakeholders in a structured, transparent, and meaningful manner throughout policy design, programme delivery, quality assurance, and continuous improvement.

(c) Effective stakeholder engagement ensures that Education and Training for Health remains relevant, trusted, and responsive to national and community needs.

(d) By institutionalising inclusive and accountable engagement, these standards strengthen governance, improve training outcomes, and enhance public confidence in the health education and training system.

S12.1. Purpose and Scope

(a) Stakeholder engagement shall promote shared ownership, policy coherence, and evidence-informed decision-making in health education and training.

(b) These standards apply to all stages of education and training, including programme design, accreditation, clinical training, internship, residency, fellowship, financing, and quality assurance, across public and private sectors.

S12.2. Identification of Key Stakeholders

Institutions and regulatory authorities shall systematically identify and engage relevant stakeholders, which may include:

(i) Ministries responsible for Education and Sports, Health, Finance, and Local Government;

(ii) Regulatory and quality assurance bodies, including; the TVET Council, NCHE and the respective Professional Councils;

(iii) Public and private training institutions and health facilities;

(iv) Learners, interns, residents, fellows, and alumni;

(v) Employers, health service providers, and professional associations;

(vi) Local governments and community representatives; and
(vii) Development partners, civil society organisations, and the private sector.

S12.3. Structured and Meaningful Engagement

(a) Stakeholder engagement shall be planned, structured, and purposeful, rather than ad hoc or symbolic.

(b) Institutions shall use appropriate mechanisms—such as consultative meetings, advisory boards, technical working groups, public notices, surveys, and feedback forums—to obtain stakeholder input on matters affecting education quality, workforce relevance, learner welfare, and service delivery.

(c) Engagement processes shall be timely and proportionate to the significance of the issue under consideration.

S12.4. Engagement Across the Training Lifecycle

Stakeholders shall be engaged at key points across the education and training lifecycle, including: Needs assessment and workforce planning; Curriculum design and review; Accreditation and designation of training sites; Internship, residency, and fellowship planning and allocation; Financing priorities and sustainability measures; and Monitoring, evaluation, and quality improvement.

S12.5. Transparency, Feedback, and Accountability

(a) Institutions and authorities shall ensure transparency in stakeholder engagement processes and outcomes.

(b) Stakeholder inputs shall be documented, considered, and—where appropriate—reflected in decisions, policies, or programme adjustments.

(c) Clear feedback mechanisms shall be established to inform stakeholders how their contributions were addressed or why alternative decisions were taken.

S12.6. Learner and Community Participation

(a) Learners and communities shall be recognised as key stakeholders in health education and training.

(b) Institutions shall provide safe and accessible channels for learners to express views on training quality, supervision, welfare, and safety.

(c) Community engagement shall be integral to field training and community-based education, ensuring that training activities respect local contexts, priorities, and ethical standards.

S12.7. Coordination and Inter-Institutional Collaboration

(a) Stakeholder engagement shall promote coordination among institutions, regulators, and service providers to avoid duplication, policy incoherence, or conflicting mandates.

(b) Where appropriate, joint planning forums or coordination committees shall be established to harmonise standards, align training supply with service demand, and strengthen referral and training networks.

S12. 8. Inclusion, Equity, and Respect

(a) Engagement processes shall be inclusive and respectful, giving due consideration to gender, regional balance, vulnerable groups, and underserved communities.

(b) Institutions shall take reasonable steps to ensure that engagement does not disadvantage or exclude any stakeholder group and that diverse perspectives inform decision-making.

S12. 9. Documentation and Evidence of Engagement

(a) Institutions shall maintain records of stakeholder engagement activities, including meeting reports, consultation outcomes, stakeholder feedback, and follow-up actions.

(b) Evidence of meaningful stakeholder engagement shall form part of accreditation, quality assurance, and regulatory review processes.

S12.10. Compliance and Continuous Improvement

(a) Compliance with stakeholder engagement standards shall be a condition for programme accreditation, policy approval, and continued recognition of institutions and training sites.

(b) Regulatory authorities shall assess the adequacy and effectiveness of stakeholder engagement and may require corrective measures where engagement is weak, tokenistic, or absent.

(c) Engagement approaches shall be periodically reviewed and strengthened based on experience and feedback.

S12.11. Institutionalised Stakeholder Coordination Mechanisms

(a) To ensure coherence, efficiency, and accountability in Education and Training for Health, formal stakeholder coordination mechanisms shall be institutionalised at national and sub-national levels. These mechanisms shall align policy, financing, regulation, and service delivery; prevent duplication and mandate overlap; and ensure that training outputs respond to national and local health system needs.

(b) Institutionalising coordination mechanisms at political, technical, and operational levels ensures that Education and Training for Health functions as a single, coherent system rather than fragmented initiatives. Clear coordination structures strengthen policy alignment, optimise resource use, improve training quality, and ensure that education outputs match service delivery and workforce needs at national and sub-national levels.

S12.11.1 Inter-Ministerial Political Coordination Committee (Political Level):

(a) An Inter-Ministerial Political Coordination Committee shall provide strategic policy direction, high-level oversight, and political accountability for Education and Training for Health.

(b) The purpose and functions of Inter-Ministerial Coordination Committee shall be to:

(i) Provide overarching policy guidance and resolve cross-sectoral policy issues affecting health education and training.

(ii) Approve strategic priorities, reforms, and major investments aligned with national development and health sector plans.

(iii) Address inter-ministerial constraints related to financing, staffing, infrastructure, and regulatory alignment.

(c) The Composition of the Inter-Ministerial Coordination Committee shall include: Ministers (or Cabinet-designated representatives) responsible for Education; Health; Finance/Planning; Public Service; Local Government; and any other relevant portfolio as may be required.

(d) Operating Modality: This shall be convened periodically or as needed to consider strategic issues of national significance and the decisions shall be minuted and communicated to the top-technical coordination mechanism for implementation.

S12.11.2 Inter-Ministerial Top-Technical Coordination Committee (Top-Technical Level)

(a) An Inter-Ministerial Top-Technical Coordination Committee shall operationalise political decisions and provide continuous technical coordination across Ministries.

(b) The Purpose and Functions of the Inter-Ministerial Top-Technical Coordination Committee shall be to:

(i) Translate political-level decisions into implementable policies, guidelines, and action plans.

(ii) Harmonise technical standards, regulations, financing instruments, and implementation schedules.

(iii) Coordinate workforce planning, training capacity, internship and residency numbers, and budget submissions.

(iv) Monitor implementation progress and report to the political-level mechanism.

(c) Composition of the Inter-Ministerial Top-Technical Coordination Committee shall include: Permanent Secretaries, Secretary to Treasury, Directors, Commissioners, or heads of relevant Agencies from Ministries responsible for Education, Health, Finance, Public Service, Local Government, and regulatory bodies as appropriate.

(d) Operating Modality of Inter-Ministerial Top-Technical Coordination Committee shall:

(i) Involve standing committee with quarterly meetings co-chaired by the Permanent Secretary for Education and Sports and Permanent Secretary for Health and a secretariat in the Ministry of Education — the Department responsible for Health Education and Training.

(ii) Be supported by technical working groups (e.g., financing, quality assurance, workforce planning) as required.

S12.11.3 Inter-Institutional (Health Training Institutions and Training Hospitals) Coordination Committee

(a) An Inter-Institutional (Health Training Institutions and Training Hospitals) Coordination Committee shall operate at operational and service-delivery levels to align education and training activities between Health Training Institutions (HTIs) and training hospitals or facilities.

(b) The Purpose and Functions of the Inter-Institutional (Health Training Institutions and Training Hospitals) Coordination Committee shall be to:

(i) Coordinate clinical placements, field training, internship, residency, and fellowship programmes.

(ii) Ensure alignment between curricula, service delivery realities, supervision capacity, and patient safety requirements.

(iii) Harmonise schedules, trainer deployment, assessment practices, and use of shared infrastructure.

(iv) Resolve operational challenges affecting learners, supervisors, and training quality.

(c) The Composition of Inter-Institutional (Health Training Institutions and Training Hospitals) Coordination Committee shall include: The leadership and designated focal persons from universities and other HTIs, teaching and internship hospitals, accredited training facilities, and local government authorities where applicable.

(d) The Operating Modality of Inter-Institutional (Health Training Institutions and Training Hospitals) Coordination Committee shall:

(i) Involve the formal coordination committees or joint management teams established through memoranda of understanding.

(ii) Hold quarterly meetings at institutional level with documented decisions and follow-up actions.

(e) Cross-Cutting Governance Provisions for Stakeholder coordination Committees

(i) Legal and Institutional Basis: Each coordination committee above shall have a clear legal or policy basis, defined terms of reference, membership, reporting lines, and decision-making authority.

S13 Monitoring, Evaluation, and Reporting Standards

(iii) Vertical and Horizontal Linkages: Coordination Committees shall be linked vertically (national ↔ sub-national) and horizontally (across sectors and institutions) to ensure policy coherence and effective implementation.

(iv) Monitoring and Accountability: Outcomes of coordination shall be monitored, and performance of coordination mechanisms shall be periodically reviewed as part of quality assurance and governance assessments.

(a) Monitoring, Evaluation, and Reporting (MER) standards are established to ensure that Education and Training for Health is effectively implemented, performance-driven, evidence-based, and accountable to government, learners, employers, and the public. MER systems shall support continuous improvement, prudent use of resources, and alignment with national health workforce objectives.

(b) Robust monitoring, evaluation, and reporting systems transform Education and Training for Health from an input-driven activity into a results-oriented and learning system. By institutionalising MER standards, policymakers and regulators ensure that training investments deliver competent health professionals, respond to workforce needs, and continuously improve in line with national priorities.

S13.1. Purpose and Scope

(a) MER standards shall provide a structured framework for tracking inputs, processes, outputs, outcomes, and impacts of education and training for health across all levels, including pre-service education, clinical and field training, internship, residency, and fellowship.

(b) These standards apply to all institutions, training sites, regulatory bodies, and implementing authorities in both public and private sectors.

S13.2. Results-Based Monitoring Framework

(a) All programmes and institutions shall operate within a results-based monitoring framework aligned with national development and health sector plans.

(b) Clear indicators, baselines, targets, and timelines shall be defined to track progress in areas such as enrolment, completion, competency attainment, graduate deployment, equity, quality assurance, and workforce relevance.

S13.3. Routine Monitoring and Data Collection

(a) Institutions and training sites shall conduct routine monitoring of education and training activities using standardised tools and indicators including periodic data on: Enrolment;(for all the cadres involved); Completion and Graduation; Internship placement; Employment outcomes. (employment rate, progression performance, satisfaction); Staffing (student staff ratios; availability of intended specialization; turnover rate); and Infrastructure appropriate for the levels delivered and any other data and information prescribed by the relevant authorities.

(b) Monitoring data shall cover programme delivery, supervision, assessment outcomes, learner welfare, resource utilisation, and compliance with training standards.

(c) Data collection shall be timely, accurate, and disaggregated where appropriate to support equity and regional analysis.

S13.4. Evaluation of Effectiveness and Impact

(a) Periodic evaluations shall be undertaken to assess the effectiveness, efficiency, relevance, and sustainability of education and training programmes.

(b) Evaluations may include programme reviews, tracer studies of graduates, employer satisfaction

surveys, skills-gap analyses, and cost-effectiveness assessments.

(c) Evaluation findings shall inform policy review, curriculum reform, financing decisions, and workforce planning.

S13.5. Reporting and Information Sharing

(a) Institutions and authorities shall prepare and submit regular, standardised reports on education and training performance to the designated oversight bodies.

(b) Reports shall present verified data, analysis of trends, challenges encountered, and corrective actions taken.

(c) Reporting timelines and formats shall be prescribed to ensure comparability and consolidation at national and sub-national levels.

S13.6. Data Quality, Integrity, and Use

(a) MER systems shall uphold high standards of data quality, integrity, confidentiality, and ethical use.

(b) Institutions shall establish mechanisms for data verification, validation, and secure storage.

(c) MER data shall be actively used for decision-making including informing workforce planning, policy review, and resource allocation, quality improvement, and accountability, rather than for compliance purposes alone.

S13.7. Roles, Responsibilities, and Capacity

(a) Clear roles and responsibilities for monitoring, evaluation, and reporting shall be assigned to institutions, training sites, regulators, and coordinating bodies.

(b) Adequate technical and human capacity shall be provided to support MER functions, including training of personnel, allocation of resources, and use of appropriate information systems.

S13. 8. Feedback, Learning, and Continuous Improvement

(a) MER processes shall incorporate feedback mechanisms that enable institutions, supervisors, learners, and policymakers to reflect on performance and implement improvements.

(b) Lessons learned and best practices shall be documented and disseminated to strengthen system-wide learning and innovation.

S13.9. Transparency and Public Accountability

(a) Summary findings from monitoring and evaluation activities shall be made accessible to relevant stakeholders to promote transparency and public accountability, subject to data protection and confidentiality requirements.

(b) Transparency in reporting shall strengthen trust in education and training systems and support informed stakeholder engagement.

S13.10. Compliance and Regulatory Oversight

(a) Compliance with MER standards shall be a mandatory condition for programme accreditation,

funding eligibility, and continued approval of institutions and training sites.

(b) Regulatory authorities shall review MER reports, conduct verification where necessary, and may require corrective actions or impose sanctions for persistent non-compliance or misreporting.

S14 Application and Enforcement of Standards

(a) Application and enforcement standards are established to ensure that all provisions governing Education and Training for Health are consistently applied, effectively implemented, and meaningfully enforced across institutions, training sites, and programmes. These standards give legal and operational effect to policy objectives and safeguard training quality, learner welfare, and public interest.

(b) Clear application and enforcement mechanisms ensure that standards are not merely aspirational but operational and credible. By embedding consistent enforcement, due process, and inter-agency coordination, these provisions strengthen regulatory authority, protect learners and patients, and maintain public confidence in Education and Training for Health systems.

S14.1. Scope of Application

(a) All standards issued under this framework shall apply to all public and private institutions, training sites, programmes, and persons involved in Education and Training for Health, including pre-service education, clinical and field training, internship, residency, and fellowship.

(b) Compliance shall be mandatory as a condition for accreditation, programme approval, learner admission, and recognition of training outcomes.

S14.2. Legal Status and Binding Effect

(a) The standards shall have binding legal and regulatory force and shall be applied uniformly by all responsible authorities.

(b) No institution, training site, or individual shall be exempt from compliance except as expressly provided by law or approved through a formal regulatory waiver process.

S14.3. Roles and Responsibilities for Enforcement

(a) Enforcement of standards shall be carried out by the designated regulatory and oversight authorities within their respective mandates, including Ministries responsible for Health and Education, the TVET Council, the National Council for Higher Education (NCHE), (where applicable), Professional Councils, and other authorised bodies.

(b) Each authority shall apply the standards in a coordinated manner to avoid duplication, regulatory gaps, or conflicting directives.

S14.4. Accreditation, Licensing, and Approval Mechanisms

(a) Application of standards shall be operationalised through accreditation, licensing, designation, and approval processes.

(b) Institutions and training sites shall demonstrate compliance with all applicable standards as a prerequisite for: (i) Programme accreditation and re-accreditation; (ii) Approval of clinical training,

internship, residency, and fellowship sites; (iii) Determination of enrolment ceilings and intake numbers; and (iv) Recognition of qualifications and training outcomes.

S14.5. Monitoring, Inspection, and Verification

(a) Regulatory bodies shall conduct regular and risk-based monitoring, inspections, and verification exercises to assess compliance with standards. The processes may include document reviews, site inspections, interviews, performance data analysis, and follow-up audits.

(b) Institutions and training sites shall cooperate fully and provide access to relevant records and facilities.

S14.6. Graduated Enforcement and Corrective Action

(a) Enforcement shall follow a graduated and proportionate approach, taking into account the nature, severity, and persistence of non-compliance.

(b) Measures may include: Issuance of warnings or improvement notices; Requirement for corrective action plans with defined timelines; Imposition of enrolment caps or intake reductions; Suspension of programme or site approvals; Withdrawal of accreditation or designation; or Any other lawful regulatory action.

S14.7. Due Process and Right to be Heard

(a) All enforcement actions shall observe principles of fairness, transparency, and due process.

(b) Institutions and affected parties shall be informed of findings of non-compliance, given reasonable opportunity to respond, and notified of decisions and reasons thereof. Appeals or review mechanisms shall be available in accordance with applicable laws and regulations.

S14.8. Inter-Agency Coordination in Enforcement

(a) Where multiple authorities have overlapping mandates, enforcement actions shall be coordinated through established inter-agency mechanisms to ensure coherence, avoid duplication, and present a unified regulatory position.

(b) Joint inspections, shared reports, and harmonised sanctions may be utilised where appropriate.

S14.9. Public Interest and Learner Protection

(a) In applying and enforcing standards, authorities shall prioritise learner protection, patient safety, and public interest.

(b) Where non-compliance poses immediate risks, regulators may take urgent interim measures to protect learners and the public, including temporary suspension of training activities.

S14.10. Continuous Review and Improvement

(a) Application and enforcement practices shall be periodically reviewed to ensure effectiveness, consistency, and alignment with evolving national priorities and international best practice.

(b) Lessons learned from enforcement actions shall inform refinement of standards, guidance, and regulatory capacity.

S15 Transitional Arrangements

S15.Transitional Arrangements

(a) Transitional arrangements are established to ensure the orderly, fair, and uninterrupted transition from previous policies, standards, and regulatory practices to the new Education and Training for Health framework.

(b) These arrangements are intended to protect learners, institutions, and service delivery while enabling progressive compliance with the new standards.

(c) Transitional arrangements provide the legal and operational bridge between reform and practice. By combining continuity with phased compliance and regulatory support, these provisions minimise disruption, protect learners and patients, and ensure that the transition to strengthened Education and Training for Health standards is credible, fair, and sustainable.

S15.1. Purpose and Principles

(a) Transitional arrangements shall provide legal and operational continuity during the implementation of new standards.

(b) They shall be guided by the principles of non-disruption of training, learner protection, regulatory certainty, proportionality, and progressive compliance.

S15.2. Continuity for Current Learners and Trainees

(a) All learners, interns, residents, and fellows who are already enrolled, deployed, or appointed at the commencement of these standards shall be allowed to continue and complete their training under the conditions that applied at the time of their admission, deployment, or appointment, unless such conditions pose a demonstrable risk to patient safety, learner welfare, or public interest.

(b) Where alignment with new standards is required, reasonable accommodation and bridging measures shall be provided.

S15.3. Transitional Compliance for Institutions and Training Sites

(a) Institutions and training sites that were lawfully accredited, designated, or approved prior to the commencement of these standards shall be granted a defined transitional compliance period within which to align with the new requirements.

(b) During this period:

(i) Existing approvals shall remain valid, subject to continued compliance with minimum safety and quality thresholds;

(ii) Institutions shall submit transition or compliance plans outlining timelines, actions, and resource requirements; and

(iii) Regulatory authorities may impose conditional approvals or phased compliance milestones.

S15.4. Recognition of Existing Qualifications and Approvals

(a) Qualifications, certifications, accreditations, licences, and approvals issued under previous frameworks shall remain recognised during the transitional period.

(b) No learner or practitioner shall be disadvantaged solely by reason of having trained or been approved under an earlier regulatory regime, provided that minimum professional and safety standards are met.

S15.5. Phased Implementation of New Standards

(a) New or enhanced standards—particularly those relating to infrastructure, staffing ratios, financing, assessment systems, and specialised training—may be implemented in a phased manner as prescribed by the responsible authorities.

(b) Phasing schedules shall be clearly communicated and shall prioritise high-risk and high-impact areas such as patient safety, supervision, and quality assurance.

S15.6. Regulatory Guidance and Support

(a) During the transition period, regulatory and coordinating authorities shall issue implementation guidance, circulars, and technical support to assist institutions and training sites to understand and comply with the new standards.

(b) Capacity-building, orientation, and stakeholder engagement activities shall form part of the transitional support measures.

S15.7. Monitoring During the Transition

(a) Transitional compliance shall be subject to monitoring and reporting to ensure that institutions are making measurable progress toward full compliance.

(b) Regulators may conduct targeted inspections or reviews focused on transition milestones rather than full enforcement, unless serious non-compliance or safety risks are identified.

S15.8. Handling of Conflicts and Inconsistencies

(a) Where inconsistencies arise between previous instruments and the new standards during the transition period, the new standards shall prevail, subject to the protections afforded under these transitional arrangements.

(b) Regulatory authorities shall provide clarifications to resolve ambiguities and prevent conflicting interpretations.

S15.9. Expiry of Transitional Period

(a) At the expiry of the prescribed transitional period, all institutions, programmes, and training sites shall be required to demonstrate full compliance with the new standards as a condition for continued accreditation, designation, or approval.

(b) Failure to achieve full compliance by the end of the transition period shall attract enforcement action in accordance with the enforcement provisions.

15.10. Protection of Public Interest

(a) Nothing in these transitional arrangements shall prevent regulatory authorities from taking immediate action where non-compliance poses a risk to patient safety, learner welfare, or public interest.

(b) Transitional flexibility shall not be construed as a waiver of fundamental safety, ethical, or professional standards.

S16 Declaration

S16.1 Pursuant to Cabinet approval of the Education and Training for Health Policy under Minute No.328 (CT2025), these Policy Implementation Standards are authorised for implementation by Ministry responsible for Education and Sports in collaboration with the Ministry responsible for Health and all regulatory bodies, institutions, and stakeholders.

S16.2 These Policy Implementation Standards are hereby issued to give full operational effect to the National Education and Training for Health Policy, 2025, and to ensure that Education and Training for Health in Uganda is coherent, high-quality, ethically grounded, and responsive to national health system needs.

S16.3 The Standards establish a unified and enforceable framework for the planning, financing, delivery, regulation, monitoring, and continuous improvement of education and training for health across all levels and cadres. They are intended to harmonise the roles of government institutions, training institutions, regulatory bodies, health facilities, and other stakeholders, and to promote consistency, accountability, and excellence throughout the education and training continuum.

S16.4 In particular, these Standards are issued to:

(i) Safeguard patient safety, learner welfare, and public interest;

(ii) Ensure competence-based, well-supervised, and quality-assured education and training outcomes;

(iii) Align education and training outputs with national health workforce priorities, service delivery requirements, and development goals; and

(iv) Strengthen governance, coordination, financing discipline, and regulatory oversight within the Education and Training for Health system.

S16.5 All institutions, authorities, and persons involved in Education and Training for Health shall apply and comply with these Standards in the execution of their mandates, subject to the applicable laws and regulations of Uganda.

S16.6 These Standards shall guide implementation, inform accreditation and enforcement decisions, and serve as the authoritative reference for quality, accountability, and continuous improvement in Education and Training for Health.

ADOPTION AND SIGNING

Policy Implementation Standards for Education and Training for Health

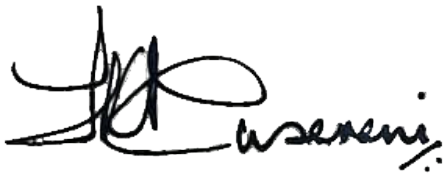
Issued under the authority of: The National Education and Training for Health Policy, 2026

ADOPTION

These Policy Implementation Standards for Education and Training for Health are hereby adopted and issued to operationalise the National Education and Training for Health Policy, 2025, and shall apply to all public and private institutions, training sites, regulatory authorities, and persons involved in the education and training of health professionals in Uganda.

The standards shall take effect on the date of signature and shall remain in force unless reviewed, amended, or replaced in accordance with applicable laws and procedures.

SIGNATURE



Signature: ..... Date: 26 Feb 2026

Janet K. Museveni
FIRST LADY AND MINISTER OF EDUCATION AND SPORTS

CONCURRED WITH

Signature: ..... Date: 26th Feb 2026

Dr. Jane Ruth Aceng Ocero.
HON. MINISTER OF HEALTH

IMPLEMENTATION AND CUSTODY

These Policy Implementation Standards shall be implemented by the Ministry responsible for Education and Sports in collaboration with the Ministry responsible for Health, the TVET Council, the National Council for Higher Education, relevant Professional Councils, Training Institutions, and Health Facilities.

The official master copy of these Standards shall be kept by the Ministry responsible for Education and Sports, and certified copies shall be issued to Ministry of Health, implementing and regulatory authorities for purposes of compliance, enforcement, and reference.

CITATION

These Standards may be cited as the: Policy Implementation Standards for Education and Training for Health, 2026

The Repulic of Uganda

MINISTRY OF EDUCATION AND SPORTS

THE NATIONAL EDUCATION AND TRAINING FOR HEALTH POLICY

IMPLEMENTATION GUIDELINES

2026

FOREWARD

These Policy Implementation Guidelines (PIGs) establish a unified operational governance framework for operationalising the National Education and Training for Health (NETH) policy commitments by establishing structured systems for cross-sectoral coordination, standardisation, implementation, accountability, and performance management across the education and training, health, Technical, and Vocational Education and Training (TVET) and the higher education systems.

The PIGs provide an integrated architecture for policy coherence, institutional alignment, regulatory coordination, financing integration, data governance, monitoring and evaluation, and compliance enforcement across sectors.

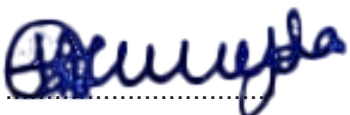
Government hereby affirms that national education and training for health and the health system performance are fundamentally a function of implementation discipline, institutional coordination, and accountability integrity. The guidelines therefore function as instruments of system control, risk management, and performance assurance across all health sector actors.

The PIGs affirm the principle that human capital development is a system function, requiring harmonised governance, coordinated institutions, standardised implementation frameworks, and shared accountability mechanisms.

They provide a binding framework for aligning health service delivery, human resources for health, training and education, quality assurance, financing, and governance within a coherent implementation architecture. The Guidelines define institutional roles, operational procedures, compliance obligations, monitoring systems, and enforcement mechanisms to ensure consistent and high-quality service delivery.

Accordingly, all Ministries, Departments and Agencies (MDAs), and Local Governments (LGs), regulatory bodies, training institutions, service delivery entities, professional councils, and implementing partners operating within these sectors are required to apply these guidelines in the planning, execution, monitoring, and evaluation of programmes and interventions.

The guidelines apply to all relevant Ministries, Departments and Agencies (MDAs), Local Governments, health training institutions (HTIs), professional councils, health facilities, regulatory bodies, and all implementing partners engaged in health sector programmes, and shall guide planning, budgeting, service delivery, supervision, and reporting processes at all levels.



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Dr. Kedrace R. Turyagyenda
Permanent Secretary,
Ministry of Education and Sports

.....

Dr. Diana Atwine
Permanent Secretary,
Ministry of Health

APPROVAL AND ADOPTION

These Implementation Guidelines are issued pursuant to the National Education and Training for Health Policy, 2025 and the National Education and Training for Health Policy Implementation Standards, 2026, and are hereby approved and adopted by the Government of the Republic of Uganda for the purpose of operationalising education and training for health across all public and private institutions.

These Guidelines are issued under the joint authority of the Ministry of Health and the Ministry of Education and Sports, with the approval of Cabinet, and shall be binding on all institutions, authorities, bodies, and persons involved in education and training for health in Uganda.

Cabinet Minute No.: 328(CT2025) — Date of Cabinet Approval: 06th October 2025

SIGNING AND ISSUANCE APPROVAL AND ADOPTION

Issued at Kampala this 26th day of February 2026.

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LIST OF ACRONYMS

AG – Attorney General

CAP – Corrective Action Plan

CAPs – Corrective Action Plans

CPD – Continuing Professional Development

HEQF – Higher Education Qualifications Framework

HTI – Health Training Institution

HTI Register – Health Training Institution Register

IPC – Infection Prevention and Control

ISCED – International Standard Classification of Education

LG – Local Government

MDA – Ministry, Department or Agency

MER – Monitoring, Evaluation and Reporting

MER Framework – Monitoring, Evaluation and Reporting Framework

MoES – Ministry of Education and Sports

MoFPED – Ministry of Finance, Planning and Economic Development

MoH – Ministry of Health

NCHE – National Council for Higher Education

NDP – National Development Plan

NETH – National Education and Training for Health

NETH-MSC – National Education and Training for Health Ministerial Steering Committee

NETH Register – National Education and Training for Health Register

NETH-TSC – National Education and Training for Health Technical Steering Committee

NETH-TWG – National Education and Training for Health Technical Working Group

PIGs – Policy Implementation Guidelines

PISs – Policy Implementation Standards

QA – Quality Assurance

RHC – Regulatory Harmonisation Committee

RPL – Recognition of Prior Learning

SI – Statutory Instrument

TVET – Technical and Vocational Education and Training

UHPAB – Uganda Health Professions Assessment Board

UQF – Uganda Qualifications Framework

UOTIA – Universities and Other Tertiary Institutions Act

UQF Mapping Matrix – Uganda Qualifications Framework Mapping Matrix

UQF Register – Uganda Qualifications Framework Register

WHO – World Health Organization

1 INTRODUCTION

1. Policy Implementation Standards (PISs) and Policy Implementation Guidelines (PIGs) serve complementary but distinct functions in the policy implementation architecture. While PISs establish mandatory and binding operational requirements that must be complied with by all duty-bearers in the policy implementation process, PIGs provide operational direction and practical interpretation on how PISs are implemented in practice. Together, PISs and PIGs ensure that policy intent is translated into enforceable obligations and workable procedures.

2. PIGs are authoritative administrative and technical instruments issued to provide clear, practical, and operational direction on the implementation of approved PISs. PISs explain how the mandatory requirements set out in the standards are to be interpreted, applied, and complied with in practice by regulators, institutions, and other duty-bearers.

3. PIGs do not create new legal obligations or substitute PISs. Rather, they translate binding standards into workable procedures, specifying roles and responsibilities, step-by-step processes, documentation requirements, timelines, coordination arrangements, and acceptable implementation modalities. PIGs reduce ambiguity, promote consistency across institutions and regulators, and support predictable, fair, and effective administration.

4. While generally non-penal in nature, PIGs are authoritative for interpretation. Regulators may rely on them to assess whether institutions have taken reasonable and appropriate steps to comply with the Standards, and institutions are expected to follow them as the recognised means of demonstrating compliance.

5. Where operational challenges arise, PIGs provide flexibility for administrative adaptation without weakening the underlying Standards.

6. PIGs function as the practical bridge between policy intent and enforceable standards, ensuring that mandatory requirements are implemented in a coherent, transparent, and efficient manner across the system.

G1.0 Binding Operational Requirements

7. For the avoidance of doubt, the term “binding” signifies that these Standards are not advisory, aspirational, or discretionary in nature, but rather constitute mandatory and enforceable compliance requirements within the regulatory framework.

8. The Standards are operationalised and given full legal and administrative effect through formal regulatory decision-making processes, including but not limited to:

G1.1 Licensing, Accreditation, and Programme Approval Decisions

9. Compliance with the standards is a pre-condition for the grant, renewal, variation, suspension, or revocation of institutional licences, accreditation status, and programme approvals by the competent authority.

10. No institution or programme shall be licensed, accredited, or approved unless it demonstrably meets the prescribed standards, as verified through the inspections, documentation reviews, and quality assurance assessments.

11. Continued compliance constitutes a condition for maintaining such approvals over time, while

non-compliance triggers corrective actions, sanctions, or withdrawal of regulatory recognition in accordance with applicable law.

G1.2 Clinical Training, Internship, and Residency Site Approval and Designation

12. Compliance with the standards is a pre-condition for approval, designation, accreditation, or continued recognition of any health facility, training centre, or practice site used for clinical training, internship, residency, fellowship, or other practice-based learning.

13. No site shall be approved unless it demonstrably meets the prescribed Standards relating to infrastructure, staffing and supervision, case mix and service volumes, patient safety and ethics, learning resources, governance arrangements, and reporting obligations, as verified through formal inspections and assessments by the competent authority.

14. Continued designation of approved sites shall be conditional upon ongoing compliance with the Standards, subject to periodic review, re-inspection, and performance monitoring.

15. Where a site is found to be non-compliant, the approving authority may impose conditions, require Corrective Action Plans (CAPs) within specified timelines, limit the number or category of trainees, suspend placements, or withdraw the approval altogether.

16. Training conducted at unapproved sites shall not be recognised for certification, registration, or progression purposes, thereby ensuring that standards are binding in practice and directly enforceable through clinical training and internship placement.

G1.3 Admission Capacity, Ceilings, and Placement Ceilings

17. The Standards prescribe the maximum permissible intake and placement numbers for institutions, programmes, and training sites, determined on the basis of approved infrastructure, staffing and supervision ratios (HTIs and Hospital), learning resources, clinical exposure or practice opportunities, safety and ethical requirements, as well as quality assurance thresholds.

18. No institution or programme shall admit learners, nor place trainees for clinical, internship, residency, or other practice-based training, in excess of the approved ceilings.

19. Admission and placement ceilings must be formally approved by the competent authority and constitute legally binding conditions attached to institutional licences, programme approvals, and site designations.

20. Compliance with approved ceilings must be monitored through admissions audits, placement verification, and inspection reports.

21. Exceeding approved ceilings constitutes material breach of Standards, attracts regulatory sanctions, including intake restrictions, nullification of excess admissions or placements, suspension of approvals, or other enforcement measures as provided by law.

22. Where capacity constraints arise such as loss of approved sites, staff attrition, or infrastructure deficiencies, the approving authority may revise the ceilings downward in public interest, with immediate effect where trainee safety or quality is at risk.

23. Conversely, where there is demonstration of increased capacity and sustained compliance with the standards, the approving authority may upon verification permit upward revision of the ceilings.

24. Accordingly, admission capacity and placement ceilings function as binding regulatory instruments to protect quality, equity, and system integrity.

G1.4 Funding Eligibility and Release Conditions

25. Compliance with standards constitutes a pre-condition for institutional and programme eligibility to access public funding, including budgetary allocations, capitation grants, scholarships, internships and residency support, student loan financing, and any other form of assistance administered or guaranteed by Government or its authorised Agencies.

26. No funds shall be approved, committed, or released to an institution, programme, or training site that has not demonstrated compliance with the prescribed standards.

27. The release of funds is conditional upon continued compliance, verified through certification by the competent regulatory authority, inspection reports, performance and financial accountability reviews, and submission of required compliance returns.

28. Funding approvals may include explicit compliance clauses, milestones, and performance conditions linked to the Standards, and disbursements may be withheld, deferred, reduced, or suspended where non-compliance is identified.

29. Where material or persistent non-compliance occurs, the responsible authority may impose funding sanctions, including suspension of releases, recovery of improperly utilised funds, reallocation of resources, or disqualification from future funding cycles, in accordance with applicable public finance and administrative law.

30. The funding eligibility and release conditions are a binding enforcement mechanism, to ensure that public resources are deployed only in support of institutions, programmes, and training sites that meet the required standards and safeguard the public interest.

G1.5 Inspection, Corrective Action, and Sanctions.

31. The standards constitute the authoritative benchmark for all routine, periodic, and special inspections, audits, and compliance reviews conducted by the competent authority.

32. Inspections must assess institutional, programme, and training-site performance directly against the standards using prescribed indicators, tools, and reporting formats, and must result in formal compliance determinations.

33. Where non-compliance is identified, the responsible authority must issue binding corrective action measures, including improvement notices and compliance directives specifying the nature of breach, required remedial actions, responsible persons, and timelines for rectification.

34. Institutions and sites must be given an opportunity to remedy deficiencies within the prescribed period, subject to follow-up inspections and verification.

35. Where there is continued, material, or high-risk non-compliance, the responsible authority must escalate enforcement in a graduated manner, applying sanctions that are lawful, proportionate, and risk-based. Such sanctions may include conditional approvals, enrolment or placement caps, suspension of specific activities, financial penalties, withdrawal of funding eligibility, suspension or revocation of licences, accreditation, programme approvals, or site designations.

36. Where trainee or learner safety, patient safety, or public interest is at immediate risk, the responsible authority may impose urgent interim measures, including immediate suspension of

operations, pending full determination.

37. All inspection findings, corrective actions, and sanctions shall be formally recorded, communicated in writing, and subject to applicable requirements of procedural fairness, transparency, and appeal.

38. In this way, inspection, corrective action, and sanctions operate as an integrated, binding enforcement mechanism that ensures sustained compliance with the standards while promoting continuous quality improvement and system integrity.

G2.0 National Issuance and Legal-Operational Activation Procedure

39. G2.0 establishes the authoritative national pathway through which standards acquire legal force and are translated into operational obligations, by clearly allocating roles, responsibilities, and sequencing among the relevant public authorities. This provision ensures that standards are not merely published, but are rather lawfully issued, formally activated, uniformly applied, and consistently enforced across the system.

40. The objective is to bring the standards into force as a national compliance instrument, and operationalise them through the regulator ecosystem. The standards shall be issued and activated through a structured, multi-step national process, with clearly delineated institutional responsibilities as follows:

G2.1 Policy Authority (Minister / Responsible Ministry)

41. The Minister responsible for Education and Sports and the Minister responsible for Health shall jointly exercise policy authority to approve and issue the standards as a formal policy and regulatory instruments, consistent with the enabling legal framework.

42. This issuance shall confer national applicability and signal executive intent that the standards are binding and enforceable. The Ministers shall cause the PISs and PIGs to be formally published and gazetted, thereby giving them official status and public notice.

G2.2 Regulatory and Quality Assurance Authorities

43. The TVET Council and NCHE, the designated regulatory and quality assurance Agencies shall on behalf of Ministry of Education and Sports be responsible for translating the issued standards into operational regulatory instruments, including licensing conditions, accreditation criteria, inspection tools, reporting templates, and enforcement guidelines.

44. The TVET Council and NCHE must integrate the standards into their routine regulatory functions and ensure that all approvals, reviews, and compliance determinations are explicitly anchored in the standards.

G2.3 Ministries and Implementation Agencies

45. Relevant Ministries and implementing Agencies shall ensure system-wide alignment and coordination, including issuance of Circulars, guidelines, and Inter-Agency directives clarifying how the standards apply across institutions, programmes, and training sites.

46. They shall further ensure coherence between the Standards and workforce planning, service delivery requirements, and public financing mechanisms.

G2.3.1 Responsibility for Compliance by Institutions and Training Sites

47. Institutions, and designated training sites shall bear primary responsibility for compliance, including internalisation of the Standards into institutional policies, programmes, governance arrangements, staffing plans, admissions controls, quality assurance systems, and reporting mechanisms.

48. Compliance with PISs and PIGs shall not be optional or deferred and shall apply from the effective date specified in the issuance instrument, subject only to expressly provided transitional arrangements.

G2.3.2 Monitoring, Enforcement, and Accountability

49. Competent authorities shall monitor implementation, conduct inspections, enforce compliance, and apply corrective actions or sanctions as prescribed.

50. Each authority shall act within its statutory mandate, but in a coordinated manner, to avoid regulatory gaps, overlaps, or inconsistent application of the Standards.

51. Compliance outcomes shall be documented and shall inform licensing, funding, and other consequential decisions.

52. National issuance and activation procedure, ensures that standards move from policy text to binding operational rules, with clear allocation of responsibility, certainty, and enforceability.

53. G2.0 ensures that accountability is traceable; who issues, who operationalises, who complies, and who enforces and that Standards function as an integrated national regulatory instrument rather than a discretionary guidance document.

G2.3.3 Formal Issuance and Custody

54. G2.1 establishes the foundational legal step through which the standards are formally brought into existence as an authoritative national instrument and placed under responsible institutional custody. This is critical to confer legitimacy, traceability, and administrative control over the standards prior to their operational deployment.

55. The Standards must be formally issued by the Ministry responsible for Education and Sports in accordance with the national policy and legal framework.

56. Formal issuance takes the form of an official Ministerial Instrument, duly approved and signed, published or gazetted to provide Legal Notice and national applicability.

57. From the date specified in the issuance instrument, the standards acquire official status and are deemed valid and binding, subject to any transitional provisions expressly provided.

58. Upon issuance, custody of the standards shall vest in the Ministry of Education and Sports (MoES). Custody includes responsibility for maintaining the official master copy, managing version control, issuing certified copies, and ensuring that no unauthorised alterations, parallel versions, or informal interpretations are produced.

59. The custodian shall further ensure secure archiving, public accessibility, and dissemination to all relevant stakeholders through official channels.

60. MoES is the Reference Authority for interpretation, clarification, and future amendment processes,

acting in coordination with the policy authority and other regulators.

61. G2.1 ensures that PISs are lawfully issued, clearly owned, and institutionally anchored, providing a stable legal and administrative foundation for subsequent operationalisation, enforcement, and accountability.

G2.3.4 Role of the Ministry of Education and Sports (MoES)

62. MoES as the lead policy authority shall bear primary responsibility for the formal issuance, custody, and authoritative management of the PISs.

63. In this capacity, MoES shall following the requisite approvals, signature, and publication and gazettement procedures issue PISs formally to the public. The issuance confers national applicability and legal-operational force, signalling that PISs are binding and enforceable across all institutions, programmes, and training sites.

64. MoES shall also maintain custody of the master copy of the NETH policy, PISs and PIGs as a single authoritative reference version. This responsibility includes document control, version management, secure archival, and protection against unauthorised modification or parallel texts.

65. No reproduction, adaptation, or derivative instrument shall be treated as authoritative unless it is traceable to, and consistent with, the master copy of the PISs held by MoES.

66. For purposes of compliance, inspection, and enforcement, MoES shall officially issue certified copies of the NETH policy, PISs and PIGs to regulators, inspection teams, implementing Agencies, and other designated bodies.

67. Certified copies shall constitute legally reliable references for regulatory decisions, inspections, corrective actions, and sanctions, and shall be admissible for official and administrative use. Through these functions, MoES ensures legal certainty, uniform application, and institutional accountability in the implementation of the Standards.

G2.3.5 Role of the Ministry of Health (MoH)

68. As a co-lead implementing authority, MoH shall exercise sectoral stewardship to ensure that PISs are effectively integrated into health service delivery, clinical training environments, and workforce development systems.

69. In this capacity, MoH shall issue a Complementary Ministerial or Administrative Circular formally directing all health sector institutions, training hospitals, internship and residency sites, and affiliated agencies to comply with PISs as issued by the MoES.

70. The circular shall affirm the binding nature of the PISs, specify their applicability within the health sector, and provide authoritative guidance on how they are to be applied in clinical training, internship, residency, and other practice-based learning settings.

71. The MoH circular shall serve as a principal instrument for harmonised implementation, ensuring alignment between education-sector regulatory requirements and health-sector operational realities.

72. The MoH circular shall clarify roles and expectations for health facilities, professional supervisors, and training site managers; align the PISs with existing health policies, service delivery norms, and workforce planning frameworks; and direct internal compliance, monitoring, and reporting arrangements within the health sector.

73. The issuance of the complementary circular, MoH operationalises PISs within its mandate, prevents fragmented or inconsistent application across the sectors, and ensures that education and training requirements are coherently embedded within the national health system. This reinforces inter-ministerial coordination, legal certainty, and system-wide compliance.

G2.4 National Issuance, Certified Copies, Publication Notice and Dissemination

G2.4.1 National Issuance Circular(s)

74. Official issuance circulars shall be released by the lead and co-lead Ministries, formally announcing the adoption of PISs, affirming their binding nature, and directing all affected institutions, regulators, and training sites to comply.

75. The circulars shall specify the effective date, scope of application, transitional arrangements (if any), and the effects of non-compliance, thereby providing clear administrative instruction.

G2.4.2 Certified Copies of the Policy Implementation Standards

76. Certified copies, derived from the master copy held by MoES, shall be produced and distributed for regulatory, compliance, inspection, and enforcement use.

77. Certified copies shall serve as authoritative references in licensing, accreditation, inspections, funding decisions, and sanctions, ensuring uniform interpretation and application across all the authorities and institutions.

G2.4.3 Policy Implementation Standards Publication Notice

78. A formal publication and gazettement notice shall be issued, confirming that PISs have been officially published and are in force.

79. This notice informs the public, establishes the commencement date, and supports enforceability by demonstrating that due process requirements have been satisfied.

G2.4.4 Official Dissemination Package

80. An official dissemination package shall be prepared and circulated, comprising the issued PISs, explanatory notes, PIGs, compliance timelines, contact points for clarification, and references to related regulatory instruments.

81. The package shall be disseminated through official government channels to Ministries, Departments and Agencies (MDAs), Regulators (TVET council, NCHE), relevant professional bodies, Health Training Institutions, training sites, and other stakeholders, ensuring accessibility, consistency, and readiness for implementation.

82. Taken together, these outputs constitute the documentary and procedural proof that the Standards have moved from approval to binding national application. They ensure legal certainty, administrative clarity, and coordinated system-wide implementation, while providing regulators and institutions with the tools necessary for compliance and enforcement.

G2.5 Joint Implementation Directive and Coordination

83. G2.5 establishes the inter-ministerial mechanism through which the issued Standards are translated into a coordinated, system-wide implementation mandate. This step ensures that

the Standards are applied consistently across policy, regulatory, service delivery, and training environments, and that no institutional or sectoral gaps arise in their execution.

84. Following formal issuance, MoES (lead Ministry) and MoH (co-lead Ministry) shall issue a joint implementation directive confirming the binding status of the PISs and directing their uniform application across all relevant institutions, regulators, training sites, and implementing agencies. The directive shall articulate shared ownership, reinforce inter-ministerial coherence, and prevent fragmented or conflicting implementation instructions.

85. The joint directive shall further establish formal coordination arrangements, including designation of focal points, inter-agency working mechanisms, and information-sharing protocols. These arrangements must clarify roles and responsibilities among Ministries, regulators, professional councils, and implementing agencies, and a structured platform for resolving overlaps, ambiguities, or operational challenges during implementation.

86. In addition, the directive provides operational guidance on sequencing, timelines, and transitional measures, including how existing approvals, placements, funding arrangements, and training sites are to be aligned with the Standards.

87. Where necessary, the directive shall mandate harmonisation of subsidiary instruments such as licensing conditions, inspection tools, funding criteria, and reporting templates to ensure that all downstream regulatory and administrative processes are anchored in the standards.

88. Through this joint implementation directive and coordination framework, G2.2 ensures that the standards are not implemented in isolation by individual actors, but function as a coherent national regulatory regime, supported by shared accountability, coordinated oversight, and consistent enforcement across sectors.

G2.6 National Coordination, Reporting, Enforcement, and Transition Arrangements

89. For the avoidance of doubt, these elements define the operational backbone through which the Standards are implemented coherently, monitored consistently, enforced effectively, and transitioned in an orderly and legally secure manner across the system.

G2.6.1 National Coordination Arrangements

90. Formal national coordination arrangements shall be established to ensure whole-of-government and whole-of-system alignment in the implementation of the Standards.

91. The National Education and Training for Health policy and the resultant Policy Implementation Standards have designated MoES as the lead authority and MoH as the co-lead authority.

92. MoES through the Department responsible for Health Education and Training shall be the National Coordination Secretariat. The two Ministries must identify participating Ministries, regulators (TVET Council and NCHE), Professional Councils, and Implementing Agencies, and establish structured coordination mechanisms, such as Inter-Ministerial Committees, Technical Working Groups, and designated focal points.

93. Coordination arrangements must provide clear mandates for decision-making, information-sharing, and dispute resolution, thereby preventing regulatory overlap, gaps, or inconsistent application of the Standards.

G2.6.2 Reporting Timelines and Compliance Cycles

94. Clear and enforceable reporting timelines shall be prescribed to support systematic monitoring

of compliance. Institutions and programmes and training sites shall be required to submit periodic compliance reports, self-assessments, and performance data against the Standards, in accordance with defined reporting cycles.

95. Authorities shall consolidate and review reports within specified timelines and provide formal feedback, including compliance determinations and required corrective actions.

96. Adherence to reporting timelines shall itself constitute a compliance obligation, with failure to report treated as non-compliance.

G2.6.3 Enforcement Coordination

97. Enforcement actions must be coordinated among relevant authorities to ensure consistency, proportionality, and legal certainty. Where multiple regulators or sector authorities have concurrent roles, enforcement coordination mechanisms must clarify lead responsibility, sequencing of actions, and information exchange. This includes alignment of inspection schedules, sharing of inspection findings, coordinated issuance of corrective directives, and harmonised application of sanctions.

98. Coordinated enforcement shall prevent duplicative or conflicting actions and ensure that regulatory responses are timely, risk-based, and defensible.

G2.6.4 Transition Milestones and Phased Implementation

99. Transition milestones must be clearly defined to manage the orderly shift from pre-existing arrangements to full compliance with the Standards.

100. Transition milestones must specify time-bound phases for alignment of licences, programme approvals, site designations, admissions ceilings, funding conditions, and reporting systems.

101. Transitional provisions must distinguish between immediate compliance requirements and those subject to phased implementation, while safeguarding learner and patient interests.

102. Progress against transition milestones must be monitored and reported, and failure to meet agreed milestones without justified cause may trigger corrective or enforcement measures.

103. Taken together, national coordination arrangements, reporting timelines, enforcement coordination, and transition milestones ensure that the standards are implemented predictably, monitored rigorously, enforced coherently, and transitioned responsibly, thereby strengthening governance, accountability, and system integrity.

G2.7 Joint Implementation Directive, Calendar, Stakeholder Distribution List

104. The completion of implementation-ready outputs that together operationalise inter-ministerial coordination, provide progressive clarity, and ensure comprehensive system-wide communication of the standards. These outputs constitute the practical instruments through which coordinated implementation is effected.

G2.7.1 Joint Implementation Directive

105. The Joint Implementation Directive is the authoritative inter-ministerial instrument that confirms shared responsibility for implementation of the standards and directs uniform compliance across all relevant authorities, institutions, programmes, and training sites.

106. It shall specify roles and responsibilities, confirm enforcement coordination arrangements, outline reporting obligations, and reference applicable transitional measures.

107. The directive binds all entities within the scope of standards and provides primary administrative basis for coordinated implementation and enforcement.

G2.7.2 Implementation Calendar

108. An official implementation calendar shall be issued to provide clear sequencing and time-bound milestones for compliance.

109. The calendar shall set out effective dates, reporting cycles, inspection windows, transition phases, and deadlines for alignment of licences, programme approvals, site designations, funding conditions, and admissions or placement ceilings.

110. The calendar shall function as a compliance management tool for both regulators and institutions, reducing ambiguity and enabling predictable, monitored implementation.

G2.7.3 Stakeholder Distribution List

111. A comprehensive stakeholder distribution list shall be compiled and maintained, identifying all ministries, regulatory authorities, professional councils, institutions, training sites, development partners, and other relevant actors to whom the directive, standards, and associated guidance must be formally communicated.

112. The distribution list shall ensure verifiable dissemination, enable tracking of receipt, and support accountability by demonstrating that all affected parties have been duly notified of their obligations under the standards.

113. Collectively, these outputs ensure that joint implementation moves beyond intent to documented, time-bound, and fully communicated action, thereby strengthening coordination, transparency, and enforceability.

G2.8 Regulatory Alignment Notice: Embedding the Standards into Approvals

114. G2.8 establishes the formal regulatory mechanism through which the standards are embedded into all downstream approval, licensing, accreditation, and designation decisions, thereby ensuring that the standards operate not as a parallel policy text but as an integral and enforceable component of the regulatory system.

115. Following issuance of joint implementation direction, each competent regulatory and quality assurance authority shall issue a regulatory alignment notice formally incorporating the standards into its regulatory instruments and decision-making processes.

116. The alignment notice confirms that the standards constitute mandatory approval criteria and shall specify how they are to be applied within the authority's statutory mandate.

117. Alignment notice requires that all licensing, accreditation, programme approval, renewal, variation, suspension, and revocation decisions are explicitly assessed against Standards.

118. Regulatory tools including application forms, evaluation criteria, inspection checklists, scoring frameworks, and decision templates shall be revised as necessary to ensure direct and traceable alignment with the Standards.

119. No approval or regulatory decision shall be issued unless compliance with the Standards has

been verified and recorded.

120. The alignment notice shall further address legacy approvals and existing operations, specifying how previously licensed institutions, approved programmes, and designated training sites are to be aligned within defined transition periods.

121. Where inconsistencies are identified, regulators must impose conditions, corrective actions, or revised terms to bring all approvals into conformity with the standards.

122. The issuance of regulatory alignment notices, ensures that the standards are embedded at the point of regulatory decision, transforming them into binding operational rules that directly determine who may operate, under what conditions, and with what consequences for non-compliance.

123. Within their respective statutory mandates, the TVET Council, and National Council for Higher Education (NCHE), and the relevant Professional Councils shall each issue a formal Regulatory Alignment Notice to embed the Standards into their regulatory and quality assurance functions.

124. Through these alignment notices, each authority shall formally declare that, from a clearly specified effective date, the Standards constitute mandatory core criteria for all regulatory determinations falling within its jurisdiction.

125. The Notices shall provide legal and administrative clarity by explicitly linking the Standards to approval and enforcement actions, as follows:

G2.8.1 Accreditation and Re-Accreditation Decisions

126. All applications for accreditation, re-accreditation, renewal, variation, or continuation of institutional, programme, or professional approval must be assessed against the standards.

127. Compliance with the standards shall be treated as a non-negotiable condition for approval, and no accreditation or re-accreditation decision shall be issued unless conformity with the standards has been verified, documented, and formally recorded.

G2.8.2 Corrective Action and Sanctions for Non-Compliance

128. The Alignment Notices shall further state that any finding of non-compliance with the Standards shall trigger mandatory regulatory follow-up, including issuance of corrective action directives, time-bound improvement plans, and follow-up inspections.

129. Where non-compliance is material, persistent, or poses risks to learners, patients, or the public interest, the authority shall apply graduated sanctions within its legal powers, which may include conditional approvals, enrolment or placement caps, suspension, or withdrawal of accreditation or recognition.

130. Each alignment notice shall specify the effective date, transitional arrangements (if any), and the mechanisms through which compliance will be monitored and enforced.

131. Collectively, these notices ensure that the standards are operationalised consistently across academic, technical, and professional regulation, while respecting institutional mandates and avoiding regulatory overlap.

G2.9 Alignment Notices, Accreditation Checklists, and Inspection Tools

132. G.2.9 presents the regulatory-operational outputs that embed the standards directly into day-to-day regulatory practice and ensure their consistent application across approval, monitoring, and enforcement functions.

G2.9.1 Regulator Alignment Notices

133. Formal alignment notices issued by TVET Council and NCHE and the relevant Professional Councils are the authoritative regulatory declarations that the Standards are binding and constitute criteria for all approvals within each regulator's mandate.

134. These notices shall specify the effective date, scope of application, and transitional arrangements, and shall provide the legal basis for applying the Standards in accreditation, re-accreditation, renewal, and enforcement decisions.

G2.9.2 Updated Accreditation Checklists

135. Accreditation and re-accreditation checklists shall be systematically revised to incorporate the standards as core assessment criteria. Each checklist item shall be explicitly mapped to the relevant standard, ensuring traceability between regulatory decisions and the issued standards. The updated checklists shall be used uniformly by evaluators and decision-makers to promote consistency, objectivity, and defensibility in accreditation outcomes.

G2.9.3 Updated Inspection Tools

136. Inspection instruments including inspection guides, audit templates, scoring frameworks, and reporting formats shall be updated to align fully with the standards. Inspectors and compliance officers shall assess institutions, programmes, and training sites directly against the standards, and inspection findings shall be documented in a manner that supports corrective action, enforcement, and follow-up. Updated tools shall also enable risk-based and graduated enforcement by clearly distinguishing minor, material, and critical non-compliance.

137. Together, these outputs ensure that standards are institutionalised within regulatory systems, moving from policy text to enforceable practice. They provide regulators with the necessary instruments to apply the standards consistently, transparently, and lawfully across the full regulatory lifecycle.

G2.10 Compliance Baseline and Profiling (System Mapping)

138. G2.10 establishes the analytical and evidentiary foundation for effective, proportionate, and risk-based implementation of the standards by requiring a comprehensive system-wide assessment of existing compliance conditions prior to full enforcement. This step ensures that regulatory action is informed, targeted, and defensible.

139. Following regulatory alignment, competent authorities must undertake a one-time, system-wide compliance baseline exercise to map the current status of institutions, programmes, and training sites against the standards. This exercise is to establish an objective reference point from which progress, risk, and enforcement priorities can be measured.

140. The compliance baseline shall involve structured data collection, self-assessments, document reviews, and targeted inspections, using the updated accreditation and inspection tools aligned to the Standards. Each institution, programme, and training site shall be profiled according to its level of compliance, capacity, risk exposure, and operational context. Profiles may distinguish, for example, between full compliance, partial compliance, transitional compliance, and critical non-compliance.

141. The resulting system map must inform regulatory planning and decision-making, including prioritisation of inspections, sequencing of corrective actions, allocation of technical support, and calibration of enforcement intensity. It also supports transparency and accountability by providing evidence for differentiated treatment, transitional arrangements, and time-bound improvement pathways.

142. Compliance baseline and profiling, ensures that implementation of the standards proceeds from a position of empirical clarity rather than assumption, enabling regulators to manage change responsibly, protect learners and patients, and maintain system stability while moving decisively toward full compliance.

G2.10.1 Role of MoES for National System Mapping

143. As the lead technical and coordinating entity for compliance baselining and system profiling, the department of Health Education and Training (HET) supported by the department of Education Policy Analysis and Research (EPAR) within the MoES shall be responsible for establishing and maintaining a comprehensive national register to support implementation of the standards.

144. HET must create, validate, and maintain an authoritative national register covering full education, training, and practice-based learning ecosystem, including:

(a) All HTIs and their programme portfolios, capturing institutional licensing status, approved programmes, accreditation history, admission capacity ceilings, and current compliance standing against the Standards;

(b) All training hospitals and clinical placement sites, including public and private (for profit and not for profit) approved or utilised for clinical training, internship, residency, or other practice-based learning, with details on designation status, supervision capacity, case mix, and compliance conditions;

(c) All internship, residency, and fellowship sites (where applicable), identifying approved pathways, trainee categories, placement ceilings, supervisory arrangements, and duration of approval, and distinguishing between fully compliant, conditionally approved, and de-designated sites;

(d) Relevant assessment bodies and professional councils, including their statutory mandates, assessment or licensing functions, and linkages to accredited programmes and approved training sites.

145. The national register serves as a single authoritative system map for regulatory planning, inspection scheduling, placement coordination, funding eligibility, and enforcement decision-making.

146. HET and EPAR departments must ensure data integrity, regular updates, version control, and controlled access for authorised regulators and implementing agencies, while maintaining interoperability with related sector databases.

147. Through this function, the MoES anchors the standards in an evidence-based regulatory architecture, enabling coordinated oversight, risk-based enforcement, and transparent accountability across the education and training for health system.

G2.10.2 Duty of Institutions to submit standardised Baseline Data

148. As a core compliance obligation, all institutions, programmes, and training sites have a mandatory

duty to submit standardised baseline data to support national system mapping, compliance profiling, and risk-based implementation of the standards.

149. Institutions and sites must compile, certify, and submit baseline information using prescribed templates, formats, and timelines issued by the competent authority.

150. Baseline data must include, information on legal status and approvals; programme offerings and enrolments; staffing and supervision capacity; infrastructure and learning resources; clinical or practice exposure; governance and quality assurance arrangements; admission and placement ceilings; and existing compliance conditions or directives.

151. Submitted data must be accurate, complete, and verifiable, and shall be endorsed by the accountable officer or head of the institution or site, thereby establishing institutional responsibility for its integrity.

152. Failure to submit baseline data within prescribed timelines, submission of incomplete or misleading information, or refusal to cooperate with verification processes constitutes non-compliance with the standards and may trigger corrective action or enforcement measures.

153. The standardised baseline data shall be used to establish the initial compliance profile of each institution and site, inform transition pathways, prioritise inspections, and guide regulatory and funding decisions.

154. The duty to submit baseline data ensures that implementation of the Standards is grounded in system-wide evidence, transparency, and shared accountability rather than assumption or discretion.

G2.11 Compliance Register, Baseline Report, and Risk Profile

155. G2.11 presents a set of authoritative analytical and operational outputs that together establish the factual and regulatory foundation for risk-based implementation and enforcement of the standards across the education and training for health system.

G2.11.1 The National Compliance Register

156. NETH Policy national compliance register shall be the single authoritative repository of verified information on institutions, programmes, training hospitals, clinical placement sites, internship, residency, and fellowship sites, and UHPAB and the regulatory bodies.

157. The national compliance register must record approval status, scope of operations, capacity ceilings, compliance determinations, conditions imposed, and enforcement history.

158. The national compliance register must be maintained on a continuous basis and used by regulators and implementing agencies as the primary reference for licensing, accreditation, inspections, funding eligibility, placement coordination, and enforcement actions.

G2.11.2 The Baseline Compliance Report

159. A consolidated baseline report must be produced, synthesising data submitted by institutions and sites and findings from verification and inspections.

160. The Baseline Compliance Report must provide a system-wide snapshot of compliance against the standards at the point of implementation, identifying areas of full compliance, partial compliance, transitional gaps, and critical deficiencies.

161. The Baseline Compliance Report must support transparency, inform policy and regulatory planning, and serve as the reference point for measuring progress over time.

G2.11.3 The Risk Profile

162. A structured risk profile must be developed on the basis of compliance register and baseline findings. Institutions, programmes, and sites must be categorised according to the risk level, taking into account factors such as learner and patient safety, supervision adequacy, infrastructure sufficiency, and historical and system compliance performance.

163. The risk profile must guide prioritisation of inspections, allocation of technical support, sequencing of corrective actions, and calibration of enforcement measures, enabling proportionate, defensible, and impact-focused regulation.

164. Together, the national compliance register, the baseline compliance report and the risk profile ensure that implementation of NETH policy, PISs and PIGs is data-driven, transparent, and risk-informed, providing regulators with the tools necessary to safeguard quality, protect the public interest, and achieve sustained compliance across the system.

G2.12 Compliance Gates Implementation (Stop/Go Rules)

165. G2.12 establishes the decisive operational stage at which standards are enforced through explicit compliance gates that determine whether activities may proceed, be conditionally continued, or be halted. This step translates compliance findings into clear regulatory outcomes, ensuring that implementation is predictable, defensible, and effective.

166. Based on the national compliance register, baseline report, and risk profile, competent authorities shall implement formal compliance gates that apply objective stop/go rules to all regulated activities. These gates shall specify the minimum compliance thresholds required for continuation or commencement of operations, including admissions, placements, funding releases, programme delivery, and site utilisation.

167. Under this framework, activities shall be categorised as:

(i) Go: Where an institution, programme, or site demonstrates full compliance with the Standards and may proceed without restriction;

(ii) Conditional go: Where partial or transitional compliance exists, permitting continued operation subject to clearly defined conditions, corrective action plans, and timelines;

(iii) Stop: Where critical or high-risk non-compliance is identified, requiring immediate suspension or prohibition of specified activities until compliance is restored.

168. Compliance gates shall be applied uniformly and transparently, using predefined criteria linked directly to the Standards and the risk profile.

169. Decisions to stop, condition, or permit activities shall be formally recorded, communicated in writing, and linked to corrective or enforcement actions where applicable.

170. The implementation of stop/go rules shall ensure that non-compliant institutions or sites cannot continue operations that compromise quality, learner safety, patient safety, or public interest, while compliant entities are enabled to operate predictably.

171. In this way, it functions as the principal enforcement mechanism that gives practical effect to the binding nature of the Standards.

G2.13 Joint Gatekeeping Role and Application of Minimum "Stop/Go" Rules

172. Acting as joint gatekeepers, TVET Council, NCHE, relevant Professional Councils, MoES, and MoH shall collectively enforce a set of non-derogable minimum compliance gates that give immediate and practical effect to the binding nature of the Standards.

173. These rules shall operate as absolute operational prohibitions, not subject to discretion, waiver, or post-hoc regularisation.

174. In this joint capacity, the authorities shall apply the following minimum "stop/go" rules, uniformly and concurrently within their respective mandates:

G2.13.1 No admissions Beyond Approved Capacity

175. Institutions and programmes shall not admit learners in excess of the formally approved admission ceilings determined through accreditation and capacity assessment.

176. Any admission beyond approved capacity shall automatically trigger a "stop" determination, rendering such admissions non-compliant and subject to regulatory nullification, corrective action, and sanctions.

177. Joint enforcement shall ensure that admissions controls are consistently applied across academic, technical, and professional training pathways.

G2.13.2 No Placements to Non-Approved Sites

178. No learner, intern, resident, or trainee shall be placed at any training hospital, clinical placement site, or practice facility that has not been formally approved or designated in accordance with the Standards.

179. Placement to an unapproved or de-designated site shall constitute immediate non-compliance, requiring suspension of placements and non-recognition of training time accrued at such sites.

G2.13.3 No Internship or Residency without Designation or Approval

180. Internship, residency, fellowship, or equivalent practice-based training shall not commence or continue unless the relevant site, programme, and supervisory arrangements have been expressly designated or approved by the competent authority.

181. Absence of designation or lapse of approval shall result in an automatic "stop" decision, prohibiting continuation of training and withholding recognition for certification, registration, or progression purposes.

182. These minimum stop/go rules shall be applied jointly and enforced in a coordinated manner, with information-sharing among gatekeeping authorities to prevent regulatory arbitrage, duplication, or inconsistent decisions.

183. Where any one gatekeeping, authority determines that a stop condition exists within its mandate, corresponding downstream actions shall be taken by the other authorities to ensure system-wide effect.

184. Through this joint gatekeeping function, the standards are operationalised at the critical control points of admissions, placements, and professional training, ensuring that non-compliance cannot translate into continued operation and that learner safety, patient safety, quality assurance, and public interest are decisively protected.

G2.14 Compliance Notices, Placement Ceiling Schedules, and Approved Site Lists

185. The implementation of G2.14 will result in a defined set of authoritative enforcement outputs that operationalise stop/go decisions, provide clarity on permissible activity, and ensure transparent, system-wide compliance with the Standards.

G2.14.1 Compliance Gate Notices

186. Formal compliance gate notices shall be issued by the competent authorities to communicate stop, conditional-go, or go determinations.

187. These notices shall specify the activity affected (e.g. admissions, placements, internships, residencies), the compliance basis for the decision, the applicable Standards, and any conditions or corrective actions required.

188. Compliance gate notices shall have immediate effect and shall constitute binding administrative decisions for regulatory, funding, and placement purposes.

G2.14.2 Placement Ceiling Schedules

189. Placement ceiling schedules set out the maximum allowable number of learners, interns, residents, or fellows that may be placed at each approved training site, by programme, cadre, and period.

190. These schedules must be derived from verified capacity assessments and compliance determinations, and bind institutions, regulators, and placement coordinators.

191. Exceeding approved placement ceilings constitutes a stop condition, triggers enforcement action and non-recognition of excess placements.

G2.14.3 Approved Site Lists

192. Authoritative lists of approved and designated training sites must be published and maintained, identifying facilities eligible to receive students, interns, residents, or fellows.

193. The lists must specify approval status, scope of designation, validity period, and any conditions attached.

194. Only sites appearing on approved site lists are eligible for placements and recognition of training, to ensure transparency and prevent unauthorised or unsafe training arrangements.

195. Collectively, these outputs provide the practical instruments through which compliance gates are enforced, enabling regulators, institutions, and trainees to determine clearly and in advance what activities are permitted, under what limits, and at which sites. They ensure predictability, accountability, and protection of quality and safety across the system.

G2.15. Routine Monitoring, Inspection, and Corrective Action

196. G2.15 establishes the continuous oversight phase through which compliance with standards is sustained over time, moving the system from initial enforcement to stable, quality-assured

operation. This step ensures that compliance is not episodic, but is embedded within routine regulatory practice.

197. Following the implementation of compliance gates, competent authorities shall conduct ongoing monitoring and periodic inspections to verify continued adherence to the standards by institutions, programmes, and training sites.

198. Monitoring includes regular review of compliance reports, admissions and placement data, funding utilisation, and performance indicators, while inspections shall involve scheduled and risk-based site visits using the updated inspection tools aligned to the standards.

199. Where monitoring or inspection identifies deviations from the standards, authorities shall initiate timely and proportionate corrective action. This shall include issuance of improvement notices, requirement for corrective action plans with defined actions and timelines, and targeted follow-up inspections to verify remediation.

200. Corrective measures must be scaled to the level of risk and materiality of non-compliance, with priority given to learner safety, patient safety, and system integrity.

201. Persistent, material, or escalating non-compliance identified through routine oversight shall trigger graduated enforcement, including imposition of additional conditions, reduction of admission or placement ceilings, suspension of specific activities, or withdrawal of approvals, in accordance with the established stop/go rules and enforcement framework.

202. All monitoring findings, corrective actions, and enforcement outcomes must be documented in the national compliance register to ensure traceability and accountability.

203. Through routine monitoring, inspection, and corrective action, G2.15 ensures that standards remain living regulatory instruments, continuously applied, updated through evidence, and enforced to promote sustained quality improvement and public confidence.

G2.15.1 Regulators and Ministries' Roles in Inspections and Corrective Action

204. Within their respective mandates, the TVET Council, NCHE, the relevant Professional Councils, together with MoES and MoH, shall jointly exercise responsibility for ongoing regulatory oversight through coordinated routine and risk-based inspections, and for the enforcement of CAPs.

205. In this capacity, these authorities shall plan and conduct inspections on both a routine and risk-informed basis, using inspection schedules and tools aligned to the Standards and informed by the national compliance register and risk profile.

206. Routine inspections shall verify continued compliance under normal operating conditions, while risk-based inspections shall be prioritised for institutions, programmes, or sites exhibiting higher risk indicators, prior non-compliance, rapid expansion, or complaints relating to learner or patient safety.

207. Where inspections identify gaps or breaches of the Standards, the responsible authority shall require the development and submission of a Corrective Action Plan (CAP).

G2.15.2 Corrective Action Plans (CAPs)

208. CAPs must specify the nature of non-compliance, concrete remedial actions, responsible officers, resources required, and clear timelines for completion.

209. Approval and monitoring of CAPs are mandatory, and progress must be verified through follow-up inspections or documentary review.

210. Failure to submit, implement, or satisfactorily complete CAP within the prescribed timeframe constitutes escalated non-compliance, triggers graduated enforcement measures in accordance with the stop/go rules and sanctions framework.

211. All inspection findings and CAP outcomes must be formally recorded and shared among the relevant authorities to ensure coordinated enforcement and avoid regulatory gaps.

212. Through coordinated routine and risk-based inspections and mandatory CAPS, the regulators and sector ministries ensure that compliance with the Standards is continuously monitored, systematically corrected, and effectively enforced, safeguarding quality, safety, and public interest across the system.

G2.16. Formal Regulatory Outputs

213. The implementation of routine monitoring and inspection under G2.15 above produces a set of formal, auditable regulatory outputs that document compliance status, track remedial action, and provide the evidentiary basis for enforcement where necessary. These outputs ensure transparency, accountability, and legal defensibility of regulatory actions.

G2.16.1 Inspection Reports

214. Inspection reports must be formally issued following each routine or risk-based inspection. Each report must document the scope of inspection, applicable standards, findings of compliance and non-compliance, risk assessment, and the required follow-up actions.

215. Reports must be signed off by the inspecting authority and communicated to the inspected institution or site, and constitute official records for regulatory, funding, and accreditation.

G2.16.2 Corrective Action Plans (CAPs) with Timelines

216. Where non-compliance is identified, institutions or sites shall be required to submit CAPs specifying remedial actions, responsible officers, resources, and defined timelines.

217. Approved CAPs are binding and form part of the compliance record.

218. Failure to adhere to agreed timelines triggers escalation in accordance with the graduated enforcement framework.

G2.16.3 Verification Results

219. Verification results must be produced following follow-up inspections, desk reviews, or other validation activities to confirm whether corrective actions have been satisfactorily implemented.

220. Verification outcomes must be recorded as compliant, partially compliant, or non-compliant, and directly inform decisions on continuation, modification, or escalation of the regulatory measures.

G2.16.4 Enforcement Decisions

221. Where verification confirms persistent, material, or high-risk non-compliance, formal enforcement decisions shall be issued. Such decisions may include conditional approvals, suspension of activities, reduction of capacity ceilings, withdrawal of accreditation or redesignation, or other

sanctions within the authority's legal mandate.

222. Enforcement decisions shall be documented, reasoned, and communicated in writing, and shall be reflected in the national compliance register.

223. Collectively, these outputs ensure that routine monitoring and inspection result in documented compliance management, enabling the regulators to move seamlessly from detection to correction and, where necessary, to enforcement—thereby maintaining the integrity and effectiveness of the standards over time.

G3.0 Entity Coverage and Obligation Mapping

224. Guideline 3.0 establishes the definitive scope of application of the standards and allocates clear, enforceable obligations to each covered entity, ensuring that responsibility for compliance is explicit, comprehensive, and traceable across the system. This guideline eliminates ambiguity regarding who is bound, by which provisions, and in what capacity.

225. G3.0 applies to all public and private HTIs, universities, colleges, training hospitals, clinical placement sites, professional councils, UPHAB, and any other entity involved in health education and training.

226. This guideline identifies all entities to which the standards apply, and requires mapping, in a structured and disaggregated manner, the specific obligations attaching to each entity type.

227. Coverage extends to institutions, programmes, training sites, regulators, UPHAB and any other actors whose functions materially affect education, training, assessment, placement, or certification outcomes.

228. For each covered entity, the guideline shall specify:

G3.1 Legal and Functional Basis of Coverage

229. The statutory, policy, or operational basis upon which the entity is subject to the standards, including whether obligations arise from licensing, accreditation, designation, funding eligibility, placement authority, or regulatory oversight.

G3.2 Nature of Obligations

230. The duties imposed by standards, distinguish between governance, delivery, supervisory, reporting and compliance duties. The obligations are framed as mandatory requirements, not discretionary practices.

G3.3 Points of Regulatory Interface

231. The approval, inspection, reporting, or enforcement processes through which compliance by each entity will be assessed and acted upon, ensuring that obligations are anchored to concrete regulatory decision points.

G3.4 Consequences of Non-Compliance

232. The regulatory, administrative, or financial consequences that attach to failure by each entity to meet its mapped obligations, including corrective action, sanctions, withdrawal of approval, or

loss of eligibility for placements or funding.

233. Obligation mapping must be presented in a clear matrix or schedule, to enable regulators, institutions, and oversight bodies determine at a glance who is responsible for what, under which authority, and with what consequences. This mapping shall be used as a reference tool for inspections, enforcement, inter-agency coordination, and dispute resolution.

234. Through G3.1, the standards achieve comprehensive entity coverage, role clarity, and enforceability, thereby ensuring that accountability is distributed across the system in a manner that is coherent, legally grounded, and operationally actionable. A clear “duty matrix” so every covered entity knows exactly what it must do.

G3.5 Mandatory Duties of Health Training Institutions (HTIs)

235. HTIs which include universities, colleges, and specialised health training institutes, are directly and unequivocally bound by PISs and bear primary, non-delegable responsibility for compliance within their institutional and programme operations.

236. The duties arise by virtue of licensing, accreditation, programme approval, funding eligibility, and placement authority, and are mandatory conditions for lawful operation. Accordingly, HTIs shall be subject to the following mandatory duties:

G3.5.1 Compliance with Approved Scope, Capacity, and Standards

237. HTIs must deliver education and training within the scope of their approved institutional licence, accredited programmes, and authorised admission and placement ceilings.

238. Institutions shall not admit learners, expand programmes, or place trainees beyond their approved capacity, nor operate unaccredited, suspended, or withdrawn programmes.

G3.5.2 Quality Assurance and Academic Governance

239. HTIs shall establish and maintain internal governance and quality assurance systems aligned to the Standards, including curriculum oversight, assessment integrity, supervision arrangements, learner support, and ethical safeguards.

240. Institutional policies and procedures shall be demonstrably aligned with the Standards and subject to regular internal review.

G3.5.3 Accredited Training Environments and Placements

241. HTIs shall ensure that all clinical training, internships, residencies, fellowships, and other practice-based learning components are conducted only at formally approved and designated sites, and within approved placement ceilings.

242. Training undertaken at unapproved or de-designated sites shall not be recognised and shall constitute non-compliance by the institution.

G3.5.4 Staffing, Supervision, and Learner Safety

243. HTIs shall maintain adequate numbers of qualified academic staff, clinical supervisors, preceptors, and mentors, consistent with approved ratios and competency requirements.

244. Institutions shall take all reasonable measures to safeguard learner welfare, patient safety, and

ethical standards within training environments.

G3.5.5 Reporting, Data Submission, and Cooperation with Regulators

245. HTIs shall submit accurate, complete, and timely reports and baseline data as prescribed, cooperate fully with inspections and audits, and provide access to records, facilities, and personnel for regulatory purposes.

246. Misrepresentation, non-reporting, or obstruction shall constitute material non-compliance.

G3.5.6. Corrective Action and Continuous Improvement

247. Where deficiencies are identified, HTIs shall prepare, implement, and complete CAPs within prescribed timelines.

248. Institutions shall treat corrective action as a binding obligation and shall not continue affected activities where stop/go rules apply.

G3.5.7 Accountability and Consequences of Non-Compliance

249. HTIs acknowledge that failure to comply with the standards may result in corrective directives, reduction of admission or placement ceilings, suspension or withdrawal of programme approval, loss of funding eligibility, or other sanctions within the law.

250. Institutional leadership shall be accountable for ensuring compliance across all levels of operation.

251. Through these mandatory duties, HTIs are positioned as the primary duty-bearers for quality, safety, and integrity within the education and training for health system. Compliance with the Standards is therefore a condition of legitimacy, continued operation, and public trust, rather than a matter of discretion or institutional preference.

G3.6 Training Hospitals / Clinical Placement Sites

252. Training hospitals and clinical placement sites including public, private (for profit and not for profit), and specialised facilities are directly bound by the Standards to the extent of their designation and role in practice-based education and training.

253. By accepting designation as training sites, these facilities assume mandatory, non-delegable duties that are conditions for approval, continued designation, and recognition of training outcomes.

254. Accordingly, training hospitals and clinical placement sites shall be subject to the following mandatory duties:

G3.6.1 Operate Strictly Within Approved Designation and Scope

255. Training sites shall provide clinical training, internships, residencies, fellowships, or other practice-based learning only within the scope of their formal approval or designation, including approved disciplines, trainee categories, supervision arrangements, and placement ceilings.

256. No site shall host trainees or expand training activities beyond what has been expressly authorised.

G3.6.2 Maintain Safe, Adequate, and Fit-For-Purpose Training Environments

257. Sites must ensure that infrastructure, equipment, service capacity, and case mix are sufficient to support quality training and safe patient care.

258. Facilities must comply with applicable clinical, ethical, and safety standards, and must not expose trainees or patients to undue risk arising from overcrowding, inadequate supervision, or resource deficiencies.

G3.6.3 Provide Qualified Supervision and Mentorship

259. Training hospitals and placement sites must ensure the availability of appropriately qualified and accredited supervisors, preceptors, consultants, or mentors in numbers consistent with approved supervision ratios.

260. Supervisors must actively oversee trainee activities, assess competence, and uphold professional and ethical standards.

G3.6.4 Comply with Placement Ceilings and Coordination Requirements

261. Sites shall not accept or retain trainees in excess of approved placement ceilings or outside approved placement schedules.

262. Placement coordination shall be undertaken in accordance with directives issued by the competent authorities, and sites shall cooperate with placement planning to avoid congestion, dilution of learning opportunities, or compromise of service delivery.

G3.6.5 Record-Keeping, Reporting, and Verification

263. Training sites shall maintain accurate and up-to-date records of trainee placements, attendance, supervision, clinical exposure, and performance.

264. Required reports and data returns shall be submitted within prescribed timelines, and sites shall facilitate verification through inspections, audits, and reviews.

G3.6.6 Cooperation with Inspectors and Regulatory Oversight

265. Training hospitals and placement sites must grant inspectors and authorised officers' access to facilities, records, supervisors, and trainees for purposes of monitoring compliance with the Standards.

266. Obstruction, misrepresentation, or refusal to cooperate constitutes material non-compliance.

G3.6.7 Corrective Action and Compliance with Directives

267. Where non-compliance is identified, sites must develop and implement CAPs within prescribed timelines and comply with all binding directives issued by regulators.

268. Failure to remedy deficiencies may result in restriction, suspension, or withdrawal of training site designation.

G3.6.8 Consequences of Non-Compliance

269. Training sites acknowledge that non-compliance with the standards may lead to de-designation,

suspension of placements, non-recognition of training undertaken at the site, exclusion from approved site lists, and other regulatory or administrative sanctions.

270. Site leadership must be accountable for ensuring sustained compliance.

271. Through these mandatory duties, training hospitals and clinical placement sites function as critical custodians of training quality, learner development, and patient safety.

272. Compliance with standards is therefore a condition for designation and continued participation in the national education and training for health system, rather than a discretionary or informal arrangement.

G3.7 Internship, Residency, and Fellowship Sites

273. Internship, residency, and fellowship sites constitute the final and most practice-intensive stage of professional formation and are therefore subject to the highest level of regulatory scrutiny under the Standards.

274. Where applicable, such sites are directly bound by the standards by virtue of their designation and role in postgraduate and post-qualification training, and they assume mandatory, non-delegable duties as conditions for approval, continued designation, and recognition of training outcomes.

275. Accordingly, internship, residency, and fellowship sites shall be subject to the following mandatory duties:

G3.7.1 Operate Strictly Within Approved Designation and Training Mandate

276. Sites shall conduct internship, residency, or fellowship training only where formally designated and approved for the specific cadre, specialty, training level, duration, and supervision model.

277. No site shall host interns, residents, or fellows in the absence of valid designation or beyond the approved scope, capacity, or validity period.

G3.7.2 Ensure Adequate Supervision, Mentorship, and Clinical Governance

278. Sites must maintain qualified, accredited, and discipline-appropriate supervisors, consultants, and mentors in numbers sufficient to meet approved supervision ratios.

279. Supervisory arrangements must ensure graduated responsibility, patient safety, ethical practice, and competency development, and shall be embedded within clear clinical governance structures.

G3.7.3 Provide Appropriate Caseload, Learning Exposure, and Training Resources

280. Sites must guarantee that interns, residents, and fellows are exposed to an adequate and diverse caseload, clinical procedures, and professional responsibilities consistent with approved training outcomes.

281. Training resources, equipment, and support services must be sufficient to enable meaningful learning without compromising service delivery or safety.

G3.7.4 Comply with Approved Placement Ceilings and Training Schedules

282. Sites must not accept trainees in excess of approved internship, residency, or fellowship

placement ceilings, nor outside authorised training cycles or schedules.

283. Over-placement or ad hoc acceptance of trainees shall constitute immediate non-compliance and may invalidate training undertaken.

G3.7.5 Assessment, Documentation, and Progression Oversight

284. Sites must implement approved assessment and evaluation mechanisms to monitor trainee progress, competence, and professionalism.

285. Accurate records of attendance, supervision, assessments, rotations, and outcomes must be maintained and submitted to the relevant authorities and professional councils.

G3.7.6 Learner Welfare, Patient Safety, and Ethical Compliance

286. Sites must safeguard trainee welfare, ensure reasonable workloads, provide access to support mechanisms, and uphold patient safety and ethical standards.

Government will continue to support the welfare and subsistence needs of health trainees on government sponsorship and guardians for the privately sponsored health trainees.

287. Unsafe, exploitative, or unsupervised practice constitutes material non-compliance.

G3.7.7 Reporting, Inspection, and Regulatory Cooperation

288. Internship, residency, and fellowship sites must submit required reports, cooperate fully with inspections and audits, and provide access to facilities, records, supervisors, and trainees for regulatory verification purposes.

289. Non-cooperation or misrepresentation shall attract enforcement action.

G3.7.8. Corrective Action and Consequences of Non-Compliance

290. Where deficiencies are identified, sites shall prepare and implement CAPs within prescribed timelines.

291. Persistent, material, or high-risk non-compliance may result in suspension or withdrawal of designation, removal from approved site lists, non-recognition of training undertaken, and other sanctions within the law.

292. Through these mandatory duties, internship, residency, and fellowship sites are positioned as critical gatekeepers of professional competence, public safety, and workforce quality.

293. Compliance with standards is therefore a condition for designation and continued participation in postgraduate and post-qualification training, not a discretionary or informal arrangement.

G3.8 Professional Councils

294. Professional Councils are statutory regulators and custodians of professional standards and are therefore directly bound by, and responsible for enforcing, the Standards within their respective professional mandates.

295. Professional Councils' duties are mandatory, non-discretionary, and arise from their legal authority over professional training, assessment, registration, licensing, and continuing professional

development.

296. Thus, Professional Councils shall be subject to the following mandatory duties:

G3.5.1 Alignment of Professional Regulation with the Standards

297. Professional Councils must formally align all professional training, internship, residency, fellowship, assessment, registration, and licensing requirements with the Standards.

298. Professional Councils' rules, guidelines, curricula frameworks, and assessment instruments must not contradict or dilute the standards and must be revised where necessary to ensure full conformity.

G3.5.2 Designation and Oversight of Professional Training Pathways

299. Councils must approve, designate, and periodically review internship, residency, fellowship, and other post-qualification training pathways strictly in accordance with the policy implementation standards.

300. No professional training pathway shall be recognised unless the underlying programme, institution, and training site are duly approved and compliant.

G3.5.3 Accreditation, Inspection, and Compliance Monitoring

301. Professional Councils must conduct routine and risk-based inspections and reviews of professional training arrangements, assessment processes, and designated sites, using tools aligned to the Standards.

302. Compliance findings shall be formally documented and shall inform accreditation status, trainee recognition, and licensing decisions.

G3.5.4 Application of Stop/Go Rules and Enforcement Powers

303. Professional Councils must apply binding stop/go rules where minimum compliance thresholds are not met, including refusal to recognise training undertaken at unapproved institutions or sites, suspension of professional training recognition, or withholding of registration and licensing.

304. Professional Councils shall not regularise or retrospectively legitimise non-compliant training.

G3.5.5 Corrective Action and Graduated Sanctions

305. Where non-compliance is identified, Professional Councils must develop CAPs with defined actions and timelines, and shall verify implementation.

306. Persistent, material, or high-risk non-compliance shall trigger graduated sanctions within the Professional Councils' legal powers, including withdrawal of approval, suspension of recognition, or disciplinary action.

G3.5.6 Coordination with Education and Sector Authorities

307. Professional Councils must cooperate with MoES, MoH, NCHE, TVET Council, and other regulators through information-sharing, joint inspections, and coordinated enforcement.

308. Councils must prevent regulatory gaps, duplication and contradictory decisions.

G3.5.7 Protection of Public Interest and Professional Integrity

309. In exercising their functions, Professional Councils must prioritise public safety, professional competence, ethical practice, and system integrity.

310. Decisions must be evidence-based, transparent, and defensible, and must not be influenced by institutional, commercial, or sectional interests.

G3.5.8 Accountability and Consequences of Non-Compliance

311. Professional Councils acknowledge that failure to align their regulatory actions with the Standards may undermine the legality, credibility, and enforceability of professional regulation.

312. Professional Councils and their leadership must therefore be accountable for ensuring that all professional regulatory functions are exercised consistently with the Standards.

313. Through these mandatory duties, Professional Councils function as critical enforcement anchors within the education and training for health ecosystem, ensuring that professional qualification, registration, and practice are grounded in compliant training pathways, safeguarded quality, and protection of the public interest.

G3.6 Mandatory Duties of Uganda Health Professions Assessment Board (UHPAB)

314. UHPAB is the statutory national authority responsible for assessment and certification of health trainees.

315. In this role, UHPAB is directly and fully bound by the standards and shall discharge mandatory, non-discretionary duties to ensure that assessment functions reinforce compliant training pathways, safeguard patient safety, and protect the public interest.

316. Accordingly, UHPAB shall be subject to the following mandatory duties:

G3.6.1 Alignment of Assessment Policy and Instruments with Standards

317. UHPAB shall ensure that all assessment frameworks, competency standards, examination blueprints, tools, scoring rubrics, moderation procedures, and appeals mechanisms are fully aligned with the standards.

318. No assessment requirement or practice shall undermine, dilute, or circumvent the Standards or permit progression based on non-compliant training.

G3.6.2 Assessment Eligibility Verification

319. UHPAB shall register candidates for assessment only where training has been completed through accredited programmes, licensed institutions, and approved clinical training sites and within authorised admission and placement ceilings.

320. Training undertaken outside approved or designated pathways shall be ineligible for assessment and recognition.

G3.6.3 Application of Binding Stop/Go Rules

321. Where minimum compliance conditions are not met such as absence of programme accreditation,

lack of site designation, or invalid placement approval UHPAB shall apply mandatory stop determinations, including refusal to examine, withholding of results, or denial of recognition.

322. UHPAB shall not retrospectively regularise or legitimise non-compliant training through assessment.

G3.6.4 Integrity, Validity, and Reliability of Assessments

323. UHPAB shall conduct assessments that are competency-based, fair, transparent, secure, and defensible. This includes ensuring qualified examiners and assessors, robust moderation and standard-setting processes, secure handling of assessment materials, and credible mechanisms for review and appeal, all consistent with the Standards and good regulatory practice.

G3.6.5 Coordination with Regulators and Sector Ministries

324. UHPAB shall coordinate with MoES, MoH, NCHE, relevant Professional Councils, and other competent authorities to verify institutional and site approvals, share compliance-relevant data, and ensure that assessment outcomes are aligned with licensing, registration, and enforcement decisions.

G3.6.6 Reporting, Data Management, and Audit Cooperation

325. UHPAB must submit accurate and timely reports on candidate eligibility, assessment volumes, outcomes, anomalies, and compliance issues, and shall cooperate fully with inspections, audits, and verification exercises conducted under the standards.

G3.6.7 Corrective Action and Enforcement Support

326. Where deficiencies in assessment processes or compliance are identified, the Board must prepare and implement CAPs within prescribed timelines and provide evidence required to support regulatory enforcement elsewhere in the system.

G3.6.8 Public Interest Protection and Accountability

327. In exercising its mandate, UHPAB must prioritise patient safety, professional competence, ethical practice, and system integrity.

328. Decisions must be evidence-based, transparent, and free from institutional, political, or commercial influence.

329. UHPAB and its leadership must be accountable for ensuring that assessment functions are exercised consistently with the Standards.

330. Through these mandatory duties, UHPAB functions as a final assurance and protection mechanism within the education and training for health ecosystem.

331. Compliance with the standards is therefore a condition for lawful assessment, recognition of outcomes, and maintenance of public trust in the health professions.

332. G 4.0 establishes a uniform national mechanism through which all entities covered by the Standards are formally identified, recorded, and notified of their binding obligations. This Guideline ensures legal certainty, traceability, and enforceability by creating an authoritative record of who is covered, on what basis, and from what effective date.

333. National registration and notification procedure: All covered entities, including; institutions, programmes, training hospitals, clinical placement sites, internship / residency / fellowship sites, regulators, assessment bodies, and other designated actors shall be subject to a mandatory registration and notification process administered by the competent authority.

334. The procedure shall include:

G4.1 Mandatory Registration of Covered Entities

335. Each covered entity is required to register in the designated national register using prescribed formats and timelines.

336. Registration must capture core identifying and regulatory information, including legal status, mandate, scope of operations, approvals held, capacity ceilings, and points of regulatory interface.

337. Registration is a pre-condition for lawful operation, approval, placement eligibility, assessment recognition, or funding access, as applicable.

G4.2 Verification and Confirmation of Status

338. Submitted registration information must be verified against existing approvals, accreditation records, designation notices, and compliance data.

339. Upon verification, the competent authority must confirm the entity's registered status, scope of coverage under the Standards, and applicable obligations.

340. Any discrepancies identified must be addressed through corrective directives prior to confirmation.

G4.3 Formal Notification of Binding Obligations

341. Following registration and verification, each entity shall be formally notified in writing that it is covered by the Standards.

342. The notification must specify the effective date of applicability, the relevant obligations attaching to the entity, applicable compliance gates, reporting requirements, and consequences of non-compliance.

343. Notification constitutes administrative notice sufficient to ground enforcement action.

G4.4 Public Listing and Transparency

344. Registered entities must be reflected in the appropriate public or controlled-access registers (as applicable), identifying approval status, scope, and validity.

345. Public listing enhances transparency, enables placement and assessment verification, and prevents reliance on unregistered or unauthorised entities.

G4.5 Ongoing Update and Duty to Notify Changes

346. Covered entities must have a continuing duty to notify the competent authority of material changes affecting their registration such as changes in scope, capacity, ownership, leadership, or compliance status within prescribed timelines.

347. Failure to update registration information constitutes non-compliance.

G4.6 Enforcement Linkage

348. Registration and notification records must be used as primary evidence in licensing, accreditation, inspection, funding, placement, assessment eligibility, and enforcement decisions. Entities that are unregistered, deregistered, or notified as non-compliant must be subjected to stop/go determinations and other sanctions in line with the standards.

349. The standards are operationalised via a clear national roll-call and notice system, ensuring that coverage is comprehensive, obligations are explicit, and enforcement is legally defensible. The guideline prevents ambiguity as to applicability and ensures that no entity can claim ignorance of its duties under the standards.

G4.7 National Registration and Notification Procedure

350. This procedure operationalises a clear, sequential, and legally defensible process that establishes coverage, records affected entities, assigns obligations, and ensures system-wide notice. Each step is mandatory and cumulative.

G4.7.1 Issue a National Coverage Notice

351. The competent authority must issue a National Coverage Notice formally declaring the scope of entities bound by the Standards.

352. The Notice must:

(a) Identify covered entity categories (institutions, programmes, training and placement sites, assessment bodies, regulators, and related actors);

(b) State the legal basis for coverage and the effective date;

(c) Signal the binding nature of the standards and the consequences of non-compliance.The coverage notice constitutes administrative notice sufficient to ground subsequent registration, compliance, and enforcement actions.

G4.7.2 Mandatory Entity Registration

353. All covered entities shall complete mandatory registration in the designated national register within prescribed timelines.

354. Registration shall:

(a) Capture verified identifiers, approvals held, scope of operations, capacity ceilings, and points of regulatory interface;

(b) Be a pre-condition for lawful operation, placement eligibility, assessment recognition, funding access, or continued approval (as applicable);

(c) Be subject to verification against existing licensing, accreditation, and designation records.

(d) Failure to register, late registration, or submission of misleading information shall constitute non-compliance.

G4.7.3 Categorisation and Compliance Obligations

355. Registered entities must be categorised according to function and risk (e.g., institution, programme, clinical site, internship/residency site, assessment body).

356. To ensure that obligations are explicit, traceable, and enforceable, for each category, the authority shall:

(a) Assign specific, non-delegable compliance obligations mapped to the Standards;

(b) Identify applicable compliance gates (stop/go rules), reporting cycles, inspection regimes, and enforcement triggers;

(c) Issue formal notifications to each entity detailing its obligations, effective dates, transitional provisions (if any), and consequences of breach.

G4.7.4 Public/Sectoral Dissemination

357. The authority shall undertake formal dissemination to ensure transparency and operational readiness by:

(a) Publishing public lists or controlled-access registers (as appropriate) of registered and approved entities;

(b) Circulating sector-specific notices, guidance, and implementation materials to regulators, institutions, and placement coordinators;

(c) Enabling verification by third parties (e.g., placement planners, assessment bodies, funders) to prevent reliance on unregistered or unauthorised entities.

358. Dissemination completes the notice cycle and supports uniform application across the system.

G4.8 Practical "Who Does What" Workflow for Cross-Entity Activities

359. G4.8 operationalises the standards by translating mapped obligations into a clear, end-to-end workflow for activities that involve multiple entities and authorities. This eliminates ambiguity at points of interaction, where approvals, placements, assessments, funding, and enforcement intersect, by specifying sequencing, decision ownership, information flows, and hand-offs.

360. This Guideline shall define, for each cross-entity activity, a standard operating workflow that answers four questions with precision: who initiates, who verifies, who decides, and who enforces. The workflow shall be binding and applied uniformly across the system.

361. Because training is multi-site and multi-regulator, the workflow is mandatory whenever learners are placed in practice settings. The guideline provides the following elements:

G4.8.1 Activity Definition and Trigger

362. Each workflow must begin with a clear definition of the activity (e.g., programme approval, admissions intake, clinical placement, internship commencement, assessment eligibility, funding release) and the event that triggers it (application submission, intake cycle, placement round, inspection finding).

G4.8.2 Role Allocation (Initiate–Verify–Decide–Notify–Enforce)

363. For every activity, responsibilities shall be assigned across five functions:

(a) Initiate: the entity responsible for submitting applications or requests;

(b) Verify: the authority responsible for checking completeness, eligibility, and compliance against the Standards;

(c) Decide: the authority empowered to approve, condition, or refuse;

(d) Notify: the authority responsible for issuing formal decisions and notices;

(e) Enforce: the authority responsible for applying stop/go rules, monitoring, and sanctions where required.

364. No function shall be implied or duplicated without explicit assignment.

G4.8.3 Sequencing and Dependencies

365. The workflow shall specify the mandatory order of actions and dependencies (e.g., accreditation before admissions; site designation before placements; compliance verification before assessment eligibility; gate clearance before funding release). Actions taken out of sequence shall be void for regulatory purposes.

G4.8.4 Information and Documentation Flows

366. The Guideline shall identify required documents, data sources, registers to be consulted, and verification checkpoints at each stage. Use of the national compliance register and approved site lists shall be mandatory where applicable.

G4.8.5 Decision Outputs and Compliance Gates

367. Each workflow shall culminate in defined outputs (approval, conditional approval, refusal, stop /go determination), linked to explicit compliance gates and recorded in the national system for traceability.

G4.8.6 Timeframes and Service Standards

368. Indicative timelines for each step shall be specified to ensure predictability and accountability, without derogating from compliance requirements.

G4.8.7 Escalation, Exceptions, and Dispute Handling

369. The workflow shall include escalation pathways for delays, conflicting determinations, or urgent risk scenarios, and identify the forum or authority for resolution. Exceptions must be limited,

documented, and legally grounded.

G4.8.8 Auditability and Accountability

370. Each step shall generate records sufficient for audit, inspection, and review. Accountability for failures or breaches must be traceable to the responsible entity or authority.

371. By prescribing a practical, role-specific workflow for cross-entity activities. This ensures that the standards function as operational rules rather than abstract principles. It prevents regulatory gaps and overlaps, supports coordinated enforcement, and enables institutions and regulators to act with certainty, speed, and legal defensibility.

G4.9 Cross-Entity Workflow for Learner Placement, Internship, and Residency

372. This workflow operationalises a clear, sequential, and non-skippable process for learner placement, internship, and residency involving HTIs, training sites, and sector regulators.

373. Each step assigns responsibility, establishes verification points, and embeds compliance gates to ensure quality, safety, and legal defensibility.

G4.9.1 HTI identifies learners due for placement and checks eligibility

374. HTI identifies learners due for clinical placement, internship, residency, or fellowship based on programme requirements and academic progression.

375. Prior to any placement action, the HTI shall verify learner eligibility, including completion of prerequisite coursework, assessment requirements, and compliance with approved admission and progression criteria.

376. Learners who do not meet eligibility conditions shall not proceed to placement consideration.

G4.9.2 HTI Confirms Proposed Site is Approved or Designated

377. The HTI shall confirm that each proposed training hospital or clinical placement site is formally approved or designated for the relevant cadre, discipline, and level of training, by consulting the authoritative approved site lists and national compliance register.

378. Placement proposals involving unapproved, expired, or de-designated sites shall be automatically disqualified.

G4.9.3 Site Confirms Supervision Capacity and Accepts Placement Numbers

379. The approved site verifies its current supervision capacity, including availability of qualified supervisors, service load, and learning resources, and shall formally accept a defined number of learners consistent with its approved placement ceiling.

380. Acceptance is documented and must not exceed the authorised numbers. Over-acceptance or informal arrangements constitute non-compliance.

G4.9.4 Placement Coordinator Confirms Placement Ceilings and Allocation

381. Where national or sectoral coordination applies, MoH or designated placement coordinator shall confirm placement ceilings, balance allocations across sites, and issue placement confirmations to prevent congestion and safeguard training quality and patient safety.

382. This step constitutes a system-level compliance gate for placements subject to central coordination.

G4.9.5 Regulator Confirms Compliance with Internship/Residency Requirements

383. For internships, residencies, or fellowships subject to professional regulation, the relevant Professional Council must confirm that all regulatory prerequisites are satisfied, including programme accreditation, site designation, supervision arrangements, and placement approval.

384. Absence of confirmation triggers a stop determination, and placement must not proceed.

G4.9.6 Placement Proceeds with Logbooks, Supervision, and Reporting

385. Upon clearance of all prior steps, placement shall commence in accordance with approved schedules.

386. Learners must maintain logbooks and training records, sites must provide structured supervision and mentorship, and HTIs and sites must submit periodic reports as prescribed.

387. Training shall be conducted strictly within approved scope and ceilings.

G4.9.7 Completion Confirmation Issued and Outcomes Shared with Regulators

388. At the conclusion of the placement or training period, the site must issue a formal completion confirmation, certifying attendance, supervision, and competency exposure.

389. The HTI shall record and track completion outcomes and transmit verified information to relevant regulators, assessment bodies, and professional councils for progression, assessment eligibility, and compliance monitoring.

390. This workflow ensures that placements, internships, and residencies occur only where eligibility, site approval, capacity, and regulatory compliance are confirmed at each stage. By embedding clear verification points and stop/go gates, it prevents unsafe or unlawful placements, supports coordinated oversight, and ensures that training outcomes are valid, recognised, and enforceable across the system.

G4.10 Rapid Operationalisation Instruments

391. To ensure swift, uniform, and legally defensible implementation of G 10, presents a defined suite of implementation instruments. These instruments translate coverage, obligations, and workflows into immediate operational controls across institutions, training sites, regulators, and assessment bodies.

G4.10.1 Joint MoES/MoH Implementation Circular

392. A joint circular issued by the MoES and the MoH shall serve as the authoritative activation instrument.

393. The circular shall:

(a) State the effective date of the Standards and transitional provisions (if any);

(b) Specify non-derogable compliance gates (e.g., admissions ceilings, approved sites only);

(c) Publish a reporting calendar (baseline submissions, routine reports, inspections);

(d) Direct regulators and institutions to align approvals, placements, and funding with the Standards.

394. The circular provides administrative notice sufficient to ground enforcement from day one.

G4.10.2 National Register and Categorisation List

395. An authoritative National Register must be established and maintained by the MoES, listing all covered entities, categorised by function (HTIs, programmes, training hospitals, placement sites, internship/residency sites, assessment bodies, councils).

396. The register must:

(a) Confirm coverage and assign entity-specific obligations;

(b) Indicate approval status, scope, and capacity ceilings;

(c) Serve as the single source of truth for placements, assessments, funding eligibility, and inspections.

G4.10.3 Approved Training Site List (including internship/residency sites)

397. A validated list of approved and designated training sites shall be published, specifying:

(a) Eligible cadres, levels, and disciplines;

(b) Validity periods, conditions, and placement ceilings;

(c) Inclusion of internship/residency/fellowship sites where applicable.

398. Only sites on this list shall be eligible for placements and recognition of training time.

G4.10.4 Standardised Reporting Templates

399. Uniform templates must be issued to ensure consistent, comparable, and auditable data, covering:

(a) Enrolment (intakes vs approved capacity);

(b) Placements (site, numbers, duration);

(c) Completion (attendance, supervision, outcomes);

(d) Incidents (safety, ethics, disruptions).

400. Use of these templates shall be mandatory and time-bound, with non-submission constituting non-compliance.

G4.10.5 Inspection and Corrective Action Plan (CAP) Templates

401. Standard inspection tools and Corrective Action Plan (CAP) templates shall be issued to:

(a) Align inspections to the Standards with clear findings and risk ratings;

(b) Require time-bound corrective actions with accountable officers;

(c) Enable follow-up verification and graduated enforcement where timelines are missed.

402. These templates ensure consistency, proportionality, and legal defensibility of enforcement actions.

403. Issued together, these instruments create an implementation-ready control stack from notice and registration, to approved sites and reporting, to inspection and correction allowing G4.10 to be operationalised immediately, consistently, and at scale.

G4.11 Standards reading together with Laws, Policies, and Frameworks

404. G4.11 establishes the legal–policy concordance rule governing interpretation and application of Standards. It provides that Standards do not operate in isolation, but form part of an integrated regulatory architecture and shall be read, applied, and enforced in harmony with specified national laws, policies, and qualifications frameworks. This ensures coherence, avoids regulatory conflict, and reinforces enforceability across the education, training, and professional regulation continuum.

405. Accordingly, the policy implementation standards and guidelines shall be read together with, and applied consistently alongside, the following policy and legal instruments:

(a) NETH Policy, 2025, which provides the overarching policy objectives, governance and implementation arrangements, and education and training system outcomes that the standards and guidelines operationalise;

(b) TVET Policy, 2019 and TVET Act, 2025, which establish the policy, legal and institutional framework for TVET delivery, assessment, and regulation, including interface points with health training;

(c) UOTIA Cap 262 which governs the establishment, licensing, accreditation, and quality assurance of universities and other tertiary institutions offering health-related programmes;

(d) The Professional Councils Acts, which regulate professional training pathways, internships, residencies, registration, and licensing within specific health professions;

(e) Where applicable, the TVET Qualifications Framework and the Higher Education Qualifications Framework, which define qualification levels, learning outcomes, progression pathways, and articulation across subsectors; and

(f) The Uganda Qualifications Framework, which provides the national reference architecture for comparability, portability, and recognition of qualifications.

406. Interpretive Effect: Where the Standards impose requirements within the scope of any of the above instruments, they shall be interpreted as operationalising and giving effect to those instruments, not derogating from them. In the event of apparent overlap, the Standards shall be applied in a manner that respects Statutory Mandates, reinforces quality assurance, and advances learner safety, patient safety, and public interest.

407. Conflict Resolution: Where an irreconcilable inconsistency arises, the hierarchy of norms shall apply, with the Acts of Parliament prevailing over policies and subsidiary legislation, policy

implementation standards prevailing over policy implementation guidelines. However, nothing in this clause permits the use of discretion to bypass the minimum requirements set out in these standards and guidelines where the enabling law allows their enforcement.

408. Through G4.11 the Standards are anchored firmly within the country's existing legal and policy ecosystem, ensuring coherence, predictability, and lawful enforcement across institutions, regulators, training sites, assessment bodies, and professional councils.

G5.0 Policy and Legal Coherence as a Mandatory Condition of Implementation

409. G5.0 establishes legal and policy coherence as a non-negotiable condition for the validity of all actions taken under the PISs. It affirms that standards are not a standalone regime, but an integrative operational instrument that must be interpreted, applied, and enforced in strict concordance with the policy, legal, and qualifications architecture.

410. All decisions, approvals, directions, inspections, corrective actions, sanctions, and enforcement measures taken pursuant to these standards shall be legally effective only where they are demonstrably consistent with the statutes, policies, and frameworks including; NETH Policy, 2025, TVET Policy, 2019, TVET Act, 2025, UOTIA Cap 262, the various Professional Councils Acts, TVET Qualifications Framework where applicable, the HEQF, and the UQF.

G5.1 Mandatory Concordance Requirement.

411. Ministries, regulators (TVET Council and NCHE), HTIs, UHPAB, and various Professional Councils shall ensure that every action under the standards:

(a) Falls within the relevant statutory mandate of the acting authority;

(b) Aligns with the applicable policy objectives and governance arrangements; and

(c) Conforms to the qualification level descriptors, progression rules, and recognition principles established under the national frameworks.

412. No approval, accreditation, placement decision, assessment eligibility determination, funding release, or enforcement action under the Standards and guidelines shall be valid if it conflicts with, circumvents, or purports to override any applicable policy or legal instrument listed under G4.11 and G5.0 above.

G5.2 Operational Effect and Decision Discipline.

413. Authorities shall apply the Standards and guidelines as the implementation layer that gives practical effect to the higher-order instruments.

414. Where discretion exists under the enabling policy and legal framework, it shall be exercised in a manner that advances coherence, strengthens quality assurance, and protects learner and patient safety.

415. Decisions taken without documented concordance such as approvals issued without reference to enabling policy, legal or qualifications frameworks shall be procedurally defective and subject to review, correction, or nullification.

G5.3 Hierarchy and Conflict Management:

416. In the event of apparent inconsistency, the hierarchy of norms shall apply (Acts of Parliament prevailing over policies and standards).

417. However, where the enabling law and policy permit the application of the Standards, G5.2 above prohibits the use of discretion to waive or dilute minimum requirements set by the Standards and guidelines in the name of or under the pretext of expediency.

418. G5.0 embeds policy and legal certainty, administrative discipline, and defensibility into implementation and ensures that the Standards and guidelines operate as a coherent, lawful, and system-integrated instrument, preventing fragmented regulation and safeguarding the integrity of approvals, placements, assessments, and enforcement across the education and training for health ecosystem.

G5.4 National Legal–Policy Concordance Procedure (Who Does What)

419. G5.4 establishes the mandatory, role-specific procedure through which legal–policy coherence is actively verified, documented, and enforced across all actions taken under the Standards. It translates the concordance requirement into a clear allocation of responsibility ensuring that coherence is not assumed, but procedurally assured at each decision point.

420. This workflow procedure operates through the following role allocations and checks

G5.4.1 Establish a Formal Legal and Policy Concordance Framework

421. This creates authoritative legal–policy foundation for implementation by institutionalising concordance as a formal, documented, and reviewable process. It ensures that every Standard is grounded in enabling authority, that mandates are respected, and that implementation actions are legally defensible from the outset.

G5.4.2 Establish a Formal Legal and Policy Concordance Framework

422. The MoES, in consultation with MoH, shall establish and maintain a Policy and Legal Concordance Framework with the following mandatory features:

(a) Standards-to-Authority Mapping: Each Standard shall be explicitly mapped to its enabling policies, legal provisions, and qualifications frameworks, identifying the precise policy provisions, statutory clauses, and framework descriptors that confer authority or impose obligations. This mapping must demonstrate how each Standard operationalises rather than duplicates or contradicts higher-order instruments.

(b) Mandate Clarification and Limits of Authority: The Framework must clearly delineate institutional mandates, specifying which authority is competent to initiate, verify, decide, notify, and enforce each requirement, and identifying limits of authority to prevent mandate creep, duplication, or ultra vires actions. Where the mandates intersect, the Framework must specify the coordination and sequencing rules.

(c) Decision-Use Guidance: The Framework must prescribe how concordance is to be checked and recorded at key decision points (licensing, accreditation, placements, assessment eligibility, funding releases, inspections, and sanctions), including the minimum references that must appear in decision records.

G5.4.3 Management and Disposal of Biomedical Training Materials

423. A legal framework shall be established to guide and direct the acquisition, transportation, utilisation, handling and disposal of biomedical training materials including cadavers

G5.4.4 Update and Governance Protocol

424. A governance mechanism must be established to update the framework in response to legislative amendments, policy revisions, or framework updates, ensuring continued accuracy and relevance.

G5.4.5 Policy– Legal Concordance Matrix

425. NETH Policy – Legal Concordance Matrix, shall be issued as an authoritative reference. Once issued, the matrix must present, in a clear tabular format, each standard alongside: (i) the enabling policy and legal instruments; (ii) the responsible authority; (iii) the applicable qualifications framework levels; and (iv) the decision points where concordance must be verified.

426. The matrix shall be binding for implementation, audit, and review purposes, and must be used by regulators (TVET Council and NCHE), institutions, UHPAB, and relevant inspectors to ensure consistent, and lawful application.

427. Formalising concordance at the outset, embeds legal certainty, mandate discipline, and auditability into implementation, reduces litigation risks, prevents regulatory conflict, and ensures that all downstream actions under the standards are grounded in clear authority.

G5.4.6 Regulator-Level Internal Alignment

428. G5.4.6 operationalises NETH Policy– Legal Concordance Framework at the level where regulatory decisions are actually made and requires that each regulator to translates concordance from a national reference into internal rules, tools, and decision discipline, to ensure that approvals and enforcement actions are lawful, consistent, and defensible.

429. TVET Council, NCHE, and Professional Councils must, within their respective mandates, undertake a structured internal alignment process comprising the following actions:

(a) Comprehensive Internal Review: Each regulator must systematically review its existing regulations, guidelines, circulars, accreditation criteria, inspection tools, approval templates, and enforcement procedures to assess alignment with the NETH Policy, PIS and PIGs as well as the Legal–Policy Concordance Framework.

(b) Identification of Overlaps, Gaps, and Inconsistencies: Regulators must identify:
(i) Overlaps, where existing rules duplicate or exceed what is authorised by enabling law;
(ii) Gaps, where existing instruments fail to operationalise mandatory elements of the Standards; and
(iii) Inconsistencies, where current practices conflict with the Standards or with higher-order legal or policy instruments.

(c) Mandate-Anchored Alignment Directives: Each regulator must issue internal alignment directives confirming that all regulatory actions shall be exercised strictly within, and aligned to, the applicable enabling instruments, namely:

(i) UOTIA Cap 262 for higher education institutions and programmes;

(ii) TVET Act, 2025 for TVET health education and training;

(iii) Professional Councils Acts for professional training, practice, registration, and licensure; and

(iv) UQF and HEQF for qualification levels, learning outcomes, and progression pathways.

(d) Tool and Process Revision: Regulators must revise accreditation checklists, inspection instruments, scoring rubrics, approval letters, and enforcement templates to ensure that:
(i) each decision criterion is traceable to the Standards and enabling law;
(ii) decision-makers apply uniform thresholds and compliance gates; and
(iii) records explicitly document policy – legal concordance at the point of decision.

(e) Internal Capacity and Standard Operating Procedures (SOPs) Updates: Internal SOPs, staff guidance notes, and reviewer instructions must be updated to embed concordance checks as a routine step in regulatory workflows, and to reduce discretion-driven variance and ultra vires risk.

430. Regulator-Level Internal Alignment must among others include:

(i) Regulator Alignment Circulars, formally declaring internal alignment and effective dates;

(ii) Revised Accreditation and Inspection Checklists, mapped to the Standards and enabling instruments;

(iii) Updated Internal Standard Operating Procedures (SOPs), embedding concordance verification into routine regulatory practice.

431. G5.4.6 ensures that the regulators (TVET Council, and NCHE) act with mandate discipline and procedural consistency, preventing contradictory decisions, avoiding regulatory overreach, and ensuring that all approvals, refusals, and sanctions under the Standards are lawful, coherent, and audit-ready across higher education, TVET health education and training, and professional regulation.

G5.4.7 Institutional Interpretation and Compliance Mapping

432. G5.4.7 translates national and regulatory concordance into institution-level accountability. It requires that each duty-bearing entity to internalise the standards and guidelines, interpret them within its operational context, and document how compliance is achieved across programmes and training pathways. This ensures that compliance is proactive, demonstrable, and auditable, rather than reactive.

433. Each HTI, Training Hospital or Clinical Placement Site, and UHPAB, as a duty bearer under the standards and guidelines, must undertake a structured institutional compliance mapping exercise comprising the following actions:

G5.4.7.1 Programme and Pathway Mapping to Standards

434. Institutions must systematically map each programme, award, internship, residency, fellowship, or assessment pathway against the relevant provisions of standards, identifying: (a) where and how each standard is met; (b) any conditions or dependencies (e.g. site designation, supervision ratios); and (c) any areas requiring corrective action or transitional alignment.

G5.4.7.2 Alignment to national qualifications frameworks

435. Each HTI, training hospital, and UHPAB (duty bearer) must: map its programmes, awards, and training pathways against: the Standards; UQF/HEQF levels; and applicable Professional Council requirements.

436. Each programme and award must be mapped to the appropriate UQF and, where applicable, the HEQF levels, including learning outcomes, credit volume, progression pathways, and award titles.

437. Misalignment with framework descriptors must be identified and addressed.

(a) Professional Council Requirements Integration:

(i) Where programmes or pathways lead to professional registration or licensure, institutions must map compliance with applicable Professional Council requirements, including internship or residency prerequisites, assessment eligibility, supervision standards, and progression rules.

(ii) Conflicts or gaps between institutional provision and professional requirements must be escalated and rectified.

(b) Risk Identification and Corrective Planning: The mapping exercise must identify compliance risks, gaps, or transitional issues, and specify the corrective measures, timelines, and responsible officers where full compliance is not yet achieved.

(c) Governance Approval and Accountability

(i) Institutions must produce an Institutional Compliance Mapping Report, and maintain it as an official institutional record to be made available upon request for inspection, accreditation, audit, or enforcement purposes.

(ii) Institutional compliance mapping report must be reviewed and approved by the institution's accountable governance authority (such as; Top Management, Council, Senate, Management Board). This establishes institutional ownership and accountability for the accuracy and implementation of the mapping.

(iii) The Institutional Compliance Mapping Report serves as evidence that the institution has systematically interpreted and aligned its operations with the Standards, qualifications frameworks, and professional requirements.

(iv) Institutional Compliance Mapping embeds compliance within institutional systems and governance, reduces ambiguity at implementation points, and enables regulators to assess compliance efficiently and consistently. Also, it ensures that institutions act as informed and accountable duty bearers, capable of demonstrating lawful alignment rather than asserting it.

G5.4.7.3 Decision-Making Protocol or "the Read-Together" Rule

438. G5.4.7.3 establishes a binding decision discipline that operationalises the "read-together" principle at every point of regulatory or administrative action under the Standards. This ensures that no decision is taken in isolation, on the basis of the standards alone, or outside the lawful authority.

439. Whenever a decision is taken pursuant to the Standards including but not limited to licensing, accreditation, re-accreditation, placement approval, capacity determination, corrective action, or sanctions the decision-making authority must apply the following mandatory protocol:

(a) Statutory Authority Confirmation

(i) The decision-maker must explicitly confirm that the action is authorised under the relevant

enabling Act, citing the specific statutory provision conferring power.

(ii) Decisions taken without identifiable statutory authority shall be ultra vires and invalid.

(b) Qualifications Framework Consistency Check

The decision-maker must verify and record that the decision is consistent with the applicable qualifications framework, including UQF and, where relevant, HEQF. This includes confirmation of correct qualification level, learning outcomes, progression pathways, and recognition status.

(c) Mandate Non-Usurpation Assurance

(i) The decision-maker must confirm that the action does not encroach upon or usurp the Statutory Mandate of another authority (e.g. a Professional Council, NCHE, or the TVET Council).

(ii) Where mandates intersect, the decision shall reflect coordination, concurrence, or sequencing as prescribed, rather than unilateral action.

(d) Concordance Reasoning and Documentation

(i) The decision must include a brief but explicit policy– legal concordance statement demonstrating how the standards have been read together with the relevant policy, Act, and any framework, and how discretion has been exercised lawfully and coherently.

(ii) Each decision must be documented in an official decision record that includes a policy – legal reference clause, citing the, applicable policy and enabling legal instruments, and qualifications frameworks relied upon. This record shall form part of the permanent regulatory file and shall be available for audit, review, or appeal.

(iii) Enforcing the read-together rule at the point of decision, ensures that actions taken under the Standards are lawful, coherent, and defensible, reduces litigation risk, prevents mandate conflict, and strengthens confidence in regulatory and administrative decisions across the education and training for health system.

G5.4.7.4 Dispute Avoidance and Resolution

440. G5.4.7.4 establishes a preventive and corrective mechanism to manage policy –legal ambiguities and mandate boundary issues before they escalate into institutional conflict, regulatory paralysis, or litigation. This ensures that interpretation of standards remains coherent, authoritative, and consistent across the system.

441. The Ministry of Education and Sports (MoES) and the Ministry of Health (MoH), acting as joint custodians of the Standards, must establish a Regulatory Coordination and Interpretation Mechanism with the following functions:

(a) Resolution of Mandate Boundary Issues

(i) The Regulatory Coordination and Interpretation Mechanism must serve as the first forum for resolving disputes or uncertainties regarding Statutory Mandates, Sequencing of Authority, or Scope of Regulatory Action among regulators, Professional Councils, UHPAB, and implementing agencies.

(ii) The Regulatory Coordination and Interpretation Mechanism must assess issues against the Policy –Legal Concordance Framework and the hierarchy of norms.

(b) Issuance of Joint Clarification Notes and Interpretation Circulars

(i) Where overlap, ambiguity, or divergent interpretations are alleged, MoES and MoH must formally issue Joint Clarification Notes or Interpretation Circulars providing authoritative guidance on how the Standards are to be applied.

(ii) The joint clarification notes and interpretation circulars, must record the issue addressed, the interpretive position adopted, the policy – legal basis, and the practical implications for implementation and compliance.

(iii) Such clarifications bind all affected entities unless and until they are lawfully revised.

(c) Prevention of Conflicting Directives: The Mechanism must proactively review proposed circulars, directives, or enforcement actions where cross-sector impact is likely, to prevent the issuance of conflicting or inconsistent instructions to institutions, training sites, or assessment bodies.

(d) Escalation and Referral

(i) Where issues cannot be resolved administratively, the Mechanism must recommend escalation pathways such as referral for legal advice, Cabinet consideration, or formal amendment while providing interim guidance to avoid regulatory uncertainty.

(ii) Institutionalising dispute avoidance and coordinated interpretation, safeguards regulatory coherence, administrative certainty, and system stability. Also, it minimises litigation risk, protects institutions from contradictory directives, and ensures that Standards are applied consistently in a complex, multi-actor governance environment.

G6.0 Practical Application by Policy –Legal Instrument Category

442. G6.0 operationalises policy –legal concordance by prescribing how the standards are to be applied differently depending on the governing instrument. It translates abstract coherence principles into clear, enforceable rules of application for education policy, laws, professional statutes, and qualifications frameworks, thereby preventing mandate overreach and invalid regulatory action.

G6.1 Application of Education Laws (UOTIA Cap. 262 and TVET Act, 2025)

443. Under the Universities and Other Tertiary Institutions Act (UOTIA) Cap. 262 and the Technical and Vocational Education and Training (TVET) Act, 2025, the standards must be applied strictly within legally defined qualification levels and institutional mandates:

(i) The TVET Council shall apply the standards only to programmes and institutions operating at UQF Levels 3–6, corresponding to ISCED Levels 3–5 (certificate, diploma, and higher diploma levels).

(ii) NCHE shall apply the standards only to programmes and institutions operating at UQF Levels 7–9, corresponding to ISCED Levels 6–8 (bachelor's, master's, and doctoral education).

(iii) No regulator (TVET Council/ NCHE) shall approve, accredit, vary, suspend, or withdraw a programme or institution outside its legally assigned qualification level mandate, whether directly or indirectly.

444. Decisions taken in accordance with these rules shall constitute legally valid accreditation and approval decisions, defensible under the relevant Acts and immune from challenge on grounds of mandate overreach.

G6.2 Application of Professional Councils Acts

445. Under the respective Professional Acts, the Policy Implementation Standards shall be applied by Professional Councils only within the sphere of professional regulation, as follows:

(a) Professional Councils Shall apply the Policy Implementation Standards to matters of:
(i) Clinical competence and practice readiness;
(ii) Internship, residency, and fellowship requirements;
(iii) Eligibility for licensure and registration;
(iv) Ethical standards and scope of professional practice.

(b) Professional Councils Shall Not:
(i) Accredit academic programmes as educational qualifications;
(ii) Award, withdraw, or invalidate academic degrees, diplomas, or certificates issued by duly authorised education institutions;
(iii) Encroach upon the academic quality assurance mandate of NCHE or the TVET Council.

446. Professional Council actions must result in practice recognition decisions, internship and residency approval instruments, and licensure determinations that are professionally authoritative but academically non-intrusive.

G6.3 Application of Qualification Frameworks (UQF / HEQF)

447. Under UQF and HEQF, PISs must be applied as verification and alignment tools, ensuring national coherence and portability of qualifications:

448. All qualifications referenced in approvals, enforcement actions, placements, or assessments shall: (i) be explicitly levelled under the UQF (and HEQF where applicable); (ii) and shall demonstrate learning outcomes, volume of learning, and progression pathways consistent with the relevant level descriptors.

449. Regulators (TVET Council/ NCHE) and Health Education Institutions must attach qualification alignment statements to programme approvals and significant regulatory decisions, demonstrating conformity with framework requirements.

450. Each decision must include a Qualification Alignment Statement confirming framework compliance, thereby supporting national recognition, learner mobility, and enforcement.

451. Prescribing instrument-specific application rules, under G6.3 ensures that the standards are applied lawfully, precisely, and without mandate conflict. Also, it protects the validity of regulatory decisions, preserves institutional roles, and embeds qualifications coherence at every stage of approval, regulation, and enforcement.

G6.4 Mandatory Documentation, Records and Enforcement

452. G6.4 establishes documentation and record-keeping as a binding condition of lawful implementation and enforcement of Standards. It recognises that policy – legal coherence is not merely a matter of intent, but must be demonstrable through attendant records capable of audit, review, and enforcement. Absence of such records renders the decisions procedurally defective.

453. Each implementing authority including MoES, MoH, NCHE, the TVET Council, Professional Councils, assessment bodies, and other designated regulators must maintain and keep the following current and mandatory documentation and records:

G6.4.1 Policy –Legal Concordance Matrix

454. An authoritative matrix mapping each applicable Policy Implementation Standard to its enabling policy provision, legal clauses, and qualifications frameworks, and identifying the competent authority and decision points. This matrix must be used as the primary reference for approvals, inspections, sanctions, and dispute resolution.

G6.4.2 Approved Mandate and Scope Records

455. Clear records defining the authority's statutory mandate, scope of action, and limits of authority, including qualification levels, programme types, and regulatory functions. These records shall guide internal decision-making and prevent ultra vires action.

G6.4.3 Qualification-Level Mapping for Each Programme

456. Verified documentation demonstrating that each approved programme or award is explicitly levelled under UQF (and HEQF where applicable), including learning outcomes, progression pathways, and recognition status.

G6.4.4 Joint Clarification Notices and Interpretation Circulars (where issued)

457. Copies of all jointly issued MoES/MoH clarification notes or interpretation circulars resolving mandate overlap or interpretive ambiguity, maintained as binding interpretive references for future decisions.

G6.4.5 Procedural Consequence.

458. Failure by an implementing authority to maintain, update, or produce these records upon request constitutes procedural non-compliance under G6.4, and renders the affected decisions subject to suspension, review, or even nullification.

G6.4.6 Enforcement

459. Enforcement action under G6.4 must be initiated where any of the following are identified:

(a) Conflicting Approvals, where two or more authorities issue inconsistent decisions affecting the same programme, institution, or training pathway;

(b) Mandate Overreach, where an authority acts outside its statutory scope or qualification-level jurisdiction;

(c) Regulatory Evasion, where institutions cite one policy, law, or framework to avoid compliance with another applicable instrument;

(d) Inconsistent Enforcement Actions, resulting in unequal treatment, regulatory uncertainty, or compromised quality and safety.

460. Upon confirmation of any trigger event above, MoES and MoH, acting singularly or jointly, may take one or more of the following actions:

(a) Joint Suspension Directive: Issue a binding directive suspending the disputed approval, action, or enforcement measure pending concordance review and resolution.

(b) Mandatory Re-Issuance of Approvals: Require the affected authority to re-issue approvals or decisions in a manner that explicitly complies with the Policy Implementation Standards and enabling instruments, including proper mandate and framework references.

(c) Withdrawal of Ultra Vires Decisions: Direct the withdrawal or nullification of decisions determined to be ultra vires, procedurally defective, or legally inconsistent.

(d) Referral to the Attorney General (Where Issue is Systemic): Where conflicts indicate systemic legal risk, repeated mandate violations, or unresolved Inter-Agency disagreement, the matter must be referred to the Attorney General for an authoritative legal opinion, guidance, or remedial action.

461. G6.4 ensures that policy – legal coherence is enforceable, auditable, and corrective, not aspirational. Mandating records and linking their absence to concrete enforcement consequences, protects the integrity of approvals, prevents regulatory arbitrage, and provides a structured mechanism for resolving conflicts in a complex, multi-authority governance environment.

462. Regulatory arbitrage is the practice of exploiting loopholes, inconsistencies, or differences between regulatory frameworks across different jurisdictions or within the same one to lower costs, reduce burdens, or gain a competitive advantage, often by restructuring operations to fit the most favourable rules.

G7.0 Transitional Interpretation and Supremacy

463. Where transitional inconsistencies arise between pre-existing instruments and these Policy Implementation Standards, the Policy Implementation Standards shall guide operational implementation, subject to conformity with the Constitution and enabling Acts.

G7.1. MoES and MoH Declare a Transition Window

464. The declaration of a transition window by the Ministry of Education and Sports (MoES) and the Ministry of Health (MoH) constitutes a formal administrative measure to manage the orderly shift and migration from pre-existing arrangements to full compliance with newly issued Policy Implementation Standards.

465. Through a joint circular or directive, MoES and MoH must specify a defined, time-bound transition period within which affected institutions, regulators, and training sites are required to align their policies, programmes, governance arrangements, and operational practices with the new Standards. The transition window provides legal and operational clarity on when the Standards take effect, which requirements apply immediately, and which requirements are subject to phased compliance.

466. During the transition window, MoES and MoH may:

(a) Set interim compliance milestones and reporting requirements;

(b) Authorise temporary arrangements or conditional approvals to avoid disruption of training and service delivery;

(c) Prioritise capacity-building, technical support, and corrective actions over punitive enforcement; and

(d) Issue clarifications to address legacy inconsistencies or overlaps in regulation.

467. The transition window does not suspend the binding nature of the Standards. Rather, it establishes a managed compliance pathway that protects learners, maintains continuity of health services, and enables institutions to achieve full compliance within a clearly defined timeframe. Upon expiry of the transition window, full enforcement applies, and any institution that remains non-compliant becomes subject to the full range of regulatory sanctions.

468. In effect, the declaration of a transition window balances regulatory certainty with implementation realism, ensuring lawful, fair, and system-wide adoption of the Standards without undermining quality, patient safety, or public interest.

G7.2 Identification of Legacy Approvals Needing Alignment.

469. The identification of legacy approvals requiring alignment by regulators is a systematic transitional process undertaken to ensure that all existing licences, accreditations, programme approvals, and professional recognitions issued under earlier frameworks are brought into conformity with newly adopted Policy Implementation Standards.

470. During this process, the relevant authorities such as the Ministry of Education and Sports (MoES), the Ministry of Health (MoH), the TVET Council, the National Council for Higher Education (NCHE), and the applicable Professional Councils must review and inventory all approvals currently in force.

471. This review determines whether such approvals: predate the new Standards; were issued under superseded policies or frameworks; or contain conditions, scopes, levels, or authorisations that are inconsistent with the current regulatory architecture.

472. Legacy approvals identified as misaligned must be classified according to the nature and severity of the gap, for example:

(a) approvals that are substantively compliant but require formal re-issuance or re-labelling;

(b) approvals that require modification of scope, level, or conditions; or

(c) approvals that are fundamentally incompatible with the new Standards and require phased withdrawal or replacement.

473. The identification exercise enables regulators to issue alignment notices, corrective directives, or conditional continuation approvals within the declared transition window. This ensures continuity of training and service delivery while preventing the perpetuation of outdated, ambiguous, or unlawful authorisations.

474. Importantly, this process does not invalidate existing approvals by default. Rather, it provides a controlled legal pathway to harmonise legacy decisions with current Standards, protect learners and institutions from regulatory uncertainty, and establish a single, coherent baseline for future enforcement.

475. In effect, the identification of legacy approvals is a foundational step in regulatory transition, ensuring that implementation of the Standards is comprehensive, legally defensible, and applied consistently across the entire education and training system.

G7.3 Institutions Submit Transition Compliance Plans.

476. The submission of transition compliance plans by institutions is a formal, time-bound obligation through which Health Training Institutions and other affected entities demonstrate how they will achieve full alignment with newly issued Policy Implementation Standards within the declared transition window.

477. Under this requirement, each institution shall prepare and submit a structured Transition Compliance Plan to the relevant regulatory authority within the timelines prescribed by MoES and MoH. The plan serves as an operational roadmap that translates the Standards into institution-specific corrective and alignment actions.

478. A Transition Compliance Plan shall, at a minimum:

(a) Identify Areas of Non-Compliance or Partial Compliance against each applicable Standard;

(b) Specify Corrective Actions required (e.g. governance reconstitution, programme realignment, capacity adjustments, infrastructure upgrades, or approval renewals);

(c) Assign Institutional Responsibility for each action (governing body, management, academic units);

(d) Define Clear Milestones and Timelines for completion within the transition window; and

(e) Indicate any regulatory support, approvals, or transitional relief required.

479. Submission of the plan enables regulators to assess feasibility, prioritise risks, and agree on phased compliance pathways, including conditional approvals or interim controls where necessary. During the transition period, progress against the approved plan may be monitored through reports, inspections, or technical engagements.

480. The Transition Compliance Plan does not suspend the binding nature of the Standards. Rather, it provides a transparent and accountable mechanism for managing legacy gaps while safeguarding learners, maintaining service continuity, and ensuring predictable enforcement. Failure to submit an acceptable plan, or failure to implement an approved plan, constitutes non-compliance and may trigger enforcement action upon expiry of the transition window.

481. In effect, the submission of transition compliance plans anchors the transition process in institutional responsibility, regulatory oversight, and measurable progress, ensuring that alignment with the Standards is orderly, equitable, and legally defensible.

G7.4 Regulatory Approval, Monitoring, and Verification of Alignment

482. The approval, monitoring, and verification of alignment by regulators constitutes the core regulatory assurance function during and after the transition to new Policy Implementation Standards. This function ensures that institutional commitments to compliance are credible, implemented as approved, and demonstrably effective.

483. Following submission of Transition Compliance Plans or other alignment instruments, the relevant regulatory authorities shall formally review and approve such plans, either in full or subject to specified conditions. Approval confirms that the proposed actions, timelines, and responsibilities are adequate to achieve full compliance with the Standards and are consistent with the institution's legal mandate, approved scope, and regulatory capacity.

484. Once approved, regulators shall actively monitor implementation through structured progress reporting, technical engagements, desk reviews, and routine or risk-based inspections. Monitoring focuses on whether agreed milestones are being met, whether corrective actions are being implemented as scheduled, and whether any emerging risks to learners, training quality, or patient safety require regulatory intervention.

485. Verification is the final assurance step, whereby regulators confirm, through evidence and on-site

validation, that alignment has been achieved in substance and not merely in form. Verification may include review of governance decisions, accreditation outcomes, staffing and infrastructure capacity, programme delivery, assessment practices, and compliance documentation. Where verification confirms compliance, regulators may issue formal confirmation of alignment, lift transitional conditions, or regularise approvals under the new Standards.

486. Where monitoring or verification identifies material gaps, regulators may require additional corrective actions, adjust timelines within the limits of the transition window, impose conditional restrictions, or initiate enforcement measures as provided by law.

487. In effect, regulatory approval, monitoring, and verification ensure that alignment with the Standards is continuous, evidence-based, and enforceable, safeguarding regulatory integrity, protecting learners and the public, and establishing a reliable compliance baseline for future oversight.

G7.5 Phasing Out of Non-Aligned Legacy Arrangements.

488. The phasing out of non-aligned legacy arrangements is a deliberate, structured regulatory action undertaken to ensure that all education and training activities ultimately operate exclusively under the current Policy Implementation Standards.

489. Where legacy licences, accreditations, programme approvals, governance structures, or operational practices are identified as incompatible with the new Standards, and cannot be regularised through alignment or transitional measures, regulators shall initiate a controlled withdrawal process. This process is typically implemented at the conclusion of the declared transition window, or earlier where the risk to quality, learner protection, or patient safety is material.

490. Phasing out may include: (i) non-renewal or expiration of outdated approvals; (ii) formal revocation or withdrawal of approvals that cannot be aligned; (iii) cessation of admissions into non-aligned programmes or cadres; (iv) discontinuation of legacy practices inconsistent with the Standards; and (v) replacement with newly issued approvals that are fully compliant.

491. The phase-out process shall be guided by proportionality and fairness. Regulators shall sequence actions to minimise disruption, particularly for learners already enrolled, while ensuring that no new cohorts are admitted under non-compliant arrangements. Learner protection measures such as teach-out plans, transfers, or remediation must be applied where necessary.

492. Phasing out does not operate retroactively to invalidate lawful training already completed under previous regimes. Rather, it establishes a forward-looking compliance baseline, ensuring that all ongoing and future provision conforms to the Standards.

493. The phase-out of non-aligned legacy arrangements marks the final step in regulatory transition, closing residual gaps, eliminating ambiguity, and securing a single, coherent, and enforceable regulatory framework that upholds quality, safety, and public interest objectives.

494. Policy implementation represents the stage where government executes an adopted policy instrument. At this stage, Ministries, Departments, and Agencies (MDAs) responsible for the respective policy area, are formally made responsible for implementation. Policy implementation is what happens after policy approval and adoption.

495. Public policy implementation is the crucial stage where government decisions, laws, and regulations are put into action to achieve societal goals, transforming abstract policies into tangible programmes and services through administrative agencies, resources, and specific actions, bridging the gap between policy intent and real-world impact.

496. Once Government has legitimised the policy, the stipulations of that policy must be put into action, administered, and enforced to bring about the desired change sought by the policy-makers. This task defaults to the government executive and necessitates the designation of a government agency with the responsibility for the new policy. The responsible agency is given the requisite resources and authority to ensure that the new policy is carried out as intended.

497. Implementation is a complex process involving all of activities designed to translate the policies objectives into concrete steps, assigning responsibilities, securing funding, and coordinating various actors to address public problems and improve welfare, often facing challenges like insufficient resources or political hurdles.

498. The activities may include the creation of new organisations (MDAs and so on) or assignment of new responsibilities to existing MDAs. Organisations must translate policy into operational standards, and guidelines. MDAs must: promulgate standards, guidelines, principles, protocols, and procedures; hire personnel; contract providers; spend money; license, inspect, enforce, adjudicate, and interpret both the policy standards and guidelines and their own rules; and perform all policy relevant tasks. All of these activities involve decisions that determine policy by bureaucrats.

G8.1 Development of the Legal–Policy Concordance Matrix

499. The development of the Legal–Policy Concordance Matrix is a foundational governance and regulatory harmonisation exercise designed to ensure that all policy implementation standards, regulatory actions, and institutional decisions in NETH sub-sector are legally grounded, internally coherent, and mandate-consistent.

500. The Concordance Matrix is an authoritative mapping instrument that systematically aligns: (i) each PIS and PIG; (ii) the enabling statutory provisions under education, health, TVET, higher education, and professional regulation laws; and (iii) the responsible institutions and regulators exercising authority under those provisions.

501. Through this mapping, the Matrix clarifies who is legally empowered to do what, under which law, and for which level or function within the health education and training system. It explicitly identifies areas of exclusive mandate, shared responsibility, and boundary conditions, thereby preventing mandate overlap, regulatory overreach, or gaps in enforcement.

502. The development process is typically led by MoES in collaboration with MoH, and involves the TVET Council, NCHE, Professional Councils, UHPAB, and the Attorney General's Chambers where necessary.

503. The process includes: (i) identifying all applicable laws, policies, regulations, and qualification frameworks; (ii) mapping each Education and Training for Health Standard and implementation function to its legal basis; (iii) reconciling inconsistencies or overlaps; and (iv) agreeing on interpretive positions for ambiguous provisions.

504. Once validated and adopted, the Concordance Matrix serves as the single reference point for: (i) regulatory decision-making (licensing, accreditation, inspections, sanctions); (ii) institutional compliance mapping; (iii) dispute avoidance and resolution; and (iv) judicial or audit scrutiny of regulatory actions.

505. The Matrix is a living instrument, subject to periodic update when laws, policies, or standards change, but it carries strong authoritative weight as the agreed legal-policy interpretation framework for the Education and Training for Health system.

506. In effect, NETH Legal–Policy Concordance Matrix operationalises the principle that no policy standard or regulatory action may be implemented in isolation from its legal authority, thereby strengthening legal defensibility, regulatory coherence, and public trust in the governance of education and training for health.

G8.2 Development and Issuance of a Joint Interpretation Circular (MoES/MoH)

507. The development and issuance of a Joint Interpretation Circular by MoES and MoH is a formal regulatory coordination mechanism intended to provide authoritative, system-wide clarification on the interpretation and application of PISs within NETH sector.

508. Through the Joint Interpretation Circular, MoES and MoH jointly articulate a common, binding interpretive position on how the Standards are to be understood and operationalised across education institutions, training sites, regulators, and professional bodies. The Circular is critical where provisions intersect multiple legal regimes such as relevant education laws, health professional laws, TVET Act, UOTIA, and professional council mandates or where legacy practices and transitional issues create ambiguity.

509. The Joint Interpretation Circular typically: (i) clarifies the intent, scope, and boundaries of specific Standards; (ii) resolves overlaps or potential conflicts between regulatory authorities; (iii) affirms mandate demarcation among MoES, MoH, TVET Council, NCHE, and Professional Councils; (iv) sets out uniform implementation positions to be applied by all regulators; and (v) provides practical guidance on compliance pathways, transition arrangements, or enforcement sequencing.

510. The development process is collaborative and consultative, involving technical teams from MoES and MoH, relevant regulators, and, where necessary, legal vetting to ensure consistency with the NETH Legal–Policy Concordance Matrix. Once issued, the Circular is formally disseminated to all affected institutions and regulators and becomes the authoritative reference for interpretation until amended or withdrawn.

511. The Joint Interpretation Circular does not amend the Standards or create new legal obligations. Rather, it standardises interpretation, prevents inconsistent directives, reduces regulatory disputes, and enhances predictability and fairness in implementation.

512. The Joint Interpretation Circular functions as a coordination and coherence instrument, ensuring that NETH Policy and PISs are applied consistently, lawfully, and in alignment with national education and health objectives.

G8.3 Development of Regulator-Aligned Accreditation and Inspection Tools

513. The development of regulator-aligned accreditation and inspection tools is a structured, collaborative process through which all relevant regulatory authorities design and adopt harmonised operational instruments to give consistent effect to PISs across NETH system.

514. This development process is led by the competent authorities typically MoES and MoH in close coordination with the TVET Council, NCHE, Professional Councils, or UHPAB. This ensures that each regulator's tools are legally grounded, mandate-consistent, and mutually reinforcing, while avoiding duplication, contradiction, or regulatory overreach.

515. The Key elements of the development process include:

(a) Mapping Standards to legal authority using the NETH Legal–Policy Concordance Matrix, so that each inspection or accreditation criterion is clearly anchored in statute or approved policy;

(b) Harmonising core criteria and definitions (e.g. scope, level, capacity, supervision, quality assurance, learner protection) to ensure uniform interpretation across regulators;

(c) Differentiating regulator roles, so that education regulators assess academic quality and qualification levels, while Professional Councils focus on cadre-specific competence, clinical readiness, and practice standards;

(d) Designing common formats and evidence requirements, including checklists, scoring rubrics, verification protocols, and documentation templates; and

(e) Integrating corrective action and enforcement pathways, ensuring that findings from inspections translate into proportionate, legally defensible decisions.

516. Throughout the development phase, draft tools are subjected to technical validation and inter-regulatory review to confirm internal consistency, legal defensibility, and practical usability. Where necessary, guidance from Joint Interpretation Circulars is incorporated to resolve ambiguities and ensure a shared regulatory position.

517. Once finalised, regulator-aligned tools are formally approved and issued for system-wide use, accompanied by orientation and capacity-building for inspectors and accreditation panels. Periodic review mechanisms are established to update the tools in response to legal changes, policy revisions, or emerging implementation lessons.

518. The development of regulator-aligned accreditation and inspection tools ensures that regulatory oversight is coherent, predictable, and evidence-based, providing institutions with clear compliance expectations while strengthening quality assurance, learner protection, and public confidence in the Education and Training for Health system.

G8.4 Establishment of Institutional Compliance Mapping Records

519. Putting in place institutional compliance mapping records is a core internal governance and accountability requirement through which institutions systematically demonstrate their alignment with NETH policy, PISs, PIGs applicable laws, and regulatory approvals.

520. Institutional compliance mapping records are structured, institution-maintained documents that map, in a clear and auditable manner: each applicable Policy Implementation Standard and regulatory requirement; the institution's corresponding policies, programmes, approvals, and practices; and the evidence demonstrating compliance or identifying gaps requiring corrective action.

521. The establishment of the records requires institutions to undertake an internal compliance self-assessment, reviewing their legal status, mandate, approved scope and levels, governance arrangements, programmes, staffing, infrastructure, clinical training partnerships, assessment practices, and learner protection measures against current Standards and regulatory conditions.

522. Compliance mapping records typically include: (i) a standards-to-practice matrix linking each requirement to institutional evidence (e.g. licences, accreditation letters, curricula, minutes, contracts, inspection reports); (ii) a compliance status classification (compliant, partially compliant, non-compliant); (iii) identified corrective actions and timelines where gaps exist; and (iv) designation of responsible officers or units for each compliance area.

523. These records must be kept up to date, approved by the institution's governing body or designated compliance authority, and made available to regulators during inspections, accreditation reviews, or audits. They form the primary reference for demonstrating compliance during transition periods and routine oversight.

524. Institutional compliance mapping records do not replace regulatory approvals. Rather, they provide a transparent, evidence-based compliance trail that enables regulators to verify alignment efficiently and enables institutions to manage compliance proactively rather than reactively.

525. Putting in place institutional compliance mapping records embeds compliance within institutional governance, strengthens internal accountability, reduces regulatory risk, and supports consistent, lawful, and sustainable implementation of Implementation Standards.

G9.0 HARMONISED LEGAL AND REGULATORY FRAMEWORK

526. G9.0 requires that every NETH decision and activity (institutional approval, programme accreditation, admissions, clinical placements, internship/residency, assessment, funding conditions, enforcement actions) must be executed through a coordinated, mandate-consistent regulatory system.

527. The central compliance tests include:

G9.1 No Mandate Overlap (No Duplication)

528. The compliance test of "No mandate overlap (no duplication)" is a core governance and regulatory principle that ensures each institution and regulator operates strictly within its legally defined authority, and that no function, approval, or control is exercised concurrently or redundantly by multiple bodies without clear legal basis.

529. Under this test, every approval, accreditation, inspection, or enforcement action within the NETH system must be traceable to a single, clearly identified mandate conferred by law or policy. Where responsibilities are shared, the respective roles of each authority must be explicitly differentiated and coordinated, rather than duplicated.

530. In practical terms, this test requires that:

(a) Ministries (MoES, MoH) exercise policy, coordination, and oversight functions, not direct academic or professional regulation unless expressly authorised by law.

(b) Education regulators (e.g. TVET Council, NCHE) exercise authority over academic quality,

programme accreditation, and qualification levels only;

(c) Professional Councils (Uganda Medical and Dental Practitioners Council [UMDPC]; Uganda Nurses and Midwives Council [UNMC]; The Allied Health Professionals Council [AHPC]; and The Pharmaceutical Society of Uganda among others) exercise authority over cadre recognition, clinical competence, internship requirements, and licensure eligibility only; and

531. No mandate overlap also applies at the institutional level. Institutions shall not establish internal structures or processes that replicate or usurp external regulatory functions, such as self-licensing, self-accreditation, or self-recognition of professional practice.

532. The compliance test is operationalised through:
(a) Legal–Policy Concordance Matrix, which maps each function to its legal authority;
(b) Regulator-Aligned Accreditation and Inspection Tools, which limit assessments to mandate-consistent criteria; and
(c) Joint Interpretation Circulars, which resolve ambiguity and prevent conflicting directives.

533. Where duplication or overlap is detected such as the two regulators issuing conflicting approvals, or an institution relying on one approval to bypass another, this arrangement is non-compliant and subject to corrective action, withdrawal, or re-issuance of approvals.

534. The no mandate overlap compliance test safeguards regulatory coherence, legal defensibility, and system efficiency, reduces institutional burden, and ensures that quality assurance, professional standards, and patient safety are upheld through clear, complementary, and non-duplicative governance roles.

G9.2 No Mandate Gaps (No Regulator Omission)

535. The compliance test of “No mandate gaps (no regulator omission)” is a foundational governance principle that ensures every critical function within the NETH system is explicitly assigned to a competent authority, and that no aspect of education, training, assessment, or professional practice operates without lawful oversight.

536. Under this test, all stages of the health training value chain; institutional licensing, programme accreditation, qualification alignment, clinical training, internship, assessment, registration, and licensure must be subject to clear regulatory responsibility.

537. No function may be left unregulated, informally regulated, or assumed to fall outside the scope of existing authorities.

538. In practical terms, the test requires that:

(a) Education Regulators (NCHE, TVET Council) oversee all academic and qualification-related matters, including curriculum standards, assessment systems, and alignment with the Uganda Qualifications Framework;

(b) Professional Councils regulate all matters relating to cadre definition, clinical competence, internship requirements, ethics, and licensure;

(c) Uganda Health Professions Assessment Board exercises oversight over national examinations and certification where mandated; and

(d) Ministries (MoES, MoH) provide policy leadership, coordination, and residual oversight to ensure that no regulatory vacuum exists.

539. The “no mandate gaps” test is applied through the NETH Legal–Policy Concordance Matrix, which maps every regulatory function to a specific legal authority. Where gaps are identified such as new training modalities, emerging health cadres, or hybrid TVET higher education pathways. MoES and MoH are required to initiate corrective measures, including policy clarification, interim directives, or legislative amendment.

540. At the institutional level, the test prevents institutions from operating in unregulated spaces, such as offering programmes that fall between existing qualification frameworks or training cadres not recognised by any Professional Council.

541. Where a mandate gap is detected, regulatory action focuses on assignment and coordination, not punishment. Interim oversight arrangements may be established to protect learners and patients while permanent legal or policy solutions are developed.

542. In effect, the “no mandate gaps” compliance test ensures that the NETH system is comprehensive, lawful, and accountable, eliminating regulatory blind spots that could compromise quality, professional standards, or patient safety, and reinforcing public confidence in the governance of health education and training.

G9.3 No Conflicting Instructions to Institutions or Sites

543. The compliance test of “No conflicting instructions to institutions or sites” is a critical coordination principle designed to ensure that HTIs, training hospitals, clinical placement sites, and other regulated entities receive clear, consistent, and authoritative directions from the regulatory system.

544. Under this test, institutions and sites must not be subjected to contradictory, overlapping, or inconsistent directives issued by different regulators, ministries, or authorities acting independently or without coordination. Conflicting instructions undermine compliance, create legal uncertainty, expose institutions to enforcement risk, and may compromise training quality, learner protection, and patient safety.

545. In practical terms, this test requires that:

(a) All Regulatory Instructions including approvals, circulars, inspection findings, compliance directives, and enforcement notices are internally consistent and aligned with the applicable standards, laws, and the NETH Legal–Policy Concordance Matrix;

(b) Each Regulator Communicates only within its mandate, avoiding directions that contradict or negate instructions issued by another competent authority; and

(c) Joint or Sequenced Communication Mechanisms are used where matters cut across education, health, and professional regulation.

546. The test is operationalised through:

(a) Joint MoES/MoH Implementation and Interpretation Circulars, which establish a single, authoritative position on contested or cross-cutting issues;

(b) Regulator-Aligned Accreditation and Inspection Tools, ensuring that findings and directives are based on shared criteria and interpretations;

(c) Formal Inter-Agency Coordination Mechanisms, including information-sharing and joint review of major regulatory decisions; and

(d) Clear Escalation and Clarification Pathways, enabling institutions to seek authoritative guidance where inconsistencies are perceived.

547. Where conflicting instructions arise, the matter is treated as a regulatory coordination failure, not institutional non-compliance. MoES and MoH, as joint custodians of NETH system, are responsible for issuing clarification or harmonisation directives and suspending enforcement action until consistency is restored.

548. The “no conflicting instructions” compliance test protects institutions from regulatory ambiguity, ensures fairness and predictability in enforcement, and reinforces a coherent, rule-based regulatory environment in which institutions can comply confidently while upholding quality, professional standards, and patient safety.

G10.0 NATIONAL HARMONISATION PROTOCOL (WHO DOES WHAT)

549. Harmonisation refers to the process of bringing national policies and standards closer in line with one another. A National Harmonisation Protocol is a set of agreed-upon, standardised rules, procedures, or standards designed to bring different national policies, regulatory frameworks, or operational systems into alignment. Its primary goal is to eliminate major discrepancies between institutional, departmental or regional practices, facilitating consistency and reducing compliance burdens.

550. The key aspects of the National Harmonisation Protocol include:

(a) Standardisation and Compatibility: Involves bringing national standards and regulations into alignment with one another to ensure they are similar or compatible.

(b) Operational Focus: Acts as a, “step-by-step guide” for implementing consistent procedures across NETH, such as in data collection or policy monitoring.

(c) Voluntary or Regulatory Nature: Which ranges from binding legal requirements to voluntary guidelines on NETH.

(d) Scope: Applies to technical regulations, conformity assessment procedures, or data management to allow for easier exchange of information and comparability of results.

551. The key objectives of the National Harmonisation Protocol include:

(a) Reduced Barriers: To diminish barriers and inequalities resulting from disparities in regulatory frameworks.

(b) Improved Efficiency: To optimise resource use by coordinating different, yet complementary, plans or departments.

(c) Enhanced Comparability: To ensure that data or results collected from different sources can be compared, such as or monitoring and evaluation data.

G10.1 The Regulatory Harmonisation Committee

552. The constitution of the NETH Regulatory Harmonisation Committee is a strategic governance measure established to provide permanent, structured coordination across the multiple legal

and regulatory authorities involved in health education and training.

553. The committee is constituted jointly by MoES and MoH and serves as the central forum for legal–policy alignment, mandate clarification, and dispute avoidance within the NETH system. This ensures that all standards, guidelines, regulatory decisions, and enforcement actions are mutually consistent, legally defensible, and aligned with national education and health objectives.

554. The Committee's core functions include:

(a) Overseeing the development, maintenance, and periodic update of the NETH Legal–Policy Concordance Matrix;

(b) Reviewing proposed policies, Standards, circulars, and major regulatory decisions for mandate consistency and legal coherence before issuance;

(c) Resolving inter-agency interpretive disputes and issuing harmonised positions through joint guidance or interpretation notes;

(d) Identifying emerging mandate gaps or overlaps arising from new training modalities, cadres, or qualification pathways; and

(e) Advising MoES and MoH on the required policy, regulatory, or legislative amendments.

555. The Committee is typically composed of senior technical and representatives from:

(a) MoES and MoH (Co-Chairs);

(b) TVET Council;

(c) National Council for Higher Education (NCHE);

(d) Relevant Health Professional Councils;

(e) Uganda Health Professions Assessment Board;

(f) Attorney General's Chambers (as legal advisor); and

(g) Any other relevant departments (MoES and MoH)

556. The committee operates under clear terms of reference, with defined decision-making procedures, reporting lines, and documentation requirements. Its deliberations and outputs are formally recorded and, where appropriate, translated into binding or authoritative instruments such as joint circulars or alignment notices.

557. The harmonisation committee does not replace the statutory powers of individual regulators. Rather, it strengthens their exercise by ensuring that regulatory action is coordinated, non-duplicative, and grounded in a shared legal–policy understanding.

558. The designation of MoES Department of Health Education and Training supported by the department of Education Policy Analysis and Research as Secretariat establishes a permanent administrative and technical backbone for coordinated governance of the Education and Training for Health system.

559. As Secretariat, the designated MoES departments serve as the central coordination,

documentation, and follow-up unit supporting the operation of NETH Regulatory harmonisation committee and related inter-agency mechanisms. Its role is not regulatory decision-making, but facilitative, organisational, and technical, ensuring that coordination outcomes are translated into timely, traceable, and actionable instruments.

560. The secretariat's core responsibilities include:

(a) Convening and servicing meetings of NETH Committees, including agenda preparation, circulation of papers, minute-taking, and follow-up on agreed actions;

(b) Maintaining and updating the NETH Legal–Policy Concordance Matrix, including version control and authorised updates;

(c) Managing official records of joint interpretations, alignment notices, circulars, and harmonised decisions;

(d) Coordinating inputs from MoH, regulators, Professional Councils, and UHPAB, and consolidating them into coherent draft instruments;

(e) Tracking implementation of agreed actions, milestones, and transition measures across institutions and regulators; and

(f) Serving as the single administrative point of contact for Inter-Agency queries related to Education and Training for Health legal and regulatory alignment.

561. The Secretariat also supports transparency and accountability by ensuring that all harmonisation decisions are properly documented, disseminated to relevant stakeholders, and retrievable for inspection, audit, or legal review.

562. Importantly, the Secretariat does not exercise statutory regulatory powers. Its authority derives from its coordination mandate, and it operates in support of MoES and MoH as joint custodians of the Education and Training for Health policy space.

563. The designation of the Departments of Health Education and Training (MoES) and Education Policy Analysis and Research as Secretariat ensures continuity, institutional memory, and operational discipline in the governance of education and training for health, anchoring coordination in a permanent structure rather than ad hoc arrangements.

564. The constitution of the Education and Training for Health Regulatory Harmonisation Committee institutionalises regulatory coherence, reduces systemic risk, and reinforces public confidence by ensuring that governance of education and training for health operates as one integrated, legally sound system rather than fragmented silos.

G10.2 Development of NETH Mandate Boundary Map

565. The development of NETH mandate boundary map is a core governance instrument designed to provide a definitive, authoritative, and system-wide reference on the distribution of legal and regulatory mandates across the NETH ecosystem. It functions as the "single source of truth" for determining who is authorised to do what, under which law, and at which point in the education–training–practice continuum.

566. NETH mandate boundary map visually and descriptively sets out:

(a) The respective statutory mandates of MoES, MoH, TVET Council, NCHE, Professional Councils,

and the Uganda Health Professions Assessment Board;

(b) The boundaries between policy leadership, education regulation, professional regulation, and service delivery oversight;

(c) The qualification levels (UQF/ISCED) and training stages to which each mandate applies; and

(d) Points of coordination, handover, or joint responsibility.

567. NETH mandate boundary map, in operational terms specifies: Who licenses institutions (legality); who accredits programmes (quality assurance by level); who recognises practice eligibility (professional councils); who authorises / coordinates placements and sites (MoH and Councils as applicable); who administers/oversees assessments and examinations (assessment body and regulators); and what each body shall not do (hard boundaries).

568. The NETH mandate boundary map is developed through a structured legal and technical process led by MoES (as Secretariat), in collaboration with MoH, regulators, and the Attorney General's Chambers, and is anchored in the NETH Policy – Legal Concordance Matrix. It reconciles NETH Policy, PISs, and PIGs into a clear, accessible representation that eliminates ambiguity and interpretive divergence.

569. Once adopted, NETH mandate boundary map must be used to: (i) guide the drafting of Standards, Guidelines, and regulatory tools; (ii) inform accreditation, inspection, and enforcement decisions; (iii) resolve inter-agency disputes and prevent mandate overreach or omission; (iv) orient institutions on which authority to engage for specific approvals; and (v) support audit, judicial review, and accountability processes.

570. The NETH mandate boundary map is a living instrument, updated when policies, laws, or institutional arrangements change, but changes are controlled through formal approval processes to preserve its authoritative status.

571. NETH mandate boundary map anchors the entire regulatory system in clarity, coherence, and legal certainty, ensuring that implementation of the Policy and its Standards proceed on the basis of a shared, unambiguous understanding of mandates—thereby reducing conflict, improving compliance, and strengthening public trust.

G10.3 The One-Window Institutional Compliance Pathway

572. Standardising the "One-Window" institutional compliance pathway is a regulatory streamlining measure designed to provide institutions with a single, coherent, and predictable interface for demonstrating compliance with NETH Policy Implementation Standards, while preserving the distinct statutory mandates of all regulators.

573. Under the One-Window approach, institutions are not required to navigate multiple, uncoordinated compliance processes or respond to overlapping requests from different authorities. Instead, compliance information, applications, reports, and corrective actions are submitted, tracked, and coordinated through a unified compliance entry point, typically managed by the designated Secretariat within MoES, in collaboration with MoH and the relevant regulators.

574. The One-Window pathway standardises:

(a) Submission Formats and Timelines for licensing, accreditation, alignment, and compliance reporting;

(b) Evidence Requirements, so that the same verified documentation is not repeatedly requested by different regulators;

(c) Sequencing of Approvals, ensuring that institutional licensing, programme accreditation, professional recognition, and site designation occur in the correct legal order; and

(d) Communication of Regulatory Decisions, so that institutions receive consolidated, non-conflicting instructions.

575. Operationally, the One-Window pathway does not centralise regulatory power or dilute statutory authority. Each regulator continues to assess and decide matters within its legal mandate. The One-Window mechanism functions as a coordination and routing system, ensuring that information flows efficiently to the appropriate authority and that decisions are harmonised before communication to institutions.

576. The pathway is supported by: (i) NETH mandate boundary map (defining which regulator acts at each stage); (ii) Regulator-aligned accreditation and inspection tools; (iii) Joint implementation and interpretation circulars; and (iv) Integrated tracking and reporting mechanisms.

577. For institutions, the One-Window approach improves clarity, efficiency, and legal certainty, reduces administrative burden, and lowers the risk of inadvertent non-compliance. For regulators, it enhances coordination, data integrity, and enforcement coherence.

578. Standardising the One-Window institutional compliance pathway transforms compliance from a fragmented, regulator-by-regulator exercise into a coherent, system-level process, without compromising legal mandates, quality assurance, or public interest safeguards.

G10.4 The Single Set of Core Compliance Data Fields

579. The joint direction by MoES and MoH to create a single, standardised set of core compliance data fields is a critical system-integration measure aimed at ensuring consistency, accuracy, and interoperability across all regulatory processes in NETH sector.

580. Under this directive, MoES and MoH formally requires all relevant regulators including the TVET Council, NCHE, Professional Councils, and UHPAB to adopt and use an identical core dataset when collecting, reviewing, and reporting compliance information from institutions and training sites. These core data fields constitute the minimum common information baseline necessary for lawful oversight, coordination, and evidence-based decision-making.

581. The single set of core compliance data fields typically covers:

(a) Institutional Identity and Legal Status;

(b) Approved Mandate, Scope, Qualification Levels, and Authorised Cadres;

(c) Accreditation and Approval References;

(d) Enrolment Numbers, capacity ceilings, and placement allocations;

(e) Staffing, Supervision, and Infrastructure Indicators;

(f) Clinical Training Sites and Internship Arrangements; and

(g) Compliance Status, Corrective Actions, and Timelines.

582. Standardisation ensures that all regulators are working from the same verified institutional profile, reducing duplication, eliminating discrepancies between datasets, and preventing conflicting regulatory conclusions based on inconsistent information.

583. Importantly, the directive does not prevent regulators from collecting additional, mandate-specific data where required by law. Rather, it establishes a shared foundational dataset upon which specialised regulatory inquiries may build.

584. The development and maintenance of the core data fields is coordinated through the designated Secretariat, with agreed definitions, data standards, validation rules, and update protocols. Institutions submit the core data once through the One-Window compliance pathway, and the information is securely shared among regulators according to agreed access rules.

585. The creation of a single set of core compliance data fields transforms compliance management from fragmented, siloed data collection into a coherent, system-wide information architecture, strengthening regulatory coherence, reducing institutional burden, and enhancing transparency, accountability, and public trust.

586. The alignment of application forms by the TVET Council, NCHE, Professional Councils, and UHPAB to a shared core compliance dataset is a practical operational step to embed regulatory coherence while fully preserving each body's statutory independence and decision-making authority.

587. Each regulator remains free and legally obliged to apply its own mandate-specific criteria, evaluative judgments, and approval thresholds. For example:

(a) TVET Council assesses occupational standards, competency-based curricula, and TVET-level quality requirements;

(b) NCHE assesses academic standards, research, and higher education quality assurance;

(c) Professional Councils assess cadre relevance, clinical competence, internship eligibility, and scope of practice; and

(d) UHPAB assesses assessment validity, examination integrity, and competence verification.

588. The shared dataset functions as a common factual foundation, not a shared decision. Decisions remain independent, mandate-specific, and legally grounded, but are informed by same verified institutional data, reducing inconsistencies and contradictory outcomes.

589. Form alignment is coordinated through the designated Secretariat, with agreed definitions, data standards, and update protocols. Regulators may add annexes or supplementary sections to their forms to capture specialised information required by law, without altering the shared core fields.

590. Aligning application forms to a shared dataset achieves regulatory interoperability without centralisation, simplifies institutional compliance, improves data integrity, and strengthens the overall credibility, efficiency, and defensibility of regulatory decision-making in the Education and Training for Health system.

G10.5 The Joint Approval Sequencing Rule

591. The adoption of a Joint Approval Sequencing Rule (Prevention of Duplication and Conflict) is a formal inter-agency governance measure designed to ensure that approvals within the NETH

system are issued in a clear, lawful, and non-conflicting order, consistent with statutory mandates and the logical progression of education, training, and professional practice.

592. The Joint Approval Sequencing Rule establishes a shared, system-wide order of regulatory decisions, clarifying which approvals must precede others and which authorities act at each stage. Its purpose is to prevent: (i) duplication of approvals by multiple regulators over the same subject matter; (ii) contradictory or premature approvals that undermine legal validity; and (iii) institutional reliance on one approval to bypass another.

593. Under the Rule, approvals are sequenced along the following general logic (subject to mandate-specific variation, the order prevents mandate duplication):

(a) Institutional Legality and Capacity: Licensing or legal establishment of the institution by the competent authority;

(b) Programme and Qualification Approval: Accreditation of programmes and confirmation of qualification level and alignment with the UQF by NCHE or TVET Council, as applicable;

(c) Clinical and Professional Recognition: Recognition by the relevant Professional Council for authorised cadres, clinical relevance, internship requirements, and practice eligibility;

(d) Training Site and Placement Designation: Approval of training hospitals, clinical sites, internships, residencies, or fellowships by MoH and/or Professional Councils; and

(e) Assessment and Certification Arrangements – Confirmation by the Uganda Health Professions Assessment Board where national or statutory assessments apply.

594. Each regulator acts only at its designated stage and within its statutory mandate.

595. No authority may issue an approval that presupposes or substitutes for an approval that legally lies with another body at an earlier or parallel stage.

596. The Rule is operationalised through: (i) NETH Mandate Boundary Map; (ii) Regulator-Aligned accreditation and inspection tools; (iii) Shared Compliance data fields and One-Window compliance pathways; and (iv) Joint Implementation and interpretation circulars issued by MoES and MoH.

597. Where sequencing is breached such as where an institution secures professional recognition before programme accreditation, or commences admissions before capacity approval—the affected approval may be suspended, conditionalised, or declared ineffective until the correct sequence is restored.

598. The Joint Approval Sequencing Rule embeds discipline, predictability, and legal defensibility into regulatory decision-making, protects institutions from contradictory approvals, and ensures that the NETH system functions as an integrated regulatory chain rather than a collection of disconnected approval processes.

G10.6 Joint Inspection and Enforcement Coordination Operating Procedure

599. The establishment of a Joint Inspection and Enforcement Coordination Standard Operating Procedure (SOP) is a formal operational measure designed to ensure that inspection and enforcement activities within the NETH system are coordinated, proportionate, and legally consistent across all regulatory authorities.

600. The Joint SOP provides a common procedural framework through which MoES, MoH, TVET

Council, NCHE, Professional Councils, and UHPAB plan, conduct, and follow up inspections and enforcement actions. This prevents duplicative inspections, inconsistent findings, and conflicting sanctions and strengthens regulatory effectiveness and fairness.

601. Key elements of the Joint Inspection and Enforcement Coordination SOP include:

(a) Inspection planning and triggers, distinguishing routine, risk-based, and complaint-driven inspections, and identifying the lead and supporting authorities for each type;

(b) Role allocation, specifying which regulator leads on academic quality, qualification levels, clinical training, professional competence, or assessment integrity, in accordance with statutory mandates;

(c) Information-sharing protocols, including pre-inspection data exchange, joint use of the shared compliance dataset, and secure communication of findings;

(d) Common inspection reporting formats, enabling consolidation of findings and consistent classification of compliance and non-compliance;

(e) Graduated enforcement pathways, setting out how corrective actions, timelines, and sanctions are sequenced and coordinated across regulators; and

(f) Due process safeguards, ensuring notice, right to be heard, and appeal rights are respected before sanctions are imposed.

602. The SOP also establishes mechanisms for joint inspections where cross-cutting issues arise (e.g. clinical training quality involving both education and professional standards), and for lead-regulator models where one authority coordinates enforcement while others provide mandate-specific inputs.

603. Once approved, the SOP is formally adopted by all participating authorities and used as the default operational framework for inspection and enforcement in the NETH sector. Training and orientation of inspectors and enforcement officers are undertaken to ensure uniform application.

604. The Joint Inspection and Enforcement Coordination SOP institutionalise coherence, efficiency, and legal defensibility in regulatory oversight, protects institutions from fragmented or arbitrary enforcement, and strengthens public confidence that compliance actions are fair, coordinated, and focused on quality, safety, and public interest outcomes.

605. To avoid multiple, duplicative and uncoordinated inspections, the Regulatory Harmonisation Committee (RHC) issues a Joint Inspection and Enforcement Coordination Standard Operating Procedure (SOP) that establishes a single, integrated inspection architecture for the Education and Training for Health system.

606. To avoid multiple uncoordinated inspections, the Regulatory Harmonisation Committee (RHC) issues a Joint SOP that sets: (a) lead inspector for each type of inspection (institution/programme/site); (b) who joins as technical members; (c) how one inspection report is shared across regulators; and (d) how corrective action plans are assigned and verified. In terms of Output; there is a Joint inspection calendar; standard inspection report template; CAP template; evidence checklist.

607. The Joint SOP provides binding procedural clarity on who inspects, who supports, how findings are consolidated, and how corrective actions are managed, ensuring that institutions and training sites are subject to one coherent inspection process, rather than parallel or conflicting regulatory

visits.

608. Under the Joint SOP, the Regulatory Harmonisation Committee formally sets out the:

(a) Designation of a Lead Inspector by Inspection Type.

609. For each category of inspection, the SOP designates a single lead inspection authority, based on statutory mandate: (i) Institutional inspections (governance, mandate, infrastructure, academic systems): led by NCHE or TVET Council, as applicable; (ii) Programme and Qualification Inspections: led by the accrediting authority (NCHE or TVET Council); (iii) Clinical training, Internship, Residency, and Practice-Site Inspections: led by MoH and/or the relevant Professional Council.

610. The lead inspector is responsible for planning, coordinating, and issuing the inspection outcome.

(b) Identification of Supporting Technical Members

611. The SOP specifies which regulators or bodies join as technical members in a given inspection, providing mandate-specific expertise without duplicating authority. For example: Professional Councils participate as technical members in academic inspections where clinical competence is relevant; MoH participates in inspections affecting service delivery or patient safety; and UHPAB participates where examination or certification systems are under review.

612. Technical members contribute findings within their mandate, but do not issue separate inspection decisions.

(c) Single Consolidated Inspection Report

613. The SOP requires that each inspection results in one consolidated inspection report, led by the designated authority and incorporating inputs from all participating regulators.

614. This report: constitutes the official inspection record; is shared formally with all participating regulators; and forms the sole evidentiary basis for regulatory follow-up, accreditation decisions, or enforcement actions.

615. No parallel or conflicting inspection reports may be issued for the same inspection event.

(d) Assignment and Verification of Corrective Action Plans (CAPs)

616. Where non-compliance is identified, the SOP establishes a single CAP process: the lead inspector assigns corrective actions, timelines, and responsible parties; mandate-specific actions are clearly attributed to the relevant regulator; and verification of compliance is coordinated, with the lead authority confirming closure based on inputs from supporting regulators. This prevents institutions from receiving multiple, inconsistent CAPs for the same findings.

617. Through this Joint SOP, inspections shift from fragmented regulator-driven activities to a coordinated system-level assurance mechanism. Institutions experience fewer inspections, clearer expectations, and unified follow-up, while regulators benefit from shared evidence, consistent enforcement, and legally defensible outcomes.

618. The Regulatory Harmonisation Committee (LRHC)-issued Joint SOP ensures that inspection and enforcement are efficient, proportionate, and mandate-consistent, eliminating regulatory duplication while strengthening quality assurance, learner protection, and patient safety across NETH system.

G10.7 The Regulatory Dispute Prevention and Resolution Mechanism

619. The establishment of a Regulatory Dispute Prevention and Resolution Mechanism is a deliberate governance safeguard designed to anticipate, prevent, and efficiently resolve regulatory disagreements within the National Education and Training for Health system before they escalate into conflicting directives, enforcement paralysis, or litigation.

620. This mechanism provides a structured, predictable pathway for addressing disputes arising between regulators, or between regulators and institutions, particularly in areas involving overlapping legal frameworks, transitional arrangements, or novel training modalities.

621. The mechanism applies to disputes relating to: mandate boundaries and regulatory authority; interpretation of Policy Implementation Standards or Guidelines; sequencing or validity of approvals; inspection findings and enforcement actions; and compliance expectations during transition periods.

622. Its primary objective is early resolution and coherence, rather than fault-finding or punitive action. The core components of the mechanism include:

G10.7.1 Early Warning and Escalation Triggers

623. Regulators and institutions are required to flag potential conflicts at the earliest stage, such as: receipt of inconsistent instructions; uncertainty over which authority is competent to decide; or disagreement over interpretation of Standards or legal provisions.

624. Routine inspections and accreditation reviews also serve as early detection points.

G10.7.2 Technical Clarification Stage

625. Initial disputes are addressed through technical consultation among the concerned regulators, facilitated by the designated secretariat. This stage focuses on factual clarification, mandate mapping, and reference to the NETH mandate boundary map and the Legal–Policy Concordance Matrix.

G10.7.3 Formal Harmonisation Review

626. Where disputes persist, the matter is referred to the Regulatory Harmonisation Committee for structured review. The Committee examines: the legal and policy basis of the competing positions; risks to learners, institutions, or patient safety; and consistency with national policy intent.

627. The Regulatory Harmonisation Committee may issue a Joint Interpretation Note, Alignment Directive, or Procedural Guidance to resolve the dispute.

G10.7.4 Interim Measures

628. To prevent harm or uncertainty, interim measures may be issued, such as: suspension of enforcement actions; conditional continuation of approvals; or temporary compliance arrangements.

G10.7.5 Escalation to Legal Opinion (if required)

629. Where disputes involve unresolved legal ambiguity, the matter may be referred to the Attorney

General's Chambers for an authoritative legal opinion, which then informs final regulatory position.

630. Resolutions under this mechanism are documented and communicated through joint circulars or formal notices, and are binding on participating regulators for purposes of implementation and enforcement. Institutions are notified of the resolved position to ensure clarity and compliance certainty.

631. By institutionalising dispute prevention and resolution, the Education and Training for Health system: avoids conflicting instructions and regulatory paralysis; protects institutions from inconsistent enforcement; reduces recourse to litigation; and strengthens regulatory legitimacy and public confidence.

632. The regulatory dispute prevention and resolution mechanism ensures that disagreements are resolved through coordination and legal clarity, preserving system coherence while upholding quality, accountability, and the public interest.

G10.7.6 -Tiered Process to Resolve Conflicting Directions or Duplication

633. Where two or more regulatory bodies issue conflicting directions, or where an institution formally alleges duplication, mandate overlap, or inconsistent regulatory action, a structured, time-bound dispute resolution pathway shall be triggered to restore regulatory coherence and protect institutional certainty.

(a) Legal and Regulatory Harmonisation Committee Technical Meeting

634. Upon identification of a conflict or allegation of duplication, the matter shall be referred to the Regulatory Harmonisation Committee for technical-level resolution.

(i) A technical meeting shall be convened within a defined period (e.g. 14 calendar days) to ensure timely resolution.

(ii) The regulatory harmonisation committee examines the issue against NETH mandate boundary map, the Legal–Policy Concordance Matrix, and applicable standards.

(iii) The focus at this stage is factual clarification, mandate demarcation, and alignment of interpretation, rather than enforcement.

(iv) Where consensus is reached, the Regulatory Harmonisation Committee issues a technical clarification or harmonised position for immediate application.

(b) Escalation: MoES / MoH Principal-Level Decision Note

635. If the Regulatory Harmonisation Committee is unable to resolve the matter at technical level, or where the issue has system-wide policy or legal implications, the matter is escalated to Principal-Level Officials of MoES and MoH.

(i) MoES and MoH jointly issue a Principal-level decision note setting out the authoritative position on mandate, sequencing, or interpretation.

(ii) This decision note provides binding direction to all regulators involved and supersedes prior inconsistent instructions.

(iii) Where appropriate, the decision may include interim measures, such as suspension or

modification of enforcement actions, to prevent institutional harm.

(c) Final Referral (Where Necessary): Attorney General Advisory

636. Where a dispute raises unresolved questions of law, statutory interpretation, or constitutional authority, MoES and MoH may jointly refer the matter to the Attorney General's Chambers for an authoritative legal advisory opinion.

(i) The Attorney General's advice guides the final regulatory position and may inform amendments to instruments, procedures, or future policy clarification.

(ii) Referral to Attorney General is reserved for exceptional or systemic issues, not routine coordination matters.

(d) Documentation and System Correction Measures

637. All disputes and their resolution shall be formally recorded and actioned through:

(i) A Dispute Resolution Register, maintained by the Secretariat, capturing the issue, resolution steps, timelines, and outcomes;

(ii) Joint interpretation notes or circulars, where clarification is of general application;

(iii) Withdrawal, amendment, or re-issuance of approvals or directives, where existing instruments are found to be duplicative, ultra vires, or inconsistent.

638. This tiered approach ensures that disputes are resolved quickly, proportionately, and at the lowest effective level, while preserving escalation pathways for complex legal issues. It protects institutions from prolonged uncertainty, prevents fragmented enforcement, and reinforces a coherent, rule-based regulatory environment.

639. The mechanism transforms potential regulatory conflict into an orderly governance process, strengthening legal certainty, institutional trust, and system-wide compliance.

G11.0 WHO DOES WHAT /HARD MANDATE LINES

640. The "Who does what" framework functions as the operational anti-duplication rulebook for the NETH system. It establishes non-negotiable mandate boundaries that prevent overlap, duplication, and regulatory overreach, ensuring that each authority acts strictly within its legally conferred role.

641. Within this framework, MoES has a clearly delimited, system-level mandate focused on education-sector policy coherence and governance alignment, rather than direct regulation of professional practice or clinical service delivery.

G11.1.0 MoES: Hard Mandate Lines and Operational Role

642. Under the anti-duplication rulebook, MoES is responsible for the following functions and only these functions:

G11.1.1 Sector Policy Coherence for Education Institutions

643. MoES provides overarching policy leadership and coordination for education institutions involved in health training. This includes ensuring that NETH Policy, its Standards, and related instruments are consistent with:

(a) National Education Policies and Strategies;
(b) TVET frameworks and higher education;
(c) Qualifications Frameworks (UQF/UHEQF); and
(d) Cross-Cutting public education governance norms.

644. MoES does not accredit programmes, license institutions, or regulate professional practice.

G11.1.2 Public Education Governance Alignment

645. MoES ensures that governance arrangements of education institutions offering health training are aligned with public education governance principles, including accountability, quality assurance, institutional differentiation, and learner protection, as articulated in national education laws and policies.

G11.1.3 Issuance of Education-Sector Circulars

646. MoES issues education-sector circulars to:

(a) Operationalise approved Standards and Guidelines within the education system;
(b) Communicate joint interpretations agreed with MoH and regulators; and
(c) Provide transitional or procedural direction affecting education institutions.

647. These circulars are policy and coordination instruments, not regulatory approvals.

G11.1.4 Ensuring Compatibility with National Education Frameworks

648. MoES acts as the compatibility gatekeeper, ensuring that regulatory actions taken by education regulators (e.g. TVET Council, NCHE) within the Education and Training for Health space remain consistent with national education frameworks and do not conflict with broader education policy, qualification structures, or governance norms.

G11.1.5 Anti-Duplication Rule

649. Under the “hard mandate lines” doctrine:

(a) MoES shall not duplicate or substitute the statutory functions of NCHE, the TVET Council, Professional Councils, or assessment bodies;

(b) MoES shall not issue institution- or programme-specific approvals or enforcement actions unless expressly authorised by law; and

(c) MoES interventions are limited to policy coherence, coordination, and interpretation, not operational regulation.

G11.1.6 Governance Rationale

650. By clearly defining MoES’s role in this manner, the “Who does what” rulebook: (i) Prevents Policy-Level actors from drifting into regulatory functions; (ii) Protects Regulators from conflicting policy directives; (iii) Gives Institutions Clarity on which authority to engage for which decision; and (iv) Strengthens the legal defensibility and coherence of the Education and Training for Health system.

651. MoES's role under the hard mandate lines is to hold the policy architecture together, ensuring consistency and coordination across the education sector—without encroaching on the specialised regulatory mandates of other authorities.

G11.2.0 MoH: Hard Mandate Lines and Operational Role

652. Within the "Who does what" framework, the MoH holds a clearly bounded, non-duplicative mandate anchored in its constitutional and statutory responsibility for health service delivery, patient safety, and health workforce development. These hard mandate lines ensure that MoH exercises sector leadership and system governance functions without encroaching on education accreditation or professional regulation functions assigned to other authorities.

653. Under the operational anti-duplication rulebook, MoH is responsible for the following exclusive and non-transferable functions:

G11.2.1 Health Workforce Planning Priorities

654. MoH leads on defining national and sub-national health workforce needs, including cadre mix, deployment priorities, skills shortages, and service delivery requirements. These priorities inform education and training planning but do not substitute for accreditation or admission decisions, which remain a function of MoES.

G11.2.2 Clinical Training System Governance

655. MoH provides governance oversight of the clinical training ecosystem, ensuring that clinical education and practice-based learning are integrated into the health system in a manner that supports service delivery, supervision quality, and patient safety.

G11.2.3 Site Readiness and Facility Oversight

656. MoH is responsible for determining and overseeing the readiness of health facilities used as clinical training, internship, residency, or fellowship sites. This includes assessment of: infrastructure and equipment; staffing and supervision capacity; case mix and service volumes; and infection prevention, safety, and ethical safeguards.

657. MoH does not accredit academic programmes but confirms that service settings are fit for training purposes.

G11.2.4 Internship Ecosystem Coordination

658. MoH coordinates the national internship and post-qualification training ecosystem, including: allocation and scheduling of internship placements where required; coordination among training institutions, facilities, and Professional Councils; and alignment of internship numbers with service capacity and workforce planning.

G11.2.5 Patient Safety and Clinical Risk Safeguards

659. MoH establishes and enforces clinical risk management and patient safety safeguards applicable to all training conducted in health facilities. This includes standards for supervision, scope of trainee practice, reporting of incidents, and corrective measures where training activities pose risks to patients or the public.

G11.2.6 Anti-Duplication Rule

660. Under the hard mandate lines:

(a) MoH shall not accredit academic programmes or determine qualification levels;

(b) MoH shall not license institutions or award professional registration;

(c) MoH actions relating to training are site- and system-focused, not academic or professional qualification-focused.

G11.2.7 Governance Rationale

661. MoH's mandate under the "Who does what" framework is to:

(a) ensure that clinical training is grounded in service delivery realities and patient safety imperatives;

(b) prevent duplication with education and professional regulators;

(c) provide institutions with clarity on MoH's role in approvals and oversight; and

(d) to strengthen integration between education, training, and health service delivery.

662. MoH's mandate is to anchor health education and training within the health system, ensuring that workforce development is safe, service-oriented, and responsive to national health priorities without encroaching on academic or professional regulatory mandates.

G11.3.0 TVET Council: Mandate and Operational Role

663. Within the "Who does what" framework, the TVET Council exercises a clearly delimited, non-overlapping regulatory mandate focused exclusively on the accreditation and quality assurance of TVET-oriented health education and training programmes.

664. Under the operational anti-duplication rulebook, the TVET Council is responsible for the following exclusive functions:

G11.3.1 Accreditation of TVET-Oriented Health Programmes

665. The TVET Council accredits health education and training programmes that are explicitly mapped to TVET-oriented qualification levels.

666. The health education and training programmes typically include certificate and diploma-level programmes designed to produce technicians, mid-level health workers, and occupational cadres.

G11.3.2 Qualification Level and Framework Alignment

667. In exercising its accreditation mandate, the TVET Council confirms that:

(a) Programmes are mapped to appropriate Uganda Qualifications Framework (UQF) Levels 3 – 6 which is equivalent to ISCED Levels 3 – 5;

(b) Curricula are competency-based, aligned to approved occupational standards and health service needs; and

(c) The assessment and certification system meets national TVET quality assurance requirements.

G11.3.3 Programme Quality Assurance within the TVET Space

668. The TVET Council assesses programme design, delivery, staffing, facilities, assessment arrangements, and progression pathways, strictly within the TVET education and training. Its focus is on work-readiness, practical competence, and employability outcomes.

G11.3.4 Hard Boundary Conditions (Anti-Duplication Rules)

669. The TVET Council shall not:

(a) accredit degree or postgraduate health programmes mapped to higher education levels except as permitted under the TVET Act;

(b) determine professional licensure, internship eligibility, or scope of clinical practice—functions reserved for Professional Councils;

(c) approve clinical training sites as service facilities—an MoH and Professional Council function.

G11.3.5 Coordination Interfaces

670. Where TVET-accredited health programmes have clinical or practice implications, the TVET Council coordinates with: (i) Professional Councils, for cadre recognition and practice relevance; and (ii) MoH, for confirmation of clinical training site readiness and placement capacity. Such coordination does not dilute the Council's mandate but ensures that TVET health training remains coherent, clinically relevant, and system-aligned.

G11.3.6 Governance Rationale

671. The TVET Council's role under the TVET-oriented qualification levels: (i) prevents duplication with NCHE and Professional Councils; (ii) protects institutional clarity on regulatory authority; (iii) ensures apt differentiation between TVET and higher education pathways; and (iv) strengthens quality assurance for mid-level health workforce training.

672. The TVET Council's mandate under the "Who does what" framework is to assure the quality and legitimacy of TVET-level health programmes, firmly anchored in occupational competence and national qualifications standards without encroaching on NCHE or health professional councils' mandate.

G11.4.0 NCHE's Mandate and Operational Role

673. Under the "Who does what" framework, NCHE exercises a clearly defined, non-overlapping regulatory mandate focused on the accreditation and quality assurance of health education and training programmes mapped to higher education qualification levels.

674. NCHE is responsible for the following exclusive functions:

G11.4.1 Accreditation of Higher Education Health Programmes

675. NCHE accredits health education and training programmes that are explicitly mapped to higher education qualification levels. These include undergraduate, postgraduate, and advanced academic programmes offered by universities and degree-awarding institutions.

G11.4.2 Qualification Level and Framework Alignment

676. In exercising its accreditation mandate, NCHE confirms that:

(a) Health education and training programmes are mapped to apt UQF Levels 7–9 and corresponding ISCED Levels 6–8;

(b) Curricula meets approved higher education qualification descriptors, learning outcomes, credit systems, research components, and practicum requirements; and

(c) NCHE ensures that the Internal Quality Assurance Systems for health education and training programmes meet the national higher education standards.

G11.4.3 Academic Quality Assurance and Institutional Capacity

677. NCHE evaluates academic governance, staffing, infrastructure, teaching and learning systems, assessment integrity, and research environment, strictly within the higher education domain. Its focus is on academic rigor, knowledge advancement, professional formation, and international comparability.

G11.4.4 Hard Boundary Conditions

678. NCHE shall not:

(a) Accredit TVET-oriented health education and training programmes mapped to certificate or diploma levels under the TVET framework;

(b) Determine professional licensure, internship eligibility, or scope of clinical practice—functions reserved for Professional Councils;

(c) Approve health facilities as clinical service sites—functions reserved for MoH and the relevant Professional Councils.

G11.4.5 Coordination Interfaces

679. For NCHE-accredited health programmes including clinical training or professional practice components, NCHE coordinates with: (i) Professional Councils, to ensure professional relevance and cadre recognition; and (ii) MoH, to confirm that clinical training sites meet service and patient safety requirements. The coordination ensures that academic quality assurance is complementary to, and not duplicative of, professional and clinical oversight.

G11.4.6 Governance Rationale

680. NCHE's mandate within higher education levels: (i) prevents overlap with the TVET Council and Professional Councils; (ii) provides institutions with clarity on the appropriate accrediting authority; (iii) upholds differentiation between academic and occupational training pathways; and (iv) strengthens the credibility and international standing of higher education health qualifications.

681. NCHE's role under the "Who does what" framework is to assure the quality, legitimacy, and academic integrity of higher education health programmes, firmly anchored in national and international qualification standards without encroaching on TVET council or professional council's mandate.

G11.5.0 Health Professional Councils: Mandate and Core Functions

682. Under the “Who does what” framework, Health Professional Councils including the Uganda Medical and Dental Practitioners Council (UMDPC), the Uganda Nurses and Midwives Council (UNMC), the Allied Health Professionals Council (AHPC), the Pharmaceutical Society of Uganda, and other Councils exercise a distinct, non-overlapping mandate centred on the regulation of professional practice and protection of public health.

683. Under the operational anti-duplication rulebook, Health Professional Councils are responsible for the following exclusive functions:

G11.5.1 Definition of Professional Competencies

684. Health Professional Councils define and periodically update profession-specific competency standards, including knowledge, skills, clinical judgement, ethical conduct, and professional behaviours required for safe and effective practice. These competencies inform education and training design but do not substitute for academic accreditation.

G11.5.2 Regulation of Internship and Practice Eligibility

685. Health Professional Councils determine the:

(a) eligibility criteria for internship, residency, fellowship, or supervised practice;

(b) required duration, structure, and supervision standards for practical training; and

(c) the completion requirements necessary for progression to full registration or licensure.

G11.5.3 Licensing and Registration of Practitioners

686. Health Professional Councils are responsible for registration, licensing, renewal, and maintenance of professional registers for their respective cadres. No other body can lawfully license health practitioners.

G11.5.4 Ethics and Scope of Practice Oversight

687. Health Professional Councils regulate professional ethics, codes of conduct, disciplinary processes, and scope-of-practice boundaries. This ensures that practitioners operate within defined legal and professional limits to protect patients and the public.

G11.5.5 Hard Boundary Conditions (Anti-Duplication Rules)

688. The Health Professional Councils shall not:

(a) Accredit academic programmes as qualifications. This remains the role of TVET Council or NCHE;

(b) Award academic degrees, diplomas, or certificates;

(c) License institutions or approve qualification levels;

(d) Substitute professional recognition for academic accreditation.

G11.5.6 Coordination Interfaces

689. Health Professional Councils coordinate with: (i) TVET Council and NCHE, to ensure that accredited programmes meet professional competency expectations; (ii) MoH, on internship site readiness, supervision capacity, and patient safety safeguards; and (iii)with UHPAB, to ensure national examinations or competence assessments are effectively done.

690. This coordination ensures that professional regulation is integrated but not duplicative, and that education, training, and practice form a coherent continuum.

G11.5.7 Governance Rationale

691. Health Professional Councils' mandate: (i) protects public health through robust professional regulation; (ii) prevents mandate creep into academic accreditation or institutional licensing; (iii) provides institutions and learners with certainty on professional pathways; and (iv) reinforces international best practice separating academic quality assurance from professional licensure.

692. Health Professional Councils under the "Who does what" framework are the custodians of professional standards, ethics, and licensure, and ensure that only competent and ethical practitioners enter and remain in clinical practice without encroaching on the mandate for education system regulation.

G11.6.0 UHPAB: Mandate and Core Functions

693. Within the "Who does what" (hard mandate lines) framework, UHPAB exercises a distinct, non-overlapping mandate focused on the administration, oversight, and quality assurance of professional examinations and assessments as mandated by the TVET Act,2025.

694. UHPAB is responsible for the following exclusive functions:

G11.6.1 Administration and Oversight of Examinations and Assessments

695. UHPAB under the TVET Act,2025 administers, or oversees the administration of, national or statutory health professions examinations and assessments. This includes setting assessment schedules, modalities, and procedures in accordance with approved standards and legal instruments.

G11.6.2 Assurance of Assessment Integrity and Standardisation

696. UHPAB ensures that all examinations and assessments under its remit meet rigorous standards of: (i) Validity and reliability (accurately measuring required competencies); (ii) Standardisation (consistent assessment conditions and criteria across candidates and sites); (iii) Security and confidentiality (protection against leakage, fraud, or manipulation); and (iv) Auditability (clear records, traceability, and verifiable assessment processes).

G11.6.3 Quality Assurance and Data Sharing

697. UHPAB maintains comprehensive assessment records and shares aggregated and anonymised results with: (i) Professional Councils, to inform registration and licensure decisions; (ii) MoH, to support health workforce planning and deployment; and (iii) Education Regulators (TVET Council and NCHE), to inform quality assurance, curriculum review, and system-level performance monitoring.

698. Data sharing is conducted in accordance with approved protocols, protecting individual candidate rights while supporting evidence-based governance.

G11.6.4 Hard Boundary Conditions (Anti-Duplication Rules)

699. UHPAB shall not: (i) accredit academic programmes or institutions; (ii) license or register practitioners; (iii) determine qualification levels or award academic credentials; and (iv) UHPAB assessments do not substitute for academic accreditation or professional licensure decisions.

G11.6.5 Coordination Interfaces

700. UHPAB coordinates with: (i) Professional Councils, to align assessment content with defined professional competencies and licensure requirements; (ii) TVET Council and NCHE, to ensure assessment feedback informs academic quality assurance without encroaching on accreditation mandates; and (iii) MoES, to ensure assessment outputs support workforce planning and patient safety objectives.

G11.6.6 Governance Rationale

701. Within the assessment function, UHPAB's mandate is to: (i) preserve the independence and credibility of professional assessments; (ii) prevent duplication with education accreditation or professional licensure; (iii) strengthen trust in examination outcomes; and (iv) to support data-driven planning and quality improvement across the NETH system.

702. UHPAB under the "Who does what" framework is the custodian of assessment integrity and comparability, and it ensures that competence verification in the health professions is fair, standardised, and auditable without encroaching on the mandates for education and training or professional regulation and practice.

G11.7.0 Mandatory Documents to Be Issued and Maintained

703. Under G11.7.0, the effectiveness of the harmonised legal and regulatory framework for NETH depends on the formal issuance, maintenance, and use of a defined set of mandatory governance instruments.

704. These mandatory governance instruments constitute the operational backbone of the anti-duplication, coordination, and enforcement architecture. Failure to issue or maintain them undermines regulatory coherence and constitutes procedural non-compliance.

705. Each mandatory output has a distinct legal–operational function, as set out below.

G11.7.1 Regulatory Harmonisation Committee (RHC)Establishment Instrument

706. This is the foundational legal-administrative instrument jointly issued by MoES and MoH formally constituting the Regulatory Harmonisation Committee (RHC).

707. The RHC Establishment Instrument:

(a) Defines the Regulatory Harmonisation Committee (RHC)'s mandate, composition, authority, reporting lines, and decision-making procedures.

(b) Establishes the Regulatory Harmonisation Committee (RHC) as the recognised coordination forum for mandate alignment, interpretation, and dispute resolution within the Education and Training for Health system; and

(c) provides the legal basis for issuing joint Standard Operating Procedures (SOPs), interpretation notes, and harmonised directives.

708. The purpose is to institutionalise regulatory coordination and prevent ad hoc or informal mandate negotiations.

G11.7.2 Approved Mandate Boundary Map

709. The approved mandate boundary map is the authoritative “single source of truth” on regulatory roles and limits.

710. The approved mandate boundary map

(a) Visually and descriptively maps who does what, by institution, function, and qualification level.

(b) Delineates mandate between MoES, MoH, TVET Council, NCHE, Professional Councils, and UHPAB.

(c) Is the reference document for all approvals, inspections, and enforcement actions.

711. The approved mandate boundary map eliminates mandate overlaps, prevents regulatory gaps, and provides legal certainty to institutions and regulators.

G11.7.3 Joint Approval Sequencing Circular (National Compliance Gate)

712. The Joint Approval Sequencing Circular issued by MoES and MoH establishes the mandatory order in which approvals must be obtained and relied upon.

713. The Joint Approval Sequencing Circular:

(a) Specifies the sequencing logic (e.g. licensing → accreditation → professional recognition → site designation → assessment).

(b) Prohibits reliance on downstream approvals to bypass upstream requirements; and

(c) Functions as a national compliance gate, that ensures that approvals are legally valid and mutually consistent.

714. The purpose of the Joint Approval Sequencing Circular is to prevent duplication, contradictory approvals, and unlawful programme or cadre operation.

G11.7.4 Joint Inspection and Enforcement Standard Operating Procedures

715. The Joint Inspection and Enforcement Standard Operating Procedure (SOP) provide the single, coordinated framework for inspection and compliance action.

716. The Joint Inspection and Enforcement Standard Operating Procedure (SOP):

(a) Designates lead inspectors by inspection type (institution, programme, site).

(b) Defines the role of supporting technical regulators.

(c) Mandates one consolidated inspection report and a single corrective action pathway.

(d) Standardises enforcement escalation and due-process safeguards.

717. The purpose is to avoid multiple uncoordinated inspections and ensure proportionate, legally defensible enforcement.

G11.7.5 Dispute Resolution Register and Joint Interpretation Notes

718. The Dispute Resolution Register and the Joint Interpretation Notes operationalise the regulatory dispute prevention and resolution mechanism.

(a) The Dispute Resolution Register records all mandate conflicts, duplications, or interpretive disputes, including timelines and outcomes.

(b) Joint Interpretation Notes documents agreed positions arising from RHC deliberations or MoES/ MoH decisions.

(c) Where required, they trigger withdrawal, amendment, or re-issuance of conflicting directives or approvals.

719. The purpose is to ensure disputes are resolved transparently, consistently, and without institutional harm.

G11.7.6 Unified Institutional Dataset and Shared Template

720. The Unified Institutional Dataset and Shared Template establish a single, standardised compliance data architecture used by all regulators.

721. The Unified Institutional Dataset and Shared Template

(a) It defines the core compliance data fields submitted once by institutions.

(b) It includes shared templates for applications, reporting, inspections, and corrective action plans.

(c) Each regulator draws from the same dataset while exercising independent mandate-specific decisions.

722. The Unified Institutional Dataset and Shared Template reduce institutional burden, eliminates inconsistent data, and supports coordinated oversight.

G11.7.7 Governance and Compliance Significance

723. Collectively, the mandatory Documents issued and maintained including: Regulatory Harmonisation Committee (RHC)Establishment Instrument; approved mandate boundary map; Joint Approval Sequencing Circular; Joint Inspection and Enforcement Standard Operating Procedure; Dispute Resolution Register and the Joint Interpretation Notes; and Unified Institutional Dataset and Shared Template:

(a) translate NETH policy into enforceable operational reality;

(b) provide documentary evidence required for audit, judicial review, and accountability;

(c) protect institutions from regulatory inconsistency; and

(d) ensure that all NETH regulation is coherent, lawful, and system-aligned.

724. In effect, G11. compliance is demonstrated not by intent, but by the existence, use, and upkeep of

these six instruments, which together anchor the NETH regulatory system in clarity, coordination, and legal certainty.

G11.8.0 Enforcement (Enforceable Implementation Guidance)

725. Enforcement operationalises the principle of harmonised legal and regulatory governance by defining clear, objective compliance triggers and the circumstances under which corrective and enforcement action must be taken.

G11.8.1 Compliance Triggers for Breach

726. A breach is deemed to occur when any of the following conditions arise. These triggers signal system-level non-compliance, requiring immediate corrective intervention rather than discretionary response.

G11.8.1.1 Duplicate Approvals by Different Bodies for the Same Decision

727. A breach occurs where two or more authorities require separate approvals for the same regulatory decision (e.g. programme scope, capacity, or site designation) without a clear legal basis for dual approval. Such duplication undermines legal certainty, increases compliance burden, and violates the anti-duplication mandate.

G11.8.1.2 Conflicting Instructions to HTIs or Clinical Sites

728. Issuance of contradictory directives—such as differing capacity limits, compliance requirements, or operational instructions—to the same institution or clinical site constitutes a direct breach. Institutions cannot be placed in a position where compliance with one regulator results in non-compliance with another.

G11.8.1.3 Regulator Mandate Overreach

729. A breach arises where a regulator acts outside its statutory mandate, such as: accrediting programmes beyond its authorised qualification levels; issuing professional practice directives without legal authority; or imposing conditions that usurp another regulator's role. Mandate overreach is treated as a serious governance failure.

G11.8.1.4 Uncoordinated Inspections Causing Contradictory CAPs

730. Conducting inspections without coordination—resulting in multiple, inconsistent inspection reports or CAPs for the same institution or site—constitutes non-compliance. Such practices undermine fairness, dilute accountability, and contradict the Joint Inspection and Enforcement Standard Operating Procedure (SOP).

G11.8.1.5 Institutions "Forum Shopping" Regulators to Evade Compliance

731. Where an institution deliberately seeks approval or favourable interpretation from one regulator to circumvent requirements imposed by another, this behaviour triggers enforcement. Forum shopping exploits regulatory fragmentation and is expressly prohibited.

G11.9.0 Enforcement Implications

732. When any of the above triggers occur, regulators are required to:
(a) Suspend or halt the affected approval, instruction, or enforcement action;
(b) Refer the matter to the LRHC for harmonised resolution;

(c) Issue joint clarification or corrective directives where necessary; and
(d) Realign approvals, inspections, or CAPs to restore coherence.

733. Enforcement focuses on system correction, not punitive action, unless persistent or wilful non-compliance is established.

G11.10. Governance Rationale

734. Clearly defining the compliance triggers, converts coordination obligations into enforceable standards; protects institutions from regulatory inconsistency; holds regulators accountable for mandate discipline; and preserves the integrity of the NETH governance architecture.

735. Enforcement ensures that regulatory coherence is treated as a compliance obligation, not an optional courtesy, thereby strengthening legal defensibility, fairness, and public trust in NETH system.

G11.11. Enforcement Actions (Graduated and Proportionate Response)

736. Enforcement actions are designed to be graduated, corrective, and legally defensible, ensuring that breaches of harmonised governance are addressed in a manner proportionate to risk, intent, and systemic impact. The objective is to restore regulatory coherence and protect learners and patients, rather than to impose punitive measures as a first response.

737. Where compliance triggers are established, to stabilise the regulatory environment and prevent escalation, the following graduated enforcement actions may apply.

(a) Immediate Harmonisation Directive by Regulatory Harmonisation Committee: Upon detection of a breach—such as conflicting approvals, mandate overlap, or contradictory instructions—the Regulatory Harmonisation Committee (RHC) shall issue an immediate harmonisation directive.

(i) The directive requires all affected bodies to cease conflicting actions.

(ii) Any disputed approval, instruction, or enforcement action is temporarily frozen pending harmonised resolution, and

(iii) This step prevents further institutional confusion or harm while facts and mandates are clarified.

(b) Withdrawal and Re-Issuance of Conflicting Approvals or Directives: Where conflicting or ultra vires approvals are confirmed, the issuing authority is required to formally:

(i) Withdraw the defective approval, directive, or condition; and

(ii) Re-Issue a corrected instrument aligned with the Mandate Boundary Map, Joint Approval Sequencing Rule, and applicable Standards.

(iii) This ensures that regulatory decisions are lawful, internally consistent, and traceable. The purpose is to correct the legal defect at source and re-establish valid authority.

(c) Single Coordinated Re-Inspection where evidence is Contested: Where disputes arise from contested inspection findings or contradictory CAPs, the Regulatory Harmonisation Committee (RHC) may mandate a single, coordinated re-inspection to operate as follows: (i) A lead inspector is designated in accordance with the Joint Inspection SOP. (ii) Supporting regulators participate as technical members; and (iii) One consolidated inspection report is issued and shared across all regulators. This helps to resolve factual disputes through a unified evidence base,

(d) Institutional Sanctions Where Duplication was Exploited

(i) Where an institution is found to have deliberately exploited regulatory duplication or inconsistency—for example, by forum shopping regulators or relying on one approval to evade another—institutional sanctions may be imposed.

(ii) Sanctions may include: suspension of admissions or placements; imposition of capacity ceilings; conditional continuation of operations; or other lawful measures applied by the competent regulator(s) within their mandate.

(iii) Sanctions should be proportionate and accompanied by due process safeguards. The purpose is to deter bad-faith exploitation of regulatory fragmentation.

(e) Escalation to the Attorney General for Persistent or Systemic Breaches: Where mandate conflicts persist, or where ultra vires actions by a regulator present systemic legal risk, MoES and MoH may escalate the matter to the Attorney General's Chambers. (i) The Attorney General will provide an authoritative legal opinion and (ii) The opinion may inform binding corrective action, regulatory reform, or legislative amendment. The purpose is to secure final legal clarity and protect the integrity of the regulatory system.

G11.12. Governance Rationale

738. This graduated enforcement framework: prioritises correction over punishment; ensures due process and proportionality; holds both regulators and institutions accountable; and reinforces the principle that regulatory coherence is an enforceable obligation.

739. In effect, enforcement transforms coordination failures into structured corrective action, safeguarding legal certainty, institutional fairness, and the public interest in high-quality, safe health education and training.

G11.13. Evidence Standards for Enforcement Actions

740. The evidence standards governing enforcement actions under the NETH framework are designed to ensure that all regulatory interventions are lawful, transparent, proportionate, and defensible.

741. No enforcement action may be taken on the basis of assumption, informal communication, or unrecorded findings. Each action must be supported by a complete and auditable evidentiary record.

G11.14. Mandatory Evidence Components

742. All enforcement actions shall be supported by the following minimum set of documents:

G11.14.1 Inspection Report

743. A formal inspection report provides the primary factual basis for enforcement. It must: (i) identify the inspection authority and mandate; (ii) specify the scope and methodology of the inspection; (iii) document verified findings, including areas of compliance and non-compliance; and (iv) reference applicable Standards, laws, and regulatory conditions.

744. Where inspections are joint, the report shall be single and consolidated, in accordance with the Joint Inspection Standard Operating Procedures (SOPs).

G11.14.2 Breach Notice

745. A breach notice formally notifies the affected institution or regulator of: (i) the specific provision(s) of the Standards, law, or approval conditions breached; (ii) the factual basis for the alleged breach; and (iii) the potential regulatory consequences.

746. The breach notice satisfies due process requirements by providing clear notice and enabling an informed response.

G11.14.3 Corrective Action Plan (CAP) and Verification Results

747. Where corrective action is appropriate, a CAP shall be issued or approved, setting out: (i) required remedial actions; (ii) the responsible parties; and (iii) clear timelines.

748. Verification results—through follow-up inspection, documentary review, or validation visit—must confirm whether corrective actions were implemented satisfactorily.

749. Enforcement escalation may occur only where CAPs are not implemented or verified.

G11.14.4 Decision Note Referencing the Mandate Boundary Map

750. Every enforcement decision must be accompanied by a formal decision note that: (i) identifies the enforcing authority and its statutory mandate; (ii) explicitly references the Mandate Boundary Map to demonstrate mandate-consistent action; (iii) explains the rationale for the enforcement measure selected; and (iv) confirms that no duplication or overreach has occurred.

751. This decision note is essential for legal defensibility, audit, and appeal.

G11.15 Governance and Accountability Rationale

752. By requiring this evidentiary bundle, the framework ensures that enforcement actions: (i) are based on verifiable facts, not discretionary judgment alone; (ii) respect procedural fairness and natural justice; (iii) are traceable and reviewable by oversight bodies, auditors, or courts; and (iv) reinforce regulator accountability to the same standards of legality imposed on institutions.

753. Therefore, these evidence standards convert enforcement from an ad hoc exercise into a disciplined administrative process, strengthening trust in regulatory decisions and ensuring that compliance actions serve quality, safety, and public interest objectives.

G12.0 CONDITIONS FOR OFFERING HEALTH TRAINING PROGRAMMES

754. G12.0 establishes the mandatory, integrated conditions under which any institution may lawfully offer education and training for health. It operationalises a three-tier regulatory architecture that safeguards legality, academic quality, professional relevance, and patient safety, while preventing regulatory overlap and institutional forum-shopping.

755. Compliance is cumulative, not alternative: all applicable conditions must be satisfied simultaneously and continuously.

G12.1 Institutional Legality and Capacity (Licensing)

756. This condition establishes the foundational legality of the provider.

(a) An institution must first be lawfully established and licensed under the applicable education law (TVET or higher education), confirming minimum requirements relating to governance, infrastructure, staffing, safety, and organisational capacity.

(b) Licensing confers legal existence and eligibility to seek programme-level approvals; it does not authorise delivery of specific health programmes.

(c) Licensing is a pre-condition for all subsequent approvals. No programme accreditation, professional recognition, or placement arrangement is valid in the absence of a valid and current licence.

757. This prevents unregistered or under-capacity entities from entering the NETH space.

758. This implies that no institution shall offer health education or training programmes unless it satisfies all three complementary regulatory requirements, aligned to the UQF, ISCED 2011, and the professional regulatory regime.

G12.2 Programme Accreditation and Qualification Alignment

759. This condition assures academic quality and qualification legitimacy.

(a) Every health training programme must be accredited by the competent authority based on its qualification level: (i) TVET Council for TVET-oriented programmes mapped to UQF Levels 3–6 (ISCED 3–5); and (ii) NCHE for higher education programmes mapped to UQF Levels 7–8 (ISCED 6–8).

(b) Accreditation confirms alignment with: (i) approved curricula and learning outcomes; (ii) qualification descriptors under the UQF/UHEQF; (iii) assessment and quality assurance standards; and (iv) approved capacity ceilings.

(c) No regulator may accredit programmes outside its level mandate, and no institution may claim equivalence across frameworks without formal approval.

760. This prevents misclassification of qualifications and protects national and international recognition.

G12.3 Professional Council Recognition (Practice Gatekeeping)

761. This condition ensures clinical relevance, ethical integrity, and patient safety.

(a) Where a programme leads to a regulated health profession, it must be recognised by the relevant Professional Council.

(b) Professional recognition confirms that the programme meets profession-specific requirements relating to: (i) defined competencies and scope of practice; (ii) internship, residency, or supervised practice prerequisites; (iii) ethics and professional conduct; and (iv) eligibility for registration and licensure.

(c) Professional recognition does not replace academic accreditation and does not authorise institutions to award qualifications. It functions strictly as a practice gatekeeping mechanism.

762. This ensures that graduates are legally eligible to practise and protects the public from unsafe training pathways.

G12.4 Integrated Rationale and System Logic

763. G12.4 articulates the coherent logic of the three-tier system: (a) Licensing establishes who may exist and operate as a provider. (b) Accreditation establishes what may be taught and awarded and at which level and (c) Professional recognition establishes who may practise and under what conditions.

764. Together, these conditions: (i) eliminate unregulated provision and mandate creep; (ii) prevent duplication among regulators; (iii) protect learners from invalid or unrecognised qualifications; (iv) safeguard patients and the public; and (v) align health training outputs with national health workforce planning and international standards (e.g., ISCED, WHO guidance).

765. This creates a single, lawful pathway from institution → programme → profession.

766. Operational meaning of the "three complementary requirements". G12.4 establishes a mandatory tripartite compliance test. An institution may offer a health training programme only if and only when it has satisfied all three of the following, in the correct sequence: (i) Institutional licensing (legality and capacity); (ii) Programme accreditation (qualification level, curriculum quality, outcomes); and (iii) Professional Council recognition (clinical relevance, scope of practice, patient safety).

767. Failure at any one stage renders the programme unlawful to offer, regardless of progress at the other stages.

768. National "Stop–Go" Rule for programme offering. The objective is to: Prevent premature admissions, unlawful programme delivery, and invalid qualifications.

(i) Stop rule: No admissions, teaching, assessment, clinical placement, or marketing shall occur until all three approvals are valid and current.

(ii) Go rule: Programme delivery may commence only after written confirmation of compliance with all three requirements.

G12.5 Implementation and Enforcement Implications

769. All three conditions must be satisfied before admissions commence and must be maintained throughout programme delivery.

770. Breach of any condition (e.g., accreditation without licensing; professional recognition without accredited programme) renders the programme non-compliant and triggers enforcement.

771. Regulators apply the Joint Approval Sequencing Rule to ensure approvals are obtained and relied upon in the correct order.

772. Institutions must maintain compliance mapping records demonstrating satisfaction of each condition.

773. Therefore, G12. operationalises the principle that health training is a regulated public-interest activity, not a discretionary academic offering. The requirement of licensing, accreditation, and professional recognition to operate together, G12. ensures that health training programmes in Uganda are legal, high-quality, professionally valid, and safe, while preserving clear mandate boundaries among regulators and institutions.

G13.0 ALIGNMENT WITH THE UGANDA QUALIFICATIONS FRAMEWORK (UQF)

774. Alignment with the Uganda Qualifications Framework (UQF) positions the UQF as the single, integrating and harmonising framework for all education and training for health, irrespective of provider type, delivery pathway, or regulatory authority.

775. This guideline operationalises the principle that all qualifications must be comparable, portable, and nationally recognisable, while respecting differentiation between TVET and higher education.

G13.1 Role of the UQF as the Integrating Framework

776. The UQF serves as the common reference architecture that links: (i) TVET qualifications and higher education awards; (ii) Academic learning outcomes and occupational competencies; (iii) education regulation and professional practice requirements; and (iv) national qualifications with international classification systems (e.g. ISCED).

777. By anchoring all health qualifications within the UQF, the system ensures coherence across levels, pathways, and institutions, eliminating fragmentation and ambiguity.

G13.2 Operational Application of UQF Alignment

778. Under this guideline, all health education and training qualifications shall:

(a) Be Explicitly Levelled Under the UQF

(i) Every qualification must be assigned a clear UQF level, based on approved level descriptors, learning outcomes, complexity, autonomy, and responsibility.

(ii) No qualification may be offered, accredited, or referenced without explicit UQF levelling.

(b) Demonstrate Learning Outcomes Consistent with Level Descriptors

(i) Programmes must evidence that their curriculum design, assessment methods, and exit outcomes match the cognitive, practical, and professional expectations of the assigned UQF level.

(ii) Misalignment constitutes non-compliance.

(c) Support Articulation and Progression Pathways

(i) The UQF alignment enables structured progression between:(1) TVET and higher education pathways; (2) certificate, diploma, degree, and postgraduate levels; and (3) pre-service training and advanced professional development.

(ii) Institutions must design programmes with clear articulation routes, consistent with UQF principles.

(d) Enable Recognition of Prior Learning (RPL) and Credit Transfer

(i) By providing a common level reference, the UQF facilitates lawful RPL and credit transfer, subject to regulator-approved rules.

(ii) This enhances lifelong learning while preserving quality and standards.

(e) Ensure National and International Comparability

UQF-aligned qualifications are mapped to ISCED levels and recognised international benchmarks, supporting regional and global mobility of health professionals and recognition of Ugandan qualifications.

(f) Regulatory and Institutional Responsibilities

(i) Education regulators (TVET Council and NCHE) enforce UQF alignment during accreditation and review.

(ii) Professional Councils reference UQF levels when determining internship eligibility and scope of practice, without redefining qualification levels.

(iii) Institutions must maintain UQF mapping records as part of compliance documentation.

G13.3 Governance Rationale

779. Using the UQF as the integrating framework: (i) prevents qualification inflation or downgrading; (ii) avoids parallel or competing qualification systems; (iii) strengthens workforce planning and skills matching; and (iv) enhances public confidence in the legitimacy of health qualifications.

780. In effect, this guideline establishes the UQF as the structural backbone of the health education and training system, ensuring that all qualifications—regardless of pathway—fit into a single, coherent, nationally and internationally credible framework.

G13.4 Who Does What in Implementing UQF Alignment

781. Effective alignment with the Uganda Qualifications Framework (UQF) depends on clearly assigned, complementary responsibilities among institutions, accrediting authorities, and the Ministry of Health. The “who does what” allocation ensures that UQF compliance is designed into programmes, enforced through regulation, and utilised for system planning, without duplication or mandate creep.

G13.4.1 Institutions – Design and Delivery Responsibility

782. Health Training Institutions bear the primary responsibility for ensuring that their programmes actually deliver qualifications at the approved UQF level.

783. Institutions shall:

(a) Design curricula, learning outcomes, and assessment strategies that explicitly correspond to the relevant UQF level descriptors, including knowledge complexity, skills, autonomy, and professional responsibility;

(b) Ensure that assessment methods validly and reliably measure the stated learning outcomes and level expectations;

(c) Maintain internal documentation mapping programme outcomes and assessments to UQF descriptors; and

(d) Demonstrate compliance during accreditation, inspection, and review processes.

784. Institutions may not claim UQF alignment by title alone. Substantive alignment of outcomes and assessments is mandatory.

G13.4.2 Accrediting Authorities – Enforcement and Assurance Role

785. Accrediting authorities; the TVET Council and NCHE, within their respective mandates; are responsible for enforcing UQF compliance at both approval and post-approval stages.

786. They shall:

(a) Verify that proposed programmes are correctly levelled under the UQF at the point of accreditation;
(b) Assess whether curricula, assessment systems, and staffing are appropriate to the claimed UQF level;

(c) Impose conditions, require revisions, or refuse approval where UQF misalignment is identified; and

(d) Review ongoing compliance during re-accreditation, audits, and inspections.

787. Accrediting authorities do not redesign programmes; they test and enforce alignment against the UQF as a quality assurance requirement.

G13.4.3 MoH– System Planning and Utilisation Role

788. MoH uses UQF-aligned data as a strategic input for health workforce planning and policy coordination.

789. Specifically, MoH:

(a) Analyses UQF-levelled qualification data to understand the skills mix and qualification profile of current and projected health workforce outputs;

(b) Aligns training outputs with national health service needs, deployment plans, and cadre requirements; and

(c) Uses standardised UQF data to coordinate internship capacity, placement planning, and service integration.

790. MoH does not accredit programmes or redefine qualification levels; it relies on UQF-aligned outputs produced and assured by the education system.

G13.4.4 Governance Rationale

791. This allocation of roles ensures that: (i) UQF alignment is embedded at source (institutions); (ii) compliance is independently verified and enforced (accrediting authorities); and (iii) UQF data is translated into workforce intelligence (MoH).

792. In effect, UQF alignment operates as a shared system discipline, with clearly differentiated responsibilities that together ensure qualification integrity, regulatory coherence, and evidence-based health workforce planning.

G13.4.5 UQF-Qualification Register and Articulation and RPL statements

793. The implementation of UQF alignment under the NETH framework requires the production and maintenance of two critical system outputs. These outputs operationalise qualification coherence, learner mobility, and regulatory transparency across the health training continuum.

(i) UQF-Levelled Qualification Register

794. The UQF-levelled qualification register is an authoritative, up-to-date record of all health education and training qualifications that have been formally approved, accredited, and aligned to the Uganda Qualifications Framework.

(a) Purpose and Content

795. The register lists each qualification by: (i) awarding institution; (ii) programme title and code; (iii) qualification type (certificate, diploma, degree, postgraduate award); (iv) assigned UQF level and corresponding ISCED classification; (v) accrediting authority (TVET Council or NCHE); (vi) relevant Professional Council recognition status (where applicable); and (vii) approval validity period and conditions.

796. It constitutes the official reference for determining whether a qualification is legitimate, levelled, and recognised for education progression, professional practice, and employment.

(b) Governance Function

797. Regulators rely on the register to prevent approval of unlevelled or misclassified qualifications.

798. Institutions use it to ensure accurate representation of awards to learners and the public.

799. Employers, Professional Councils, and MoH use it to verify qualifications for recruitment, licensure, and workforce planning.

(c) Compliance Significance

800. Only qualifications appearing in the register may be lawfully awarded or referenced for progression or practice.

801. Absence from the register constitutes non-recognition, regardless of institutional claims.

(ii) Articulation and Recognition of Prior Learning (RPL) Statements

802. Articulation and RPL statements are formal documents that explain how learners may progress across qualification levels and pathways, and how prior learning may be recognised, within the UQF-aligned system.

(a) Purpose and Content

803. Articulation statements specify: (i) permissible progression routes between TVET and higher education qualifications; (ii) entry requirements and credit transfer arrangements; and (iii) conditions under which bridging or supplementary learning is required.

804. RPL statements define: (i) criteria for recognising prior formal, non-formal, or informal learning; (ii) assessment methods and evidence requirements; and (iii) limits and safeguards to protect qualification integrity.

(b) Governance Function

805. These statements ensure that learner mobility is structured, transparent, and quality-assured, rather than ad hoc or discretionary.

806. They prevent qualification inflation, inappropriate lateral movement, or unsafe progression into

higher clinical responsibility.

(c) Compliance Significance

807. Institutions must apply articulation and RPL decisions strictly in accordance with approved statements.

808. Unauthorised progression or credit recognition constitutes a breach of accreditation conditions.

(d) System Rationale

809. Together, the UQF-levelled qualification registers and articulation/RPL statements: (i) translate UQF alignment from principle into operational reality; (ii) protect learners from misleading qualification claims; (iii) support lifelong learning and skills progression; (iv) strengthen workforce planning and deployment; and (iv) enhance national and international credibility of health qualifications.

810. In effect, these outputs provide the visible, verifiable infrastructure through which UQF alignment is enforced, navigated, and trusted across the Education and Training for Health system.

G14.0 ALIGNMENT WITH RECOGNISED INTERNATIONAL STANDARDS: CREDIBILITY AND MOBILITY

811. Alignment with recognised international standards is a strategic requirement that ensures NETH system is credible, comparable, and competitive at regional and global levels. This guideline operationalises the principle that national qualifications and training standards must not only be internally coherent, but also externally intelligible and benchmarked against evolving international best practice.

G14.1 Purpose of International Alignment

812. International alignment ensures that health education and training in Uganda: (i) produces graduates whose qualifications are understandable and comparable across jurisdictions; (ii) supports regional and global mobility of health professionals; and (iii) remains responsive to advances in health science, education pedagogy, and professional regulation.

G14.1 Key Dimensions of International Alignment

G14.1.1 Comparability of Qualifications

813. Alignment with international classification and reference frameworks—such as ISCED 2011, relevant WHO education and training guidelines, and recognised global or regional professional education norms—ensures that Ugandan health qualifications can be accurately compared in terms of: level and complexity; duration and credit load; learning outcomes and competence expectations; and professional preparation.

814. This comparability protects graduates from misclassification and enhances recognition by employers, regulators, and academic institutions abroad.

G14.1.2 Regional and Global Mobility

815. International alignment facilitates lawful and ethical mobility of health professionals within

regional frameworks (e.g. East Africa Community [EAC], East, Central, South African Health Community [ECSA-HC], Inter Governmental Authority on Development, African Union) and globally. By aligning curricula, competencies, and qualification levels with recognised standards, Uganda: (a) reduces barriers to mutual recognition; (b) supports participation in regional labour markets and exchange programmes; and (c) enhances attractiveness of Uganda as a training destination.

816. Mobility remains subject to host-country licensure and immigration laws, but alignment removes avoidable technical obstacles.

G14.1.3 Benchmarking Against Evolving Best Practice

817. Health education and training is a dynamic field. International alignment enables continuous benchmarking against evolving best practice, including: (a) advances in competency-based education; (b) patient safety and ethics standards; (c) digital health and emerging technologies; and (d) inter-professional education and team-based care.

818. Benchmarking informs periodic review of curricula, assessment methods, and training models, ensuring relevance and quality over time.

G14.1.4 Implementation Responsibilities

819. Institutions benchmark curricula and learning outcomes against relevant international standards during programme design and review.

820. Accrediting authorities assess international benchmarking evidence as part of accreditation and re-accreditation.

821. Professional Councils reference international professional norms when defining competencies and practice requirements, without substituting them for national law.

822. MoES and MoH support strategic international alignment through policy guidance and international cooperation.

G14.1.5 Governance Rationale

823. International alignment: strengthens confidence in Ugandan health qualifications; supports workforce sustainability through ethical mobility; enhances quality assurance through external reference points; and positions Uganda within regional and global health education ecosystems.

824. In effect, this guideline ensures that Uganda's health education and training system is nationally grounded yet globally credible, enabling graduates to compete, collaborate, and contribute effectively in an interconnected health workforce environment.

G14.1.6 Mandatory Outputs

825. Alignment of health education and training qualifications with national and international frameworks must be demonstrated through a defined set of mandatory documentary outputs. These outputs provide the objective evidence base that qualifications are correctly classified, quality-assured, and internationally benchmarked. They are not optional annexes; they are core compliance artefacts required for approval, review, audit, and enforcement.

826. Each output serves a distinct legal–technical function, as outlined below.

(a) Framework Determination Note (TVET / Higher Education)

827. The Framework Determination Note is a formal regulatory determination issued by the competent accrediting authority (TVET Council or NCHE) confirming whether a programme falls under: the TVET framework; or the Higher Education framework.

828. The Framework Determination note; establishes the correct regulatory pathway and accrediting authority; Prevents misclassification of programmes (e.g. diploma programmes masquerading as degrees, or vice versa); and anchors subsequent approvals, inspections, and enforcement actions.

829. The Compliance Significance is that: No programme may proceed to accreditation or admission without a valid Framework Determination Note and Misclassification constitutes a material regulatory breach.

(b) UQF Mapping Matrix

830. The UQF Mapping Matrix is a structured document that maps the qualification to the Uganda Qualifications Framework level descriptors.

831. Its main function is to: Demonstrate alignment of learning outcomes, competencies, assessment complexity, autonomy, and responsibility with the assigned UQF level; provide a transparent basis for accreditation and review decisions; and to supports articulation, RPL, and workforce planning.

832. The Compliance Significance is that: The Matrix is the primary technical evidence of UQF alignment and its absence or inconsistency invalidates claims of qualification level.

(c) ISCED Classification Statement

833. The ISCED Classification Statement formally assigns the programme to the appropriate ISCED 2011 level and field of education.

834. The ISCED Classification Statement; enables international comparability and statistical reporting, supports regional and global recognition of qualifications, and aligns national data with UNESCO and international reporting standards.

835. The Compliance Significance is that; it is required for international credibility and cross-border recognition, and it ensures consistency between UQF level and international classification.

(d) Assessment Blueprint and Validation Report

836. These documents show how learning outcomes are assessed and verified. The assessment blueprint shows alignment between learning outcomes, assessment methods, and weighting. The validation report confirms that assessments are valid, reliable, standardised, and fit for purpose. Where applicable, it integrates requirements of various professional councils or the Uganda Health Professions Assessment Board.

837. The documents demonstrate that the qualification claims are supported by credible assessment systems and that weak or unvalidated assessment is ground for conditional approval or rejection.

(e) International Benchmarking Statement

838. The International Benchmarking Statement explains how the qualification aligns with recognised

international standards and norms. It identifies reference standards (e.g. WHO guidelines, regional professional standards, comparator jurisdictions). The statement also, demonstrates equivalence in level, outcomes, duration, and competence expectations and also supports international mobility and mutual recognition.

839. The International Benchmarking Statement confirms that the programme is not inward-looking or outdated and is required for programmes with international practice or mobility implications.

(f) Published, UQF-Levelled Qualification List

840. This is the public-facing output of the alignment process. It lists all approved health qualifications with: (i) programme title; (ii) awarding institution; (iii) UQF level; (iv) ISCED classification; (v) accrediting authority; and (vi) professional recognition status (where applicable).

841. The list serves as the authoritative reference for learners, employers, regulators, and international partners. Only qualifications appearing on the published list may be lawfully awarded or advertised. Omission from the list renders a qualification non-recognised, regardless of internal institutional claims.

G15.0 INSTITUTIONAL GUIDELINES

G15.1 classification of health training institutions (htis)

842. HTIs shall be formally classified to ensure clear institutional mandates, appropriate regulatory oversight, and alignment of training functions with national health workforce needs.

843. Institutional classification categories establish what an institution is, what it may lawfully do, and what it is prohibited from doing. Each category corresponds to a distinct function in the education–training–practice continuum, and no category may assume the role of another without formal reclassification and regulatory approval.

844. The recognised categories are: (i) Universities and University Constituent Colleges; (ii) Tertiary Health Training Institutions; (iii) Specialised Health Institutes and Fellowship Training Centres; and (iv) Internship Centres. The details are explained here below.

G15.1.1 Universities and University Constituent Colleges

845. Definition and Core Function: Universities and University Constituent Colleges are degree-awarding higher education institutions legally established under the higher education framework and authorised to provide academic and professional education at undergraduate and postgraduate levels in health-related disciplines.

846. Authorised Scope: Universities and University Constituent Colleges: (i) Offer academic and professional degree programmes (e.g. medicine, dentistry, nursing, pharmacy, public health, biomedical sciences). (ii) Conduct research, innovation, and advanced academic inquiry in health sciences. (iii) Provide structured clinical education as part of degree programmes, in partnership with approved clinical training sites.

847. Regulatory Jurisdiction: Universities and University Constituent Colleges are regulated under: (i) National Council for Higher Education (NCHE) especially; academic accreditation, institutional governance, quality assurance. (ii) Professional Councils: particularly, recognition of programmes for professional eligibility. (iii) MoH: especially the oversight of clinical training environments and patient safety.

848. Qualification Levels: Universities and University Constituent Colleges offer qualifications equivalent to UQF Levels 7–8 [The International Standard Classification of Education (ISCED) Levels 6–8].

849. Prohibitions: Universities and University Constituent Colleges: (i) May not offer TVET-level certificate or diploma programmes outside approved articulation arrangements. (ii) Shall not license practitioners or approve professional practice independently. (iii) Shall not designate internship sites.

850. System Role: Universities and University Constituent Colleges serve as centres of academic formation, research leadership, and specialist knowledge production, not as regulators or practice-licensing bodies.

G15.1.2 Tertiary Health Training Institutions

851. Definition and Core Function: Tertiary Health Training Institutions are non-university institutions authorised to deliver competency-based, practice-oriented health training aimed at producing technicians, mid-level health workers, and occupational cadres.

852. Authorised Scope: Tertiary Health Training Institutions: (i) Offer certificate and diploma programmes aligned to occupational and service delivery needs. (ii) Deliver competency-based education and training (CBET) with strong practical and clinical components. (iii) Support workforce expansion at community, district, and regional levels.

853. Regulatory Jurisdiction: Tertiary Health Training Institutions are regulated under: (i) TVET Council mainly for accreditation, quality assurance, occupational standards. (ii) Professional Councils mainly for recognition where training leads to regulated cadres and MoH mainly for oversight of clinical training arrangements and site readiness.

854. Qualification Levels: Tertiary Health Training Institutions offer qualifications equivalent to UQF Levels 3–6[The International Standard Classification of Education (ISCED) Levels 3–5].

855. Prohibitions: Tertiary HTIs: (i) May not award degrees or post-graduate qualifications. (ii) Shall not re-classify programmes as “degree-equivalent” without NCHE approval. (iii) Shall not independently determine professional licensure eligibility.

856. System Role: Tertiary Health Training Institutions are the backbone of mid-level health workforce production, distinct from academic universities and from practice-only sites.

G15.1.3 Specialised Health Institutes and Fellowship Training Centres

857. Definition and Core Function: Specialised Health Institutes and Fellowship Training Centres are advanced training entities—stand-alone or affiliated—that provide specialist, sub-specialist, and fellowship-level training beyond initial qualification. Specialty areas frequently housed in centres of excellence include cardiology, orthopaedics, oncology, ophthalmology, bariatric surgery, and neurology, just to name a few

858. Authorised Scope: Specialised Health Institutes and Fellowship Training Centres: (i) Deliver advanced and highly focused, clinical, specialist, and post-residency training in defined disciplines (e.g. paediatric surgery, orthopaedic surgery, anaesthesia, epidemiology or health policy within public health sub-specialties). (ii) Support research-informed practice, innovation, and professional leadership development and (iii) Offer fellowship or specialist certifications where authorised.

859. Regulatory Jurisdiction: Specialised Health Institutes and Fellowship Training Centres are regulated under: (i) Professional Councils and specialist bodies mainly for competency standards, fellowship requirements, and certification. (ii) NCHE mainly where training leads to academic postgraduate awards; and MoH mainly for clinical governance, patient safety, service integration.

860. Qualification Levels: Specialised Health Institutes and Fellowship Training Centres offer qualifications equivalent to UQF Levels 8–9, aligned with international specialist benchmarks.

861. Prohibitions: Specialised Health Institutes and Fellowship Training Centres: (i) May not operate as general undergraduate teaching institutions unless separately licensed. (ii) May not award academic degrees without NCHE authorisation, and (iii) May not self-define specialist status outside recognised frameworks.

862. System Role: Specialised Health Institutes and Fellowship Training Centres function as centres of excellence — places where excellence on a particular medical front is delivered in a unique, focused manner to patients leading to advanced professional development, not entry-level training providers.

G15.1.4 Internship Centres

863. Definition and Core Function: Internship Centres are accredited health service facilities authorised to provide structured, supervised post-qualification practical training required for professional registration and licensure.

864. Authorised Scope: Internship Centres: (i) Provide mandatory internship or supervised practice placements. (ii) Offer real-world clinical exposure under defined supervision standards, and (iii) Support transition from graduate to independent practitioner.

865. Regulatory Jurisdiction: Internship Centres are regulated under: (i) Professional Councils: mainly for approval, supervision standards, completion certification and MoH mainly for facility readiness, patient safety, intern supervision and service capacity.

866. Qualification Levels: Internship Centres do not offer any qualifications. They are non-qualification-awarding and operate post-qualification.

867. Prohibitions: Internship Centres: (i) May not award academic qualifications. (ii) May not admit pre-service learners unless formally approved as clinical training sites, and (iii) Internship Centres may not license practitioners.

868. System Role: Accordingly, Internship Centres are practice consolidation environments, not education providers.

G15.2. System-Level Governance Rationale

869. This four-part classification: (i) establishes clear functional differentiation; (ii) prevents institutional and regulatory mandate creep; (iii) aligns each institution type with appropriate regulators and standards; (iv) protects learners from invalid pathways; and (v) safeguards patients and the public.

870. These classifications form the structural spine of the Education and Training for Health system, ensuring that education, training, specialisation, and practice occur in the right institutions, under the right authorities, and at the right stages of professional development.

G15.3 Purpose and operational intent of classification

871. Institutional classification is mandatory and determinative. It establishes: (1) What an institution is authorised to do (mandate and function); (2) Which regulator(s) apply (and at what qualification levels); (3) What programmes may be offered (scope, level, cadre); and (4) What the institution may not do (hard boundaries to prevent mandate creep). No institution may offer health education or training outside its approved classification.

G15.4. National classification and designation workflow (Who does what)

872. These standards place every Health Training Institution into a single, legally recognised category, linked to approvals, admissions, placements, and enforcement.

G15.5 Mandatory and Determinative Nature of Institutional Classification

873. Institutional classification is mandatory and determinative within the NETH regulatory framework. It is not a descriptive label or administrative convenience; it is a binding legal–operational determination that defines an institution's authorised role, regulatory pathway, and permissible activities within the health education and training system.

874. Once an institution is formally classified, that classification becomes the primary control mechanism against mandate creep, regulatory confusion, and unlawful programme expansion. All subsequent approvals, inspections, and enforcement actions are anchored to this classification.

G15.5.1 What an Institution is Authorised to Do (Mandate and Function)

875. Institutional classification establishes the institution's core mandate and functional role in the health training ecosystem—such as a university, tertiary health training institution, specialised institute, or internship centre.

876. This determination specifies: (i) whether the institution may deliver academic education, technical training, specialist training, or practice-based training; (ii) the extent to which it may engage in research, clinical instruction, or supervised practice; and (iii) its position within the education–training–practice continuum.

877. An institution may exercise only those functions explicitly permitted by its approved classification.

G15.5.2. Which Regulator(s) Apply (and at What Qualification Levels)

878. Classification determines which regulator(s) have jurisdiction over the institution and at what qualification levels:

(a) NCHE applies to institutions classified to offer higher education programmes at UQF Levels 7–9;

(b) TVET Council applies to institutions classified to offer TVET-oriented programmes at UQF Levels 3–6— Level 3: Upper secondary education; Level 4: Post-secondary non-tertiary education; Level 5: Short-cycle tertiary education (e.g., technical diplomas) and Level 6: Bachelor's degree or equivalent (e.g., National Technical Universities);

(c) Professional Councils apply to the regulation of practice eligibility, internships, and licensure where programmes lead to regulated cadres;

(d) MoH applies to clinical training systems, site readiness, and patient safety oversight.

879. No regulator may act outside the bounds set by institutional classification, and no institution may select its regulator by preference.

G15.5.3. What Programmes May be Offered (Scope, Level, and Cadre)

880. Institutional classification authoritatively defines the programme envelope within which an institution may operate: (i) the fields or disciplines it may offer (scope); (ii) the qualification levels it may deliver (Uganda Qualifications Framework (UQF)/ International Standard Classification of Education (ISCED); (iii) the professional cadres or occupational roles it may train.

881. Programme accreditation, admissions, placements, and awards are lawful only where they fall squarely within the approved classification.

882. Any programme outside this envelope is unauthorised, regardless of institutional capacity or market demand.

G15.5.4. What the Institution May Not Do (Hard Boundaries to Prevent Mandate Creep)

883. Equally important, institutional classification establishes hard negative boundaries—activities the institution is expressly prohibited from undertaking, including: (i) offering programmes at levels beyond its classification; (ii) expanding into new cadres without reclassification and approval; (iii) assuming regulatory, licensing, or professional functions reserved to statutory bodies; or (iv) rebranding or restructuring internally to bypass classification limits.

884. These prohibitions are essential to maintaining system differentiation, quality assurance, and patient safety.

G15.5.5 Binding Effect and Enforcement Consequence

885. No institution may offer health education or training outside its approved classification, whether temporarily, experimentally, or by implication.

886. Operating beyond classification constitutes a material regulatory breach, triggering enforcement actions including suspension of programmes, nullification of awards, admissions freezes, or withdrawal of accreditation, in accordance with the Standards.

G15.5.6 Governance Rationale

887. By making institutional classification mandatory and determinative, NETH framework: (i) creates a clear and enforceable division of institutional roles; (ii) aligns regulation with capacity, competence, and public interest; (iii) prevents uncontrolled expansion and dilution of standards; and (iv) provides institutions, regulators, learners, and the public with legal certainty.

888. Thus, institutional classification is the keystone of the NETH regulatory architecture: it defines authority, constrains discretion, and ensures that every institution operates only where it is lawfully equipped, regulated, and accountable to do so.

G15.5.7 Mandatory Outputs

889. Institutional classification is operationalised and enforced through a defined set of mandatory documentary outputs. These outputs translate classification from a policy statement into a legally effective, auditable, and enforceable regulatory instrument. Their absence or inconsistency

undermines the validity of approvals, inspections, and enforcement actions.

890. Each output performs a distinct governance function within NETH system.

(a) National HTI Classification Register

891. NETH Institution Classification Register is the authoritative, consolidated record of all institutions formally classified under the Education and Training for Health framework.

892. Purpose and Content: NETH Institution Classification Register Lists every HTI by: (i) legal name and registration status; (ii) approved institutional category (university, tertiary HTI, specialised institute, internship centre); (iii) authorised mandate and functions; (iv) applicable regulators and qualification levels; and (v) approval validity periods and conditions. It serves as the single source of truth for determining an institution's lawful status and role.

893. NETH Institution Classification Register: Anchors all regulatory decisions—licensing, accreditation, inspection, and enforcement; Prevents institutions from operating under ambiguous or self-declared classifications; and enables cross-regulator coherence and information sharing.

894. Therefore, only institutions appearing in the Register may lawfully offer health education or training. Also, classification disputes are resolved by reference to the Register.

(b) Formal Classification / Designation Notices

895. Formal classification or designation notices are official instruments issued to institutions confirming their approved classification.

896. Purpose and Content: Formal classification or designation notices specify: (i) the institutional category and scope; (ii) authorised qualification levels and activities; (iii) applicable regulators; and (iv) explicit prohibitions and boundaries; (v) and provide institutions with clear, enforceable notice of their rights and obligations.

897. Formal classification or designation notices; establish the binding legal effect of classification, and serve as primary evidence in inspections, audits, and enforcement proceedings.

898. Thus, institutions may not rely on implied or historical status; but rather they rely only on valid formal classification or designation notices. Operating outside the Formal classification or designation notices constitutes a regulatory breach.

(c) Published Health Training Institution (HTI) Category Lists

899. Published HTI category lists are public-facing outputs that disclose institutional classifications.

900. Purpose and Content: Published HTI category lists: (i) Group institutions by category and authorised function; (ii) Indicate regulators, qualification levels, and approval status; (iii) Updated periodically and made accessible to learners, employers, and the public.

901. Published HTI category lists: (i) Enhances transparency and public accountability; (ii) enable learners and employers to verify institutional legitimacy; and (iii) Published HTI category lists deter misrepresentation and misleading marketing.

902. Institutions not appearing on the published Health Training Institution (HTI) category lists may not advertise or enrol trainees. This public disclosure supports consumer protection and trust.

(d) Classification-Linked Approval and Inspection Records

903. These regulatory records are explicitly cross-referenced to institutional classification. The term "classification-linked approval and inspection records" refers to documentation related to the management and organisation of official records for approval and inspection processes. These records are organised using a structured system to ensure efficient retrieval, compliance with regulations, and appropriate retention / disposition.

904. Purpose and Content: Classification-Linked Approval and Inspection Records are important to the extent that: (a) accreditation decisions, inspection reports, and CAPs must: (i) cite the institution's approved classification; and (ii) confirm that the activity reviewed falls within that classification; (b) Records document compliance or breach relative to classification limits.

905. Classification-Linked Approval and Inspection Records: (i) Embed classification into day-to-day regulation. (ii) Prevent regulators from approving activities outside classification boundaries; and (iii) support coordinated inspections and enforcement.

906. Classification-Linked Approval and Inspection Records are important since all approvals issued without reference to classification are procedurally defective and all the inspection findings outside classification scope are invalid.

G15.5.8 System Rationale

907. Together, these mandatory outputs: (i) make institutional classification visible, verifiable, and enforceable; (ii) create a defensible evidentiary trail for regulation and appeals; (iii) protect learners from unlawful training pathways; and (iv) ensure that every HTI operates only within its approved role.

908. In effect, outputs convert institutional classification into a living regulatory control, ensuring that differentiation, quality assurance, and public safety are upheld across the entire Education and Training for Health system.

G15.5.9 Enforcement and Classification Compliance

909. Enforcement gives operational force to institutional classification by defining clear trigger events and ensuring swift, proportionate regulatory response where institutions act outside their approved category.

910. Classification compliance is a threshold legality requirement: once breached, all downstream approvals, enrolments, and awards are rendered procedurally defective.

G15.5.10 Nature of Classification Compliance

911. Institutional classification establishes hard legal boundaries. Operating outside an approved category is not a technical irregularity; it is a material regulatory breach that undermines quality assurance, professional standards, and patient safety. Enforcement under S3.1 therefore prioritises early detection, immediate containment, and corrective or punitive action, depending on severity and intent.

G15.5.11 Enforcement Triggers and Their Regulatory Meaning

(a) Institutions Offering Programmes Outside their Approved Category

912. This trigger arises where an institution delivers or advertises programmes that do not fall within its formal classification (e.g. a tertiary HTI offering academic degree programmes, or a university offering TVET programmes without reclassification).

913. Regulatory meaning: Constitutes unauthorised expansion of mandate. Invalidates programme approvals and enrolments associated with the unauthorised activity and signals potential regulatory arbitrage or misrepresentation.

(b) Degree Programmes Offered by Non-Degree Institutions

914. This occurs where institutions not classified as universities or constituent colleges award or purport to award degree-level qualifications.

915. Regulatory meaning: Direct breach of higher education law and the UQF. Degrees issued are legally void for academic and professional purposes and High-risk trigger warranting immediate suspension and public notice.

(c) Internship Hosting Without Designation

916. This trigger arises where health facilities host interns or supervised practice without formal designation as internship centres.

917. Regulatory meaning: Undermines professional training integrity and patient safety. Exposes learners and patients to unmanaged clinical risk and constitutes breach of Professional Councils' practice requirements.

(d) Fellowship Training Offered Without Specialist Approval

918. This occurs where institutions offer specialist or fellowship-level training without recognition by the relevant Professional Council or specialist body.

919. Regulatory meaning: Creates false claims of specialist competence. Risks unsafe practice and professional misrepresentation and May attract both regulatory and professional disciplinary action.

G15.5.12 Enforcement Response Logic

920. Once a trigger is established: (i) Regulators apply immediate containment measures (e.g. admissions freeze, suspension of programme delivery). (ii) A formal breach notice is issued, followed by inspection and evidence gathering. (iii) Corrective Action Plans may be permitted where remediation is possible; otherwise, sanctions apply and (iv) Learner protection measures are activated to prevent penalisation for institutional non-compliance.

G15.5.13 Governance Rationale

921. These triggers ensure that: (i) institutional roles remain clearly differentiated; (ii) regulatory authority is respected and not circumvented; (iii) learners are protected from invalid qualifications; and (iv) patient safety is not compromised by unauthorised training.

922. In effect, enforcement under S3.1 treats institutional classification as a non-negotiable gatekeeper of legality. Once classification boundaries are crossed, enforcement is mandatory—not discretionary—to preserve the integrity of the Education and Training for Health system.

G15.5.14 Enforcement Actions

923. Once a breach of institutional classification is established, regulators are required to apply decisive, proportionate, and coordinated enforcement actions. These actions are designed to immediately stop unlawful activity, protect learners and patients, restore regulatory order, and deter recurrence.

924. Enforcement actions are applied in a graduated manner, guided by risk, severity, and intent, but immediate containment measures are mandatory where patient safety or qualification validity is at risk.

(a) Immediate Cessation Directive for Unauthorised Activities

925. An immediate cessation directive is the first-line containment action.

926. Purpose and Effect: An immediate cessation directive: (i) Orders the institution to stop all unauthorised programmes, training activities, admissions, assessments, or placements with immediate effect; (ii) Applies regardless of institutional justification or claimed capacity; and (iii) Prevents further regulatory harm while investigations or corrective processes proceed.

927. An immediate cessation directive: Stops mandate creep in real time and Prevents compounding of learner exposure to invalid training pathways.

(b) Admissions and Placement Suspension

928. Where unauthorised activities involve learners or clinical exposure, regulators shall impose admissions and placement suspensions.

929. Purpose and Effect: Admissions and Placement Suspension: (i) Freeze new admissions into affected programmes; (ii) Suspends placement of learners into unauthorised clinical or internship sites; and (iii) ensures that no additional learners are exposed to non-compliant conditions.

930. Admissions and Placement Suspension;(i) Protects prospective learners from enrolling into invalid programmes; and preserves patient safety by halting unsafe or unapproved clinical training.

(c) Withdrawal of Accreditation or Designation

931. Where non-compliance is serious, persistent, or deliberate, regulators may withdraw: (i) programme accreditation (TVET Council or NCHE); (ii) institutional designation (e.g. internship centre, specialised institute); or (iii) recognition status relevant to the unauthorised activity.

932. Purpose and Effect: Withdrawal of Accreditation or Designation: Removes the legal basis for continued operation of the affected activity; and signals zero tolerance for systemic or wilful breaches.

933. Withdrawal of Accreditation or Designation: Reinforces the binding nature of classification and approvals, and protects the integrity of the national qualifications and training system.

(d) Learner Protection Measures (Transfer or Remediation)

934. Learner protection measures are designed to ensure a safe, supportive, and secure environment for students, safeguarding their well-being, rights, and educational continuity. These measures address various forms of harm (physical, sexual, emotional, financial) and institutional risks. Thus, learners must not be penalised for institutional non-compliance. Regulators must activate

learner protection measures.

935. Learner Protection Measures: Require (a) the institution to: (i) facilitate transfer of affected learners to properly authorised institutions or programmes; or (ii) fund remediation, bridging, or re-training as directed, (b) ensure continuity of learning and preservation of learner investment. Learner Protection Measures: Upholds principles of fairness and public interest and Maintains confidence in regulatory oversight.

(e) Public Notification of Non-Compliance Status

936. Public notification is applied where transparency is necessary to protect learners and the public.

937. Public Notification of Non-Compliance Status: (i) Discloses the institution's non-compliance status through official channels; (ii) Identifies affected programmes or activities and the nature of the breach; and (iii) Provides accurate information to prospective learners, employers, and partners.

938. Public Notification of Non-Compliance Status; prevents misleading advertising or representation and also acts as a deterrent to other institutions considering similar breaches.

G15.5.15 Integrated Enforcement Logic

939. These actions operate as a coherent enforcement package: (i) cessation and suspension contain immediate risk; (ii) withdrawal removes unlawful authority; (iii) learner protection mitigates harm; and (iv) public notification ensures transparency and deterrence.

940. Together, they ensure that breaches of institutional classification under S3.1 are addressed swiftly, lawfully, and in the public interest, preserving the integrity of the Education and Training for Health system and safeguarding learners, professionals, and patients alike.

G16.0 Institutional Requirements for Health Training Institutions (HTIs)

941. The Institutional Requirements for Health Training Institutions (HTIs) establish the minimum, non-negotiable conditions that every institution must satisfy to lawfully participate in the Education and Training for Health (ETH) system.

942. These requirements operate as baseline eligibility criteria—without which no institution may be licensed, accredited, approved for placements, or recognised for professional training.

943. They ensure that health training is delivered only by institutions that are legally constituted, properly governed, adequately resourced, and capable of safeguarding learners, patients, and the public interest.

944. HTIs must meet prescribed minimum institutional requirements to ensure lawful governance, quality education and training, patient safety, and accountability.

G16.1 Purpose and Legal Effect

945. Institutional requirements serve three core functions:

(i) Legality Gate – confirm that an institution has lawful existence and authority to operate under Ugandan law.

(ii) Quality and Safety Gate – ensure that training environments meet minimum academic, clinical, and safety standards.

(iii) Accountability Gate – assign clear responsibility for academic outcomes, clinical conduct, and regulatory compliance.

946. Failure to meet institutional requirements constitutes a material regulatory breach, regardless of programme-level approvals.

G16.2 Core Institutional Requirements

G16.2.1 Clearly Defined Legal Status

947. Every HTI must possess a clearly defined and verifiable legal status, established under the relevant laws of Uganda.

(i) Institutions may operate as: (a) public institutions; (b) private not-for-profit entities; or (c) private for-profit entities.

(ii) Legal status must be evidenced by valid incorporation or establishment instruments and determines: (a) ownership and governance arrangements; (b) regulatory obligations; and (c) eligibility for public funding, partnerships, or placements.

948. This is important because clear legal status enables enforcement, financial accountability, and protection of learners and patients where institutional failure occurs.

G16.2.2 Approved Institutional Mandate

949. Each HTI must operate strictly within an approved institutional mandate.

(i) The mandate defines: (a) authorised fields of training; (b) qualification levels and pathways; (c) professional cadres; and (d) intended workforce outcomes.

(ii) The mandate must align with: (a) the institution's legal status; (b) its classification under the ETH framework; and (c) national education and health workforce priorities.

950. This is important because mandate discipline prevents uncontrolled expansion, protects system differentiation, and ensures training capacity matches national need.

G16.2.3 Functional Governance and Management Structures

951. HTIs must maintain functional and clearly separated governance and management organs, appropriate to their classification.

952. Minimum expectations include: (a) a governing body with fiduciary and strategic oversight responsibilities; (b) an academic authority responsible for academic standards and quality assurance; and (c) an executive management structure responsible for day-to-day operations.

953. Effective governance safeguards academic integrity, financial probity, and regulatory compliance, while preventing concentration of power and conflicts of interest.

G16.2.4 Adequate Academic, Clinical, Administrative & Co-curricular Infrastructure

954. Institutions must demonstrate adequate, fit-for-purpose infrastructure proportionate to their approved mandate and enrolment.

955. This includes: (a) academic facilities (classrooms, laboratories, libraries, skills labs, digital systems); (b) access to accredited clinical training sites for practicum and internships; (c) administrative systems for records, quality assurance, and student services; and (d) co-curricular and welfare facilities supporting student well-being.

956. Infrastructure adequacy is assessed relative to: (a) programme requirements; (b) student numbers; (c) accreditation standards; and (d) patient safety considerations.

957. This is important because Health training without adequate infrastructure compromises learning outcomes, professional competence, and patient safety.

G16.2.5 Biomedical Materials, Radioactive Materials and Medical Waste Management

958. HTIs must establish clear and compliant systems for managing biomedical materials, radioactive materials and medical waste generated through training and clinical practice.

959. Requirements include: (a) institutional policies and SOPs; (b) trained personnel; (c) designated facilities and equipment; and (d) arrangements with licensed waste handlers where applicable.

960. Compliance must align with health, safety, and environmental laws.

961. This is important because improper biomedical waste management poses serious risks to students, staff, patients, communities, and the environment, and is incompatible with safe health training.

G16.3 Regulatory Oversight and Continuous Compliance

962. Institutional requirements are: (a) verified during licensing, accreditation, and designation; (b) monitored through inspections and audits; and (c) enforced through corrective actions or sanctions where breached.

963. Compliance is an ongoing, dynamic and continuous obligation rather than a one-time event achieved at the point of licensing, accreditation, or initial approval. Institutions are required to continuously uphold the prescribed standards throughout their entire operational life, irrespective of age, ownership, programme mix, or accreditation history.

964. This principle recognises that institutional capacity, risk profiles, student populations, and operating environments evolve over time. Accordingly, compliance must be embedded into routine governance, management, and quality assurance systems, including regular self-assessments, internal audits, periodic reporting, and responsiveness to regulatory inspections and emerging risks.

965. Failure to sustain compliance at any stage—whether due to governance lapses, deterioration of facilities, staffing shortfalls, or breakdowns in quality assurance—constitutes a regulatory breach and may trigger corrective actions, sanctions, or withdrawal of approval. Continuous compliance therefore serves both as a risk-management mechanism and as a safeguard for learners, staff, and the public interest, ensuring that institutional standards remain consistently fit for purpose over time.

G16.4 System-Level Rationale

966. Collectively, institutional requirements: (a) create a credible and enforceable baseline for health training provision; (b) protect learners from substandard or unlawful institutions; (c) safeguard patients and public health; (d) support effective workforce planning; and (e) strengthen national and international confidence in Uganda's health education system.

967. Institutional requirements ensure that only institutions that are legally sound, properly governed, adequately resourced, and safety-compliant are permitted to train the health workforce. They form the foundation upon which all programme approvals, professional recognition, and practice pathways are built.

G16.5 Operational intent of institutional requirements

968. Institutional needs are not aspirational benchmarks or best-practice recommendations, they are mandatory baseline fitness conditions that determine whether an institution may lawfully function as a HTI within NETH system.

G16.6 Baseline Institutional Fitness

969. Institutional fitness is the threshold test. An institution that fails this test is ineligible to participate in the health training ecosystem, regardless of market demand, historical practice, or partial compliance at programme level.

970. Baseline Institutional Fitness refers to the minimum, non-negotiable threshold of organisational, legal, and operational capacity that an institution must possess in order to exist, operate, and deliver education and training lawfully, safely, and credibly. It establishes the foundational conditions without which no academic programme, qualification, or learning activity can be considered valid or sustainable.

971. This concept encompasses core institutional attributes, including legal status and governance legitimacy, competent leadership and management, adequate physical and learning infrastructure, qualified and sufficient human resources, functional quality assurance and academic governance systems, and effective student welfare, safety, and ethical safeguards. These elements are not performance enhancers or optional quality improvements; they are preconditions for institutional existence within the regulated education system.

972. Baseline Institutional Fitness applies uniformly across all institutions, regardless of programme level, size, ownership, or specialisation, and is assessed independently of programme-specific accreditation or outcomes. An institution that fails to meet baseline fitness requirements is, by definition, institutionally unfit to operate, even if individual programmes appear academically sound.

973. By anchoring regulation at the level of baseline institutional fitness, the regulatory framework ensures system integrity, protects learners and the public interest, and prevents the proliferation of structurally weak or unsafe institutions. It also provides a clear regulatory signal that institutional compliance is a continuous obligation, forming the foundation upon which programme approval, quality enhancement, and system expansion are legitimately built.

974. Institutional fitness must be demonstrated before programme-specific decisions are made and must be maintained continuously.

G17.0 PRECONDITION FOR CORE REGULATORY DECISIONS

975. Compliance is a precondition for the following regulatory actions:

(a) Programme Accreditation and Renewal

976. No health training programme may be accredited, re-accredited, or renewed unless the host institution demonstrably meets all institutional requirements.

977. Programme quality cannot cure institutional deficiencies; where institutional fitness is lacking, programme approval is procedurally invalid.

(b) Admissions and Capacity Approval

978. Admissions numbers, cohort sizes, and capacity ceilings are approved only for institutions that meet baseline governance, infrastructure, staffing, and safety standards.

979. Institutional non-compliance triggers admission freeze or capacity reductions, irrespective of programme accreditation status.

(c) Clinical Placement and Internship Authorisation

980. Authorisation of clinical training, practicum, internships, residencies, or fellowships depends on the institution's ability to provide or access safe, accredited, and well-governed training environments.

981. Institutional failure in governance, infrastructure, or waste management automatically disqualifies the institution from hosting or placing learners in clinical settings.

(d) Continued Operation as a Health Training Institution (HTI)

982. Institutional needs are conditions of continued operation, not one-time entry checks.

983. Persistent or serious non-compliance may result in suspension of operations, withdrawal of designation as a HTI, or other enforcement measures under the Standards.

G17.1 Regulatory Logic and Enforcement Consequence

984. Making institutional requirements a gateway condition, ensures that: (a) health training is delivered only by institutions that are fit for purpose; (b) regulators avoid approving programmes within structurally weak or unsafe institutions; (c) learners and patients are protected from systemic institutional failure; and (d) regulatory resources are focused on institutions capable of sustainable compliance.

985. An institution that does not meet cannot lawfully progress to programme-level approvals or continue operating as a Health Training Institution until compliance is restored.

G17.2 Governance Rationale

986. The operational intent is to shift regulation from a programme-by-programme tolerance model to an institution-first compliance model. This approach: (a) strengthens accountability at institutional

leadership level; (b) prevents regulatory fragmentation; (c) reinforces public trust; and (d) ensures that quality assurance, professional standards, and patient safety are addressed systemically, not piecemeal.

987. Institutional fitness constitutes the foundational pillar of the entire Education and Training for Health regulatory system. It represents the essential condition upon which all subsequent regulatory approvals, academic programmes, clinical training arrangements, and professional outcomes are constructed. Where an institution lacks baseline fitness, no level of programme quality, curricular sophistication, or examination performance can compensate for that deficiency.

988. This principle reflects a systemic logic: education and training for health are high-risk public interest activities that directly affect patient safety, population health, and professional integrity. If the institution itself is legally deficient, poorly governed, inadequately staffed, unsafe, or lacking effective quality assurance and ethical safeguards, then all teaching, assessment, and clinical training delivered within that institution are inherently compromised.

989. Accordingly, institutional fitness (Infrastructure, Human resource and Clinical Placement Sites) precedes and conditions every other regulatory decision, including programme accreditation, student admissions, internship recognition, and graduate eligibility for professional registration. An unfit institution cannot produce trustworthy health professionals, regardless of the apparent strength of individual programmes.

990. By anchoring the regulatory framework at the level of institutional fitness, the system ensures coherence, risk containment, and public protection. It sends a clear regulatory signal that education and training for health are built from the ground up: where the institutional foundation is weak or defective, the entire structure fails, and no regulatory endorsement can legitimately be sustained.

G17.3 Institutional Requirements Principles

991. Institutional requirements apply regardless of programme level and are non-substitutable. This principle clarifies the scope, capacity, hierarchy, and non-waivable nature of institutional requirements within NETH framework. It establishes that institutional fitness is universal and foundational, and cannot be reduced, bypassed, or replaced by programme-level compliance.

992. Universal Application Across Programme Levels: Institutional requirements apply uniformly to all Health Training Institutions, irrespective of: (a) the qualification level offered (certificate, diploma, degree, postgraduate, fellowship); (b) the regulatory framework applied (TVET or higher education); or (c) the scale, size, or specialisation of the programme.

993. Whether an institution offers a single certificate programme or multiple postgraduate programmes, it must meet the same baseline standards of legal status, governance, infrastructure, safety, and accountability. Programme level does not dilute institutional obligations.

994. Non-Substitutability of Institutional Compliance: Institutional requirements are non-substitutable. This means: (a) compliance at programme level cannot compensate for institutional deficiencies; (b) professional recognition cannot override failures in institutional governance or safety; (c) high academic outcomes cannot excuse lack of legal status, inadequate infrastructure, or unsafe practices.

995. For example: (i) an accredited degree programme cannot operate in an institution lacking lawful establishment or functional governance; (ii) professional council recognition does not cure absence of accredited infrastructure or waste management systems; and (iii) clinical excellence claims do not substitute for institutional compliance with health, safety, and environmental

standards.

996. Continuous and Non-Negotiable Obligation: Institutional requirements: (i) apply at entry, during operation, and at renewal; (ii) are not subject to waivers, offsets, or equivalence claims; and (iii) must be maintained continuously as a condition of operating as a Health Training Institution. Temporary, partial, or promised future compliance does not satisfy this obligation.

997. Governance and Public Interest Rationale: This principle: (i) prevents regulatory arbitrage and selective compliance; (ii) ensures consistent protection of learners and patients; (iii) strengthens accountability at institutional leadership level; and (iv) reinforces system integrity across TVET, higher education, and professional regulation.

998. In effect, stating that institutional requirements apply regardless of programme level and are non-substitutable affirms that no health training programme—at any level—may lawfully exist in an institution that is not institutionally fit. Institutional compliance is the indivisible foundation of lawful, safe, and credible NETH.

G17.3 Hierarchical Compliance Logic

999. NETH framework applies a hierarchical compliance logic: (i) Institutional fitness – threshold requirement; (ii) Programme approval and accreditation; and (iii) Professional recognition and practice eligibility.

1000. Failure at the first level invalidates all subsequent approvals. Institutional compliance is therefore a gatekeeping condition, not a parallel requirement.

G17.3 Mandatory Institutional Compliance Domains for HTIs

1001. To ensure that NETH is lawful, high-quality, safe, and accountable, every HTI must demonstrate compliance across six mandatory institutional domains. These domains collectively constitute the minimum institutional fitness test under NETH framework.

1002. Compliance must be evidenced through documentation, operational practice, and verifiable outcomes, and must be maintained continuously.

1003. Failure in any one domain constitutes institutional non-compliance, regardless of the performance in the others.

G17.3.1 Legal Status and Governance

1004. This domain establishes the institution's lawful existence, authority, and accountability.

1005. HTIs must demonstrate: (i) valid legal establishment under Ugandan law (public, private not-for-profit, or private for-profit); (ii) an approved institutional mandate consistent with classification and regulatory approvals; (iii) a duly constituted governing body with defined fiduciary and policy oversight responsibilities; and (iv) compliance with conflict-of-interest, fit-and-proper-persons, and ethical governance standards.

1006. This is important because it provides the legal foundation for enforcement, accountability, and protection of learners and patients in cases of institutional failure.

G17.3.2 Institutional Leadership and Management Capacity

1007. This domain assesses the institution's ability to translate governance decisions into effective

operations.

1008. HTIs must demonstrate: (i) a competent executive management team with clear roles and delegated authority; (ii) organisational structures that support academic delivery, clinical coordination, and compliance; (iii) financial management systems, budgeting, and internal controls; and (iv) capacity to manage growth, risk, and change responsibly.

1009. This is important because weak leadership or management capacity undermines even well-designed programmes and creates systemic quality and safety risks.

G17.3.3 Physical Infrastructure and Learning Resources

1010. This domain ensures that the training environment is fit for purpose.

1011. Health Training Institutions must demonstrate: (i) adequate classrooms, laboratories, skills labs, libraries, and digital learning platforms; (ii) safe, accessible, and accredited clinical training environments or formalised access arrangements; (iii) administrative facilities for records, quality assurance, and student services; and (iv) infrastructure proportional to approved enrolment and programme requirements.

1012. This is important because health training without adequate infrastructure compromises competence development and patient safety.

G17.3.4 Human Resources for Education and Training

1013. This domain addresses the availability, competence, and deployment of personnel responsible for training.

1014. Health Training Institutions must demonstrate: (i) qualified and appropriately licensed lecturers, health tutors, clinical instructors, and clinical supervisors (preceptors and consultants); (ii) staff numbers sufficient for approved student intake and supervision ratios; (iii) systems for recruitment, appraisal, professional development, and retention; and (iv) compliance with applicable Human Resource Management (HRM) standards (including TVET Human Resource Management (HRM) standards where applicable).

1015. This is important because human resources are the primary determinants of training quality and safe clinical supervision.

G17.3.5 Quality Assurance and Academic Governance Systems

1016. Quality Assurance (QA) and Academic Governance systems are the core mechanisms through which an institution guarantees the integrity, consistency, and credibility of its education and training functions. They provide the formal structures, policies, and decision-making processes that ensure teaching, learning, assessment, and certification are aligned with approved standards, regulatory requirements, and professional expectations. These ensure continuous control of academic standards and outcomes.

1017. HTIs must demonstrate: (i) internal quality assurance policies and procedures; (ii) academic governance structures responsible for curriculum approval, assessment integrity, and review; (iii) mechanisms for monitoring teaching, learning, and clinical training quality; and (iv) systems for addressing deficiencies through corrective actions.

1018. Effective QA systems enable institutions to systematically plan, monitor, evaluate, and improve academic delivery. This includes curriculum approval and review, assessment moderation,

staff appointment and promotion criteria, student progression rules, academic appeals, and the management of academic risks. Without such systems, academic outcomes become arbitrary, uneven, and vulnerable to error, bias, or malpractice.

1019. In regulatory terms, QA and academic governance systems are the means by which compliance is sustained over time. They allow institutions to detect weaknesses early, respond to regulatory findings, implement corrective actions, and demonstrate continuous compliance rather than episodic conformity at inspection points.

1020. Ultimately, strong QA and academic governance systems protect learners, uphold public trust in qualifications, and ensure that graduates are competent, ethical, and fit to practise. They are therefore not procedural formalities, but essential safeguards at the heart of a credible and accountable NETH system. Without functioning quality assurance, compliance becomes episodic and outcomes unreliable.

G17.3.6 Student Welfare, Safety, and Ethical Safeguards

1021. This domain protects learners as individuals and future professionals.

1022. Health Training Institutions must demonstrate: (i) student support services (this includes: feeding, accommodation, security and medical attention for trainees), counselling, and grievance-handling mechanisms; (ii) policies on health, safety, and infection prevention; (iii) systems for managing biomedical materials, radioactive materials and medical waste; and (iv) ethical safeguards, including codes of conduct and mechanisms to address harassment, abuse, or exploitation.

1023. This domain matters because training environments that neglect student welfare undermine learning, professionalism, and public trust.

G17.4 Integrated Compliance Logic

1024. These six domains operate as a single, integrated institutional fitness framework: (i) they are non-substitutable—strength in one cannot offset failure in another; (ii) they apply regardless of programme level or institutional category; and (iii) they are assessed before and during programme approval, admissions, and placements.

G17.5 Governance Rationale

1025. By compliance across these domains, the NETH framework: (a) ensures that HTIs are structurally capable of delivering safe, effective health training; (b) protects learners and patients from institutional failure; (c) strengthens regulatory consistency and defensibility; and (d) supports a sustainable, credible health workforce development system.

1026. In effect, these six domains define what it means for an institution to be fit to train the health workforce—legally, academically, ethically, and operationally.

G17.6 Mandatory Outputs

1027. Under S3.2, institutional requirements are made operational and enforceable through a defined set of mandatory documentary outputs. These outputs constitute the objective evidence base that an institution is fit to operate as a Health Training Institution (HTI).

1028. They are not procedural formalities; they are core compliance artefacts that must be produced, verified, maintained, and made available for regulatory review at all times.

1029. Each output corresponds to one or more of the six mandatory institutional compliance domains and collectively demonstrates continuous institutional fitness.

G17.6.1 Verified Legal Status and Governance Records

1030. All public records can affect the rights and obligations of the government and citizens. Records by their very nature provide proof of the activities of organisations or persons within a society. Thus, records serve as evidence of the rights and obligations of individuals, organisations and governments. Records enforce and support the agency's laws or binding rules. Verified legal status and governance records confirm the institution's lawful existence, mandate, and accountability framework.

1031. Verified legal status and governance records present: (i) Valid incorporation or establishment instruments under Ugandan law; (ii) institutional statutes, charters, or trust deeds (as applicable); (iii) approved institutional mandate and classification notice; (iv) composition of the governing body, appointment instruments, and tenure; and (iv) declarations of interest, fit-and-proper-persons attestations, and governance codes.

1032. Verified legal status and governance records: Establish the legal basis for operation and enforcement; support legal rights and obligations; provide evidence that a particular activity took place; contribute to accountability in organisations and in government and enable the regulators to attribute responsibility and apply sanctions where necessary.

1033. Absence of verified legal status and governance records can lead to significant negative consequences across various domains, primarily affecting: the institution's eligibility for accreditation, admissions approval, or continued operation. It leads to operational risk and legal non-compliance such as legal penalties, fines, operational shutdowns, and potential invalidation of contracts; inability to engage in formal business, reputational damage, and lack of liability protection among others

G17.6.2. Approved Leadership and Staffing Registers

1034. Approved leadership and staffing registers are formal, verified records that document the individuals entrusted with institutional governance, executive leadership, academic oversight, and delivery of education and training. They serve as an official assurance that persons occupying key positions meet the prescribed legal, professional, academic, and ethical requirements set by the regulatory authority. The registers demonstrate institutional leadership capacity and human resource adequacy.

1035. Approved leadership and staffing registers present: (i) approved appointments of senior management (principal, vice chancellor, directors, deans); (ii) staffing registers showing qualifications, licensure (where applicable), and deployment; (iii) evidence of compliance with staffing norms, ratios, and HRM standards; and (iv) records of staff induction, appraisal, and professional development.

1036. The registers include governing body members, principal officers, senior management, heads of academic units, programme leaders, faculty, clinical trainers, and other key staff. Approval signifies that appointments have been subjected to due diligence, including verification of qualifications, professional registration where applicable, experience, employment status, and absence of conflict of interest or disqualifying conditions.

1037. From a regulatory perspective, leadership and staffing registers are a core instrument for accountability and risk management. They enable regulators to confirm that institutional decisions

and academic processes are being directed and implemented by competent and authorised individuals, and that staffing levels are sufficient and appropriately distributed to support safe, effective teaching and clinical training.

1038. The registers are living documents. Thus, institutions are required to keep them accurate and up to date, promptly notifying the regulator of appointments, departures, role changes, or material alterations in staffing profiles. Failure to maintain approved and current registers constitutes a breach of institutional requirements and may undermine the validity of academic decisions, programme delivery, and learner outcomes.

1039. Approved leadership and staffing registers operationalise the principle that institutions do not function in the abstract: they are governed, managed, and staffed by identifiable individuals whose competence and integrity are central to institutional fitness, educational quality, and public trust. They confirm that programmes are led and delivered by competent, authorised personnel; and also support safe supervision of learners, particularly in clinical settings.

1040. The absence of approved leadership and staffing registers constitutes a key institutional failure with serious regulatory, academic, and public-interest consequences. Without verified and regulator-approved records of who governs, manages, and delivers education and training, the institution lacks demonstrable accountability and cannot credibly establish that it is being directed or staffed by competent and authorised individuals.

1041. From a governance perspective, the absence of such registers creates uncertainty as to the legality and validity of institutional decisions. Decisions taken by unverified or unauthorised individuals—including appointments, curriculum approvals, assessments, examinations, and awards—may be rendered procedurally defective and open to regulatory invalidation or legal challenge.

1042. Academically, the lack of approved staffing registers undermines assurance of teaching quality, supervision, assessment integrity, and, in the context of Education and Training for Health, clinical safety. It becomes impossible to confirm that learners are being taught, supervised, and assessed by suitably qualified and professionally registered personnel, exposing students, patients, and the public to unacceptable risk.

1043. Regulatorily, the absence of approved leadership and staffing registers is a direct indicator of institutional unfitness. It may trigger immediate compliance action, including denial or suspension of programme approvals, prohibition on student admissions, issuance of corrective directives, or withdrawal of institutional recognition. Persistent non-compliance may result in closure or de-registration.

1044. Ultimately, the absence of approved leadership and staffing registers erodes trust in the institution's operations and in the qualifications it awards. It signals a breakdown in institutional control and transparency, rendering the institution incapable of meeting its obligations to learners, regulators, professional bodies, and society at large.

1045. The absence of these registers leads to staffing deficiencies which may trigger capacity caps, admissions freeze, or programme suspensions.

G17.6.3. Infrastructure and Safety Inspection Reports

1046. Infrastructure and safety inspection reports provide verified evidence that the physical and clinical training environment is safe and fit for purpose.

1047. Infrastructure and safety inspection reports present: (i) inspection reports covering classrooms,

laboratories, skills laboratories, libraries, and Information and Communication Technologies (ICT) systems; (ii) verification of access to accredited clinical training sites; (iii) health, safety, and environmental compliance findings, including biomedical waste management; and (iv) corrective action plans and follow-up verification where deficiencies are identified.

1048. Infrastructure and safety inspection reports: (i) Protect learners, staff, patients, and the public from unsafe training conditions; and ensure infrastructure adequacy relative to enrolment and programme scope.

1049. The absence of these reports leads to unsafe or uninspected facilities which in turn may result to immediate suspension of training activities.

G17.6.4 Quality Assurance (QA) Policies and Audit Reports

1050. QA policies are the documented rules, standards, and procedures an organisation creates to proactively ensure its products or services consistently meet specific requirements and customer expectations, focusing on preventing defects and improving processes through systematic activities like audits, reviews, and testing. Thus, both QA policies and audit reports evidence the institution's internal control over academic standards and outcomes.

1051. QA policies and audit reports present: (i) internal quality assurance policies, procedures, and governance arrangements; (ii) curriculum approval and review processes; (iii) assessment integrity frameworks and moderation records; and (iv) internal and external quality assurance audit reports and corrective actions.

1052. QA policies and audit reports: Demonstrate continuous monitoring and improvement of training quality; and support defensible accreditation and review decisions.

1053. The absence of QA policies and audit reports represents a critical institutional deficiency that undermines the credibility, legality, and safety of education and training provision. Without formally approved QA policies, an institution lacks a coherent framework to define academic standards, regulate teaching and assessment, manage academic risk, and ensure consistency across programmes and cohorts. In such circumstances, academic delivery becomes ad hoc, discretionary, and vulnerable to error, bias, or malpractice.

1054. Equally, the absence of QA and audit reports signals a failure to implement and test QA systems in practice. Audits—whether internal or external—are the primary means through which institutions verify compliance, identify weaknesses, and demonstrate continuous improvement. Without audit evidence, there is no assurance that policies are operational, effective, or responsive to identified risks and regulatory requirements.

1055. From a regulatory perspective, this absence constitutes prima facie evidence of institutional unfitness. Regulators cannot rely on unsupported assertions of quality and are unable to validate the integrity of curricula, assessments, examinations, awards, or progression decisions. As a result, programme approvals may be withheld, suspended, or withdrawn, and institutions may be prohibited from admitting or graduating students.

1056. In NETH, the implications are especially severe. Weak QA systems directly compromise patient safety, professional competence, and ethical standards, as failures in assessment, supervision, or curriculum alignment may go undetected until harm occurs.

1057. The absence of QA policies and audit reports erodes public trust in qualifications awarded, exposes institutions to legal and reputational risk, and signals a systemic breakdown in academic governance. It confirms that the institution is operating without the internal controls necessary to

sustain quality, accountability, and regulatory compliance over time.

G17.6.5 Student Welfare and Ethical Compliance Records

1058. Student welfare and ethical compliance records are formal, verifiable documents that demonstrate an institution's commitment to safeguarding the rights, safety, dignity, and wellbeing of learners, while upholding ethical standards in education and training. They provide evidence that the institution has established, implemented, and enforced systems to protect students from harm, discrimination, exploitation, and unethical practices.

1059. Student welfare and ethical compliance records typically cover policies and actions related to student health and safety, accommodation and learning environment standards, counselling and psychosocial support, safeguarding and protection from abuse or harassment, disability inclusion, grievance and appeals mechanisms, academic integrity, and ethical conduct in teaching, assessment, research, and clinical practice.

1060. In NETH, they also extend to ethical oversight of clinical placements, informed consent, patient confidentiality, and professional conduct of trainees. They confirm that the institution provides a safe, ethical, and supportive learning environment.

1061. Student welfare and ethical compliance records present: (i) student support and counselling policies; (ii) health, safety, and infection prevention measures; (iii) codes of conduct and disciplinary procedures; (iv) records of grievances, complaints, and their resolution; (v) safeguards against harassment, exploitation, and abuse.

1062. From a regulatory standpoint, student welfare and ethical compliance records are critical risk-management instruments. They enable regulators to verify that institutions do not merely espouse welfare and ethical principles in policy, but actively operationalise them through documented procedures, incident reporting, investigations, corrective actions, and continuous improvement measures.

1063. The absence, inadequacy, or falsification of these records signals a serious institutional breach. It suggests that student safety and ethical standards are unmanaged, exposing learners and, in health training contexts, patients and communities to harm. Such deficiencies may warrant immediate regulatory intervention, including sanctions, suspension of admissions, or withdrawal of programme or institutional approval.

1064. In essence, student welfare and ethical compliance records translate institutional values into accountable practice. They affirm that the institution recognises students not simply as academic participants, but as rights-bearing individuals whose wellbeing and ethical treatment are central to educational quality, professional formation, and public trust.

G17.6.6 Integrated Compliance Logic

1065. These mandatory outputs: are interdependent and non-substitutable; must be current, accurate, and verifiable; are reviewed during licensing, accreditation, inspections, and audits; and form the evidentiary basis for regulatory decisions.

G17.6.7 Governance Rationale

1066. Institutional compliance is: evidence-based, not declaratory; continuous, not episodic; and enforceable, not discretionary.

1067. In effect, the mandatory outputs provide the documented proof of institutional fitness, enabling

regulators to protect learners and patients, uphold standards, and maintain the integrity of the Education and Training for Health system.

G17.6.8 Consolidated Enforcement Triggers

1068. The consolidated enforcement triggers define the non-negotiable institutional failure points that require regulatory intervention. These triggers signal that an institution no longer meets the baseline fitness requirements to operate as a Health Training Institution.

1069. Once triggered, regulatory action is mandatory and is applied to protect learners, patients, and the public, regardless of programme accreditation status or historical performance.

1070. Each trigger reflects a systemic institutional deficiency, not a minor or technical irregularity.

(a) Governance Failure

1071. Governance failure at an institutional level refers to the inability of an organisation's systems, rules, and processes to achieve its stated objectives, uphold its normative commitments, or effectively manage its responsibilities, leading to negative outcomes for its stakeholders and the broader community. It goes beyond individual mistakes and points to systemic flaws that can result in significant financial, social, and reputational damage.

1072. Governance failure arises where a Health Training Institution is unable to demonstrate effective, lawful, and ethical governance. This includes: absence or dysfunction of the governing body; failure to observe fiduciary duties, conflict-of-interest rules, or fit and proper standards; concentration of authority undermining checks and balances; or persistent non-compliance with regulatory directives.

1073. Regulatory significance: Governance failure removes the foundation of institutional accountability. Without functional governance, no assurance exists that quality, safety, or corrective actions can be sustained.

1074. Enforcement implication: Triggers heightened oversight, leadership directives, or suspension of operations until governance is restored.

(b) Unsafe Facilities

1075. Unsafe facilities occur where infrastructure or clinical environments pose health, safety, or environmental risks.

1076. The examples of unsafe facilities include: unfit classrooms, laboratories, or skills labs; unaccredited or unsafe clinical training sites; failure in biomedical waste management; or serious breaches of infection prevention and control standards.

1077. Regulatory significance: Unsafe facilities create immediate risk to learners, staff, patients, and surrounding communities.

1078. Enforcement implication: Requires immediate cessation of affected activities and remediation before operations resume.

(c) Inadequate Staffing

1079. Inadequate staffing occurs where the institution lacks sufficient, qualified, or authorised personnel to deliver approved programmes safely and effectively.

1080. The indicators of inadequate staffing include: staff numbers below approved ratios; lack of licensed or professionally recognised instructors or supervisors; excessive reliance on unapproved part-time or volunteer staff; or absence of supervision in clinical settings.

1081. Significance: Staffing deficiencies directly undermine training quality and patient safety.

1082. Enforcement implication: May trigger admissions caps, placement suspensions, or programme withdrawal until staffing is corrected.

(d) Absence of Quality Assurance (QA) Systems

1083. Weak or absent QA systems create significant business risks, leading to product failure, substantial financial losses, reputational damage, and potential legal liabilities. This applies where the institution lacks functional internal quality assurance mechanisms.

1084. The examples of weak or absent QA systems include: where there is no approved Quality Assurance policies or governance structures; where there is failure to review curricula or assessments; where there is lack of monitoring of clinical training quality; or where there is repeated non-compliance without corrective action.

1085. Regulatory significance: Without quality assurance systems, compliance becomes episodic and standards unenforceable.

1086. Enforcement implication: Triggers conditional approvals, mandatory CAPs, or suspension where deficiencies persist.

(e) Student or Patient Safety Incidents

1087. Student or Patient Safety Incidents occur where there is actual or imminent harm to students or patients linked to institutional failure.

1088. The examples of student or patient safety incidents include: serious injuries or infections arising from unsafe training practices; ethical violations, abuse, or exploitation of learners; clinical errors attributable to inadequate supervision; or repeated safety complaints substantiated by investigation.

1089. Significance: Student or patient safety incidents present the highest public interest priority.

1090. Enforcement implication: Student or patient safety incidents may result in immediate suspension, public notification, and referral to other authorities, including professional councils or law enforcement where applicable.

G17.6.9 Integrated Enforcement Logic

1091. Student or Patient Safety Incidents are: individually sufficient to warrant enforcement action; assessed based on evidence, risk, and severity; and applied regardless of programme level or institutional category.

1092. Once triggered, regulators apply graduated but decisive enforcement, with immediate containment where safety is at risk.

G17.6.10 Governance Rationale

1093. By consolidating enforcement triggers against student or patient safety incidents, NETH framework: ensures early detection of systemic institutional failure; prioritises protection of learners and patients; provides regulators with clear, defensible intervention points; and reinforces that institutional fitness is the foundation of lawful health training.

1094. Student or patient safety incidents triggers function as the red lines of institutional compliance: when crossed, regulatory intervention is obligatory to preserve quality, safety, and public trust in the health education and training system.

1095. Sanctions: conditional approvals, enrolment caps, suspension of programmes, or institutional closure, depending on severity.

G18.0 INSTITUTIONAL COMPLIANCE, ACCOUNTABILITY, AND SUSTAINABILITY REQUIREMENTS

1096. Institutional compliance, accountability, and sustainability requirements define the minimum conditions under which institutions delivering education and training for health must operate in order to remain legally recognised, credible, and viable over time.

1097. These requirements ensure that institutions do not merely attain initial approval, but continuously function in a manner that is lawful, responsible, and capable of sustaining quality education and training in the public interest.

1098. Therefore, HTIs shall demonstrate continuous compliance with regulatory requirements, ensure institutional accountability, and maintain financial and operational sustainability in the delivery of health education and training.

1099. Compliance is continuous, demonstrable, and auditable. HTIs must not only meet entry requirements but must sustain compliance over time, manage public and private resources responsibly, and remain operationally viable without compromising quality, safety, or integrity. Compliance is a condition for renewal of licences, accreditations, and designations.

G18.1 Institutional Compliance

1100. Institutional compliance refers to the continuous obligation of an institution to operate strictly within the regulatory, and policy framework governing NETH. It is the foundational requirement that legitimises an institution's existence, authority, and activities, and it applies at all times throughout the institution's operational life.

1101. HTIs must not only meet these requirements at the point of approval, but must sustain them consistently as circumstances, programmes, and operating environments evolve.

1102. Compliance requires adherence at all times to applicable; policies, standards, and directives on one hand and all applicable laws, regulations, and rules governing education, training, professional practice, and health service delivery on the other hand.

1103. This includes compliance with requirements relating to: licensing and accreditation; governance and leadership; staffing; infrastructure; quality assurance; student welfare; ethical safeguards; and reporting, and oversight obligations.

1104. Institutional compliance is demonstrable and evidence-based. Institutions are required to maintain accurate, complete, and verifiable records; submit required statutory and regulatory reports within prescribed timelines; cooperate fully with inspections, audits, and monitoring

activities; and implement corrective actions promptly where deficiencies are identified within prescribed timelines. Assertions of compliance without documentary evidence are insufficient.

1105. Failure to maintain compliance constitutes a regulatory breach, regardless of intent or historical performance. Non-compliance at any stage may result from governance failures, staffing gaps, deterioration of facilities, breakdowns in QA systems, or disregard of ethical and student welfare obligations.

1106. Non-compliance at any stage constitutes a breach and may trigger graduated enforcement actions, including directives, sanctions, suspension of admissions or programmes, or withdrawal of institutional recognition.

1107. Institutional compliance is the practical expression of regulatory accountability. It ensures that institutions delivering NETH remain lawful, safe, quality-assured, and aligned to national priorities, thereby protecting learners, patients, and the public interest.

G18.2 Core Pillars of Compliance

1108. Each HTI must demonstrate compliance across four interlinked core pillars namely: (i) Regulatory and statutory compliance; (ii) Financial accountability and transparency; (iii) Institutional sustainability and risk management; and (iv) Reporting, audit, and public accountability.

1109. Each HTI is required to demonstrate full and continuous compliance across four interlinked core pillars that collectively define institutional legitimacy, integrity, and long-term viability. The pillars operate as an integrated compliance framework. Weakness in any one pillar undermines the others and exposes learners, regulators, and the system to unacceptable risk.

(a) Regulatory and Statutory Compliance

1110. HTIs must operate strictly within the regulatory framework governing education, training, professional practice, and health service delivery. This includes licensing and accreditation, governance structures, approved leadership and staffing, compliance with QA and academic governance standards, and adherence to student welfare and ethical requirements.

1111. Regulatory compliance is non-negotiable and continuous; failure at any point constitutes institutional unfitness regardless of past approvals or performance.

(b) Financial Accountability and Transparency

1112. HTIs must demonstrate prudent, transparent, and lawful management of financial resources. This includes approved budgets, proper financial controls, accurate accounting records, and compliance with public finance and procurement requirements where applicable.

1113. Financial transparency ensures that resources intended for education and training are used for their lawful purposes and that institutional decisions are not distorted by financial mismanagement, conflicts of interest, or unsustainable cost structures.

1114. Financial mismanagement constitutes a serious breach of institutional compliance and directly undermines the integrity, sustainability, and public trust of NETH.

1115. Where evidence of financial mismanagement is identified—whether through audits, inspections, reports, or credible complaints—regulatory enforcement mechanisms are activated in a graduated but decisive manner.

(c) Conditional Approvals

1116. As an initial enforcement response, regulatory authorities may impose conditional approvals on the institution. These conditions restrict institutional operations and require the implementation of specific corrective measures within defined timelines. Conditions may include enhanced financial oversight, submission of recovery or remedial plans, appointment of approved financial officers, or limitations on student admissions or programme expansion.

1117. Conditional approval signals that continued operation is permitted only subject to demonstrable correction of identified financial weaknesses.

(d) Funding suspension

1118. Where financial mismanagement poses a material risk to institutional viability, learner interests, or public funds, regulators and funding authorities may suspend or withhold funding. This measure prevents further misuse of resources and creates a strong compliance incentive.

1119. Funding suspension may apply to government subventions, grants, or other public financing mechanisms and remains in effect until the institution demonstrates restored financial integrity and compliance.

(e) Referral to audit or investigative authorities

1120. In cases involving serious irregularities, suspected fraud, or breaches of financial and procurement laws, matters are referred to competent audit or investigative authorities. This includes statutory auditors, inspectorates, or law enforcement agencies, as appropriate. Such referrals shift the matter beyond administrative correction into formal accountability and potential legal sanction.

1121. Collectively, these enforcement measures ensure that financial governance is treated as a core institutional obligation rather than a peripheral administrative function. They protect public resources, safeguard learners, and reinforce the principle that institutions entrusted with NETH must operate with the highest standards of financial probity and accountability.

(f) Institutional Sustainability and Risk Management

1122. Institutional sustainability and risk management refer to the capacity of an institution to maintain lawful operations, quality standards, and learner protection over time, notwithstanding internal pressures or external shocks.

1123. Sustainability, in this context, is not about growth or profitability, but about continuity assurance—the ability of the institution to deliver education and training reliably, safely, and compliantly throughout its operational life. Sustainability is thus a core regulatory concern, particularly in NETH, where institutional failure can disrupt training pipelines, compromise competence development, and expose learners and patients to harm.

1124. Institutions must demonstrate the capacity to sustain operations, quality standards, and compliance over time. This requires realistic planning, stable and qualified staffing, maintenance of infrastructure and learning resources, and systematic identification and management of institutional risks, including financial, academic, clinical, reputational, and governance risks.

1125. Sustainability safeguards learners and the health system against abrupt institutional failure, disruption of training, or erosion of quality.

1126. Requirements for Institutional sustainability and risk management

(1) Viable Business and Operational Models

1127. Institutions must demonstrate realistic and lawful business and operational models that are aligned with their mandate, scale, and regulatory obligations.

1128. This includes credible revenue structures, cost controls, and planning assumptions that support sustained delivery of approved programmes without reliance on unsustainable practices, irregular funding, or ad hoc arrangements that threaten continuity.

(2) Adequate Staffing and Infrastructure Maintenance

1129. Sustainability requires the continuous availability of qualified staff and the systematic maintenance of physical and learning infrastructure.

1130. Institutions must plan for staff recruitment, retention, succession, and professional development, as well as for upkeep, replacement, and upgrading of facilities, equipment, and learning resources.

1131. Deferred maintenance or chronic understaffing is treated as a sustainability risk, not a temporary inconvenience.

(3) Risk Identification and Mitigation (Academic, Financial, Safety)

1132. Institutions must operate formal risk management systems capable of identifying, assessing, and mitigating key risks.

1133. These include academic risks (such as compromised assessment integrity or supervision gaps), financial risks (such as liquidity shortfalls or mismanagement), and safety risks (including learner, staff, and patient safety).

1134. Risk registers, mitigation plans, and periodic reviews are essential tools in this process.

(4) Contingency Planning for Disruptions

1135. Institutions are required to maintain contingency and business continuity plans to address foreseeable disruptions, such as funding interruptions, staff losses, infrastructure failure, public health emergencies, or regulatory interventions.

1136. These plans must prioritise learner protection, orderly continuation or teach-out arrangements, and communication with regulators and stakeholders.

1137. Taken together, these requirements ensure that institutional sustainability is treated as a matter of public protection and system stability.

1138. By embedding sustainability and risk management as regulatory obligations, the framework ensures that Education and Training for Health is delivered by institutions capable of withstanding disruption while safeguarding quality, safety, and public trust.

(5) Reporting, Audit, and Public Accountability

1139. Reporting, audit, and public accountability are the mechanisms through which institutional compliance is made transparent, verifiable, and enforceable. They ensure that institutions delivering Education and Training for Health are not self-regulating in isolation, but are subject

to continuous oversight in the public interest. Transparency and traceability are therefore treated as core regulatory obligations rather than administrative formalities.

1140. HTIs are required to submit accurate and timely reports to regulators and oversight bodies, cooperate with audits and inspections, and make information available as required in the public interest. Public accountability reinforces trust in institutions and in the qualifications awarded.

1141. Reporting and audit mechanisms provide assurance that compliance claims are verifiable, performance is monitored, and deficiencies are addressed transparently.

1142. Together, the four pillars ensure that HTIs are not only technically capable of delivering education and training, but are also lawfully governed, financially responsible, institutionally resilient, and publicly accountable. This integrated approach anchors NETH in credibility, stability, and protection of the public interest.

G19.0 Transparency and Traceability Requirements

1143. Institutions must be able to demonstrate, at any point, a clear and documented trail linking decisions, actions, resources, and outcomes to approved policies, standards, and legal authority.

1144. This traceability enables regulators and the public to verify that institutional claims of compliance, quality, and sustainability are supported by evidence and are not merely declaratory.

(i) Timely submission of academic, financial, and compliance reports

1145. Institutions are required to submit complete, accurate, and timely reports covering academic performance, financial management, staffing, infrastructure, quality assurance, and student welfare.

1146. Reporting timelines are mandatory and failure to comply constitutes a regulatory breach. These reports form the basis for monitoring performance, identifying risk, and informing regulatory decisions.

(ii) Cooperation with inspections and audits

1147. Institutions must cooperate fully with regulatory inspections, audits, and reviews conducted by authorised bodies. This includes granting access to premises, records, systems, staff, and students as required.

1148. Obstruction, delay, or non-cooperation is treated as non-compliance and may attract enforcement action independent of any underlying findings.

(iii) Maintenance of Accurate Institutional Records

1149. Institutions must maintain complete, accurate, and up-to-date records relating to governance, staffing, finances, academic delivery, assessments, student progression, and welfare.

1150. Record integrity is essential for auditability, learner protection, and the legal validity of academic and administrative decisions.

(iv) Disclosure of Material Changes Affecting compliance

1151. Institutions are obligated to promptly disclose any material changes that may affect compliance or institutional fitness. This includes changes in ownership, location, governance, leadership, staffing profiles, financial position, infrastructure, programme scope, or affiliation arrangements. Failure to disclose such changes undermines regulatory trust and shall invalidate approvals.

1152. Together, these requirements ensure that institutions are continuously accountable, that compliance is demonstrable rather than assumed, and that regulators can act proactively to protect learners, patients, and the public interest.

1153. Reporting, audit, and public accountability form the backbone of a credible, transparent, and enforceable NETH regulatory system.

G19.1 Enforcement — Non-Reporting or Obstruction

1154. Non-reporting or obstruction of reporting, inspection, or audit processes constitutes a serious breach of institutional obligations and directly undermines transparency, accountability, and regulatory oversight.

1155. Where an institution fails to submit required reports, provides incomplete or misleading information, or obstructs authorised inspections or audits, enforcement action shall be initiated without regard to the institution's academic performance or historical standing.

(a) Sanctions

1156. Regulatory authorities may impose graduated sanctions proportionate to the severity and persistence of the breach. These may include formal warnings, compliance directives with binding timelines, financial penalties, where permitted by law, restrictions on admissions or programme expansion, or enhanced monitoring and supervision.

1157. Sanctions are intended both to correct non-compliance and to deter future breaches.

(b) Public Compliance Notices

1158. In cases where non-reporting or obstruction compromises public interest, learner protection, or system integrity, regulators may issue public compliance notices. These notices formally disclose the institution's non-compliant status, the nature of the breach, and required remedial actions.

1159. Public disclosure serves as a transparency mechanism, protects prospective learners, and reinforces accountability to stakeholders and the wider public.

(c) Withdrawal of Approvals

1160. Persistent, wilful, or serious non-reporting or obstruction may result in withdrawal of institutional or programme approvals. This is a measure of last resort, applied where the regulator can no longer rely on the institution's representations or oversight cooperation.

1161. Withdrawal of approvals may be accompanied by enrolment freezes and the implementation of teach-out arrangements to safeguard affected learners.

1162. Collectively, these enforcement measures affirm that transparency and cooperation are non-negotiable conditions of participation in the NETH system.

1163. Institutions that undermine oversight through non-reporting or obstruction forfeit regulatory confidence and expose themselves to decisive corrective action in the public interest.

G19.2 Institutional Accountability

1164. Accountability ensures that institutions are answerable for their decisions, performance, and use of authority and resources.

1165. Institutions must operate through properly constituted governing bodies and management structures, with clear lines of responsibility and documented decision-making.

1166. Financial accountability, academic accountability, and ethical accountability are central, requiring transparency in budgeting and expenditure, integrity in academic processes, and responsiveness to student, regulatory, and public concerns.

1167. Accountability mechanisms also ensure that failures are identified, responsibility is assigned, and remedial action is taken.

G19.3 Institutional Sustainability

1168. Sustainability refers to the institution's demonstrated capacity to maintain operations, quality standards, and compliance over the long term.

1169. This includes financial viability, adequate and stable staffing, maintenance of infrastructure and learning resources, and the resilience of governance and quality assurance systems.

1170. Institutions must plan for risks, transitions, and growth in a manner that does not compromise educational quality, student safety, or professional standards.

G19.4 Integrated Regulatory Logic

1171. Taken together, compliance, accountability, and sustainability form an integrated regulatory logic. Compliance ensures legality, accountability ensures responsibility, and sustainability ensures continuity.

1172. An institution that fails in any one of these dimensions is inherently unstable and poses risks to learners, patients, regulators, and the health system.

1173. By enforcing these requirements, the Policy affirms that education and training for health must be delivered by institutions that are not only technically competent, but also lawfully governed, ethically accountable, and structurally capable of sustaining quality and public trust over time.

G19.5 Enforcement — Unsustainable Operations

1174. Unsustainable institutional operations constitute a serious regulatory risk, as they threaten continuity of training, academic integrity, and learner protection.

1175. Where an institution is assessed as unable to sustain compliant operations—whether due to financial fragility, chronic staffing gaps, deteriorating infrastructure, governance failure, or unmanaged risk—regulatory authorities shall intervene by invoking sanctions to prevent harm to learners and the health system.

1176. Sanctions are regulatory instruments applied to address non-compliance, manage institutional risk, and protect learners and the public interest. They are imposed in a graduated and proportionate manner, calibrated to the nature, severity, and persistence of the identified risks or breaches. The objective of sanctions is corrective where possible and protective where necessary.

1177. Sanctions may include any or all of the following: Conditional renewal, enrolment caps, suspension, mandated restructuring, teach-out orders, or closure, proportionate to risk and severity.

G19.5.1 Conditional Renewal

1178. Conditional renewal of institutional or programme approval may be applied where deficiencies are identifiable and remediable.

1179. Under this sanction, continued operation is permitted subject to strict conditions, defined corrective actions, and enhanced monitoring within specified timelines. Failure to meet conditions results in escalation to more severe measures.

G19.5.2 Enrolment Caps

1180. Enrolment caps are imposed to limit institutional exposure and prevent further risk to learners when capacity, staffing, infrastructure, or financial sustainability is inadequate.

1181. Enrolment caps stabilise operations, reduce exposure to additional risk, and allow the institution to focus resources on current learners. At the same time, they allow implementation of corrective actions and ensures that existing learners are prioritised.

1182. As an immediate containment measure, regulators may impose enrolment caps to prevent the institution from admitting new learners beyond its demonstrated capacity.

G19.5.3 Suspension

1183. Suspension involves the temporary withdrawal of approval to admit new learners or to operate specific programmes or institutional functions.

1184. It is applied where risks are significant and immediate, but where there remains a possibility of restoration of compliance through decisive remedial action.

G19.5.4 Mandated Restructuring

1185. Where deficiencies are systemic but potentially remediable, institutions may be required to undertake mandated restructuring. This may include changes to governance and management arrangements, financial recovery plans, consolidation or suspension of programmes, staff reorganisation, or revision of operational models.

1186. Restructuring is conducted under regulatory oversight and within defined timelines to restore institutional viability and compliance.

G19.5.5 Orderly Teach-Out

1187. Where sustainability cannot be credibly restored, regulators shall require the implementation of orderly teach-out arrangements. These measures prioritise learner protection by ensuring that enrolled students are able to complete their programmes, transfer to accredited institutions, or receive appropriate academic recognition.

1188. Teach-out orders are issued where continued admissions or operations would expose learners to unacceptable risk, but where enrolled students must be protected.

1189. Institutions are required to facilitate completion of programmes, transfer of learners, or other approved arrangements under regulatory supervision to ensure academic continuity and integrity.

G19.5.6 Closure Arrangements

1190. Where sustainability cannot be credibly restored, regulators shall require the implementation of closure arrangements. These measures prioritise learner protection by ensuring that enrolled students are able to complete their programmes, transfer to accredited institutions, or receive appropriate academic recognition.

1191. Closure is a measure of last resort, applied where an institution is irreparably non-compliant, unsafe, or unsustainable. Closure processes are orderly and supervised, with safeguards for learner transition, record preservation, and public notification.

1192. Closure processes are structured, transparent, and supervised, ensuring continuity of records, safeguarding of qualifications, and minimisation of disruption.

1193. Collectively, these enforcement measures affirm that institutional continuity must never be pursued at the expense of learner rights, educational quality, or public safety.

1194. Regulatory intervention in cases of unsustainable operations is thus preventive and protective, ensuring system integrity while upholding the paramount obligation to protect learners.

1195. By applying sanctions proportionately, the regulatory framework balances institutional correction with learner protection, ensuring that responses to non-compliance are firm, fair, and aligned with the level of risk posed.

G19.6 Consolidated Enforcement Triggers

1196. Consolidated enforcement triggers define the threshold conditions under which regulatory authorities must escalate oversight into formal enforcement action. These triggers reflect patterns of institutional behaviour that signal systemic risk, loss of regulatory confidence, or imminent harm to learners, patients, and the public interest.

1197. They are applied cumulatively and holistically, rather than in isolation, recognising that serious institutional failure often emerges through persistent or interrelated deficiencies.

G19.6.1 Persistent Regulatory Breaches

1198. Repeated or sustained non-compliance with laws, policies, standards, or regulatory directives constitutes a clear enforcement trigger.

1199. Persistent breaches indicate structural governance or management failure, rather than isolated error, and demonstrate an institution's inability or unwillingness to maintain continuous compliance. Escalation is warranted even where individual breaches may appear minor in isolation.

G19.6.2 Financial Opacity or Insolvency Risk

1200. Lack of financial transparency, unreliable financial reporting, unexplained deficits, or indicators of insolvency trigger enforcement due to the direct threat they pose to institutional continuity and learner protection.

1201. Financial opacity erodes trust and prevents regulators from assessing sustainability, while insolvency risk necessitates early intervention to avoid abrupt institutional collapse.

G19.6.3 Failure to report or cooperate with audits

1202. Non-submission of required reports, provision of misleading information, or obstruction of inspections and audits undermines the entire regulatory framework.

1203. Such conduct is treated as a serious enforcement trigger because it removes the regulator's ability to verify compliance and manage risk, irrespective of the institution's claimed performance.

G19.6.4 Non-Implementation of Corrective Actions

1204. Failure to implement agreed or directed corrective actions within prescribed timelines demonstrates disregard for regulatory authority and an absence of institutional capacity or commitment to reform.

1205. This trigger applies whether corrective actions relate to governance, finance, quality assurance, staffing, or student welfare.

1206. When one or more triggers are present, regulators are obligated to move beyond routine monitoring to formal enforcement measures, which may include conditional approvals, sanctions, enrolment restrictions, public compliance notices, or withdrawal of approvals.

1207. Consolidated enforcement is both preventive and protective to restore compliance where possible and to safeguard learners, patients, and public trust where risks cannot be mitigated.

G19.7 Mandatory Outputs

1208. Mandatory outputs are the tangible, verifiable products through which institutions demonstrate ongoing compliance, accountability, and sustainability under the regulatory framework for Education and Training for Health.

1209. They are not optional administrative documents, but compulsory evidence that institutional obligations are being actively managed, monitored, and fulfilled.

G19.7.1 Institutional Compliance Register

1210. The institutional compliance register is a consolidated, up-to-date record of all applicable legal, regulatory, and policy obligations, together with the institution's compliance status against each requirement.

1211. The register documents approvals, conditions, inspection findings, deadlines, and responsible officers. The register enables both institutional leadership and regulators to track compliance systematically and to identify emerging risks or gaps in real time.

G19.7.2 Audited or certified financial statements

1212. Audited or certified financial statements provide independent assurance of the institution's financial position, performance, and integrity. They confirm that resources are managed lawfully, transparently, and sustainably, and that financial risks are identifiable and controlled. These statements are essential for assessing institutional viability and for protecting learners and public funds.

G19.7.3 Sustainability and Risk Management Plan

1213. This plan sets out the institution's strategy for maintaining continuity of operations and managing key risks.

1214. It identifies academic, financial, operational, and safety risks, assesses their likelihood and impact, and specifies mitigation measures, responsible officers, and review timelines. The plan demonstrates forward-looking governance and preparedness for disruption.

G19.7.4 Periodic Academic and Compliance Reports

1215. Periodic reports provide structured updates on academic performance, quality assurance outcomes, staffing, infrastructure, student welfare, and regulatory compliance.

1216. Submitted at prescribed intervals, these reports enable ongoing oversight, evidence-based decision-making, and early intervention where performance or compliance deteriorates.

G19.7.5 Verified corrective action records

1217. Verified corrective action records document how identified deficiencies or non-compliance issues have been addressed. They include action plans, implementation evidence, timelines, and confirmation of closure or verification by the regulator or authorised body.

1218. These records demonstrate institutional responsiveness, accountability, and capacity to remediate weaknesses.

1219. Collectively, these mandatory outputs operationalise continuous compliance. They provide reliable evidence, support institutional self-governance, and ensure that NETH is delivered by institutions that are transparent, accountable, and sustainable over time.

G20.0 GOVERNANCE AND AFFILIATION ARRANGEMENTS

1220. PIGs for Governance and affiliation arrangements provide the operational framework through which institutional authority, accountability, and collaborative relationships are lawfully established and managed within the education and training system. They translate high-level policy and legal provisions into clear, enforceable rules that define how institutions are governed internally and how they relate to external entities through affiliations, partnerships, and training arrangements.

1221. Governance Architecture under the TVET Act, 2025 and UOTIA, Cap. 262. With respect to governance, the TVET Act, 2025 and UOTIA, Cap. 262, both establish structured governance frameworks for post-secondary education institutions, anchored on a clear separation of oversight, management, and academic authority. While they apply to different sub-sectors, their underlying governance logic is aligned: institutional legitimacy and quality depend on defined roles, checks and balances, and protection of academic integrity.

1222. The TVET Act, 2025 and the UOTIA, Cap. 262 clarify the composition, powers, and responsibilities of governing bodies, councils, boards, and academic organs, as well as the separation of oversight, management, and academic authority. They establish standards for appointment, tenure, decision-making processes, conflict-of-interest management, and reporting lines, ensuring that institutions are governed transparently, competently, and in the public interest.

1223. Regarding affiliation arrangements, the guidelines set out the conditions under which institutions may affiliate with universities, training hospitals, professional bodies, or other recognised entities for purposes such as programme delivery, clinical training, supervision, assessment, or award of qualifications. They require that affiliations be formally approved, documented, and time-bound,

with clearly defined roles, responsibilities, quality assurance obligations, and liability provisions for each party.

1224. Critically, these guidelines prevent the misuse of affiliations as substitutes for institutional capacity. They affirm that affiliation does not transfer or dilute regulatory responsibility: each institution remains fully accountable for compliance with governance, quality assurance, staffing, and student welfare standards within its mandate. Unapproved, informal, or opaque affiliation arrangements are therefore prohibited.

1225. By standardising governance and affiliation practices, the PIGs promote system coherence, protect learners and the public, and reduce regulatory risk. They ensure that institutional authority is exercised lawfully and that collaborative arrangements enhance—rather than undermine—quality, accountability, and integrity in education and training delivery.

G20.1 Governance Structures for Education and Training for Health

1226. Governance structures for NETH shall be formally established, clearly mandated, and fully institutionalised at national, sub-national, and institutional levels to ensure coherent oversight, effective coordination, and consistent accountability across the entire health education and training ecosystem. This multi-level governance approach recognises that health workforce development is a system-wide function that intersects education, health service delivery, regulation, and public finance.

1227. At the national level, governance structures provide strategic leadership, policy direction, and inter-ministerial coordination. They align NETH with national health priorities, workforce plans, service delivery models, and fiscal frameworks. National structures also ensure harmonisation between education regulators, professional councils, and health authorities, reducing fragmentation, duplication, and regulatory conflict.

1228. At the sub-national level, governance arrangements operationalise national policies within regions, local governments, and health service delivery units. They facilitate coordination between training institutions and training hospitals, manage clinical placement capacity, support supervision and mentorship, and ensure that education and training respond to local health needs, disease burdens, and service realities while remaining compliant with national standards.

1229. At the institutional level, governance structures ensure lawful and accountable management of education and training activities. Governing bodies, executive management, and academic organs are responsible for implementing policies, maintaining quality assurance systems, safeguarding student welfare, and ensuring ethical and professional standards in teaching, assessment, and clinical training.

1230. Across all levels, these governance structures must be clearly defined, adequately resourced, and linked through formal coordination mechanisms, reporting lines, and information-sharing systems. Their institutionalisation ensures continuity beyond individual office holders and prevents reliance on ad hoc or informal arrangements.

1231. By embedding governance at national, sub-national, and institutional levels, the system ensures that education and training for health are coherent, quality-assured, and responsive to national health system needs—ultimately strengthening workforce competence, patient safety, and public trust.

G20.2 Operational Intent of Governance Structures

1232. The governance arrangements are mandatory and multi-level by design, intended to prevent

structural fragmentation between education, training, and health service delivery. They respond to the systemic risk that arises when education institutions, training sites, regulators, and service providers operate in silos, resulting in misalignment between curricula, competencies, workforce supply, and actual health system needs.

1233. These arrangements operate across national, sub-national, and institutional levels, ensuring that policy direction, operational planning, and implementation are coherently linked. Through this architecture, decisions on admissions, training capacity, clinical placements, supervision, assessment, and graduate deployment are informed by service delivery realities, workforce planning data, and quality and safety considerations.

1234. Governance is expressly not advisory. It is functional and decision-oriented, vested with defined authority to make binding determinations within its mandate. Each governance structure has clearly specified membership, decision-making powers, terms of reference, and reporting obligations. Its outputs—such as approved training capacities, placement allocations, compliance directives, coordination plans, and performance reports—carry institutional and regulatory force.

1235. Accountability is integral to the governance arrangements. Decisions are documented, responsibilities are assigned, and outcomes are subject to monitoring and review. Failure to participate in, comply with, or implement decisions arising from governance structures constitutes a breach of institutional and regulatory obligations.

1236. By institutionalising mandatory, decision-oriented governance mechanisms, ensures that education and training for health function as an integrated system rather than disconnected activities, thereby strengthening quality, efficiency, workforce relevance, and patient safety across the health sector.

1237. Governance structures established under this Standard serve as the central coordinating and enforcement mechanisms for NETH, translating policy intent into coherent system-wide action. Their functions are operational, authoritative, and outcome-oriented, extending beyond consultation to active direction and control of implementation.

1) Coordinate Policy Implementation and Oversight

1238. These governance structures ensure that national policy decisions are implemented consistently across institutions, training sites, regulators, and service delivery units.

1239. They provide structured oversight of implementation progress, harmonise roles and timelines among responsible actors, and monitor adherence to approved plans, standards, and directives.

1240. Through regular reporting and review, they detect implementation gaps early and initiate corrective action.

2) Align Training Outputs with Health Workforce Needs

1241. A core function of these structures is to ensure that education and training outputs are responsive to current and projected health workforce requirements.

1242. This includes aligning admissions, programme mix, training capacity, and clinical placements with national and sub-national workforce plans, disease burden profiles, and service delivery models. By doing so, the system avoids both overproduction in saturated cadres and shortages in critical skill areas.

3) Resolve Inter-Institutional and Inter-Regulatory Issues

1243. Governance structures provide an authoritative forum for resolving coordination failures, mandate overlaps, and conflicts between institutions, regulators, professional councils, and service providers.

1244. They clarify roles, issue binding determinations where responsibilities intersect, and prevent regulatory fragmentation that could otherwise undermine quality assurance, accreditation, and professional standards.

4) Enforce Compliance with the Policy and Standards

1245. Beyond coordination, these structures have explicit responsibility to enforce compliance. They monitor institutional adherence to policy and standards, review compliance reports and inspection findings, and trigger enforcement actions where breaches occur.

1246. This may include issuing directives, imposing corrective measures, recommending sanctions, or escalating matters to the appropriate regulatory or executive authority.

1247. Collectively, these functions ensure that governance under this Standard is not symbolic but instrumental—driving alignment, accountability, and quality across the NETH system in service of national health outcomes and public protection.

G20.3 National Governance Structures (Who Does What)

G20.3.1 NETH Ministerial Steering Committee

1248. NETH Ministerial Steering Committee is the apex policy-level governance body established to provide strategic direction, political oversight, and inter-ministerial coordination for the Education and Training for Health system.

1249. Its primary purpose is to ensure that education and training for health are coherently aligned with national development priorities, health system needs, and government policy commitments, and that implementation is supported at the highest level of the Executive.

(a) Purpose

1250. At the policy level, the national ministerial steering committee serves as the authoritative forum for setting strategic priorities, resolving cross-sectoral policy issues, and providing political stewardship. It ensures alignment between education, health, public service, finance, and other relevant sectors, since health workforce development is a whole-of-government responsibility.

1251. The national ministerial steering committee shall: endorse major policy directions; approve strategic implementation frameworks; address high-level bottlenecks that cannot be resolved at technical levels; and also, the committee shall provide guidance on; resource mobilisation, regulatory reforms, and Inter-Ministerial obligations.

1252. Also, the national ministerial steering committee shall serve as the principal accountability mechanism for ensuring that the various Ministries and Agencies fulfil their respective commitments as provided under the National Education and Training for Health Policy.

(b) Composition

1253. The national ministerial steering committee is composed of Cabinet Ministers and senior political representatives from the sectors whose mandates directly affect education, training, regulation,

and deployment of the health workforce.

1254. The membership includes the:
(i) Minister of Education and Sports — Chair,
(ii) Minister of Health — Co-Chair,
(iii) Minister of Finance, Planning and Economic Development — Member,
(iv) Minister of Public Service — Member,
(v) Attorney General — Member.
(vi) Chairperson, TVET Council — Member,
(vii) Chairperson, NCHE— Member,
(viii) Chairperson, Uganda Health Professions Assessment Board (UHPAB)— Member,
(ix) Chairperson, Uganda Medical & Dental Practitioners Council (UMDPC)— Member,
(x) Chairperson, Uganda Nurses and Midwives Council (UNMC)— Member,
(xi) Chairperson, Health Service Commission (HSC) — Member,
(xii) Chairperson, Allied Health Professionals Council (AHPC) — Member, and
(xiii) Chairperson, Pharmaceutical Society of Uganda (PSU) — Member

1255. The national ministerial steering committee may co-opt other ministers with a relevant statutory or policy role as members. Membership to this committee shall be structured to ensure balanced representation and collective ownership.

(c) Leadership

1256. The national ministerial steering committee shall be chaired by the Minister of Education and Sports and co-chaired by the Minister of Health.

(d) Secretariat Support

1257. The national ministerial steering committee shall have a secretariat composed of officials from the Ministry of Education and Sports in the departments of Health Education and Training and Education Policy Analysis and Research and from Ministry of Health, in the department of clinical services and the Policy Analysis Unit.

1258. The secretariat shall; ensure continuity, documentation of decisions, follow-up on resolutions, and link technical and implementation-level structures.

G20.3.2 NETH Technical Steering Committee

1259. NETH technical steering committee is the principal technical-level structure established to operationalise, coordinate, and monitor and evaluate the implementation of NETH Policy actions.

1260. NETH technical steering committee shall serve as the bridge between high-level ministerial policy direction and day-to-day institutional implementation. It shall ensure that all the policy and political decisions are translated into technically sound, coherent, and enforceable actions.

(a) Purpose of NETH Technical Steering Committee

1261. NETH technical steering committee shall provide expert technical leadership and inter-agency coordination across the education, health, regulation, and service delivery sectors.

1262. Its core purpose is to guide implementation planning, harmonise standards and procedures, resolve technical and regulatory bottlenecks, and ensure that education and training outputs are aligned with health workforce requirements, quality standards, and service delivery realities.

1263. NETH technical steering committee; reviews implementation progress, analyses data and reports, proposes corrective actions, and prepares consolidated briefs and recommendations to the ministerial steering committee for make policy decisions.

(b) Functions of NETH Technical Steering Committee

1264. Key functions of NETH technical steering committee include:

(i) Coordinating the implementation of the policy across Ministries, regulatory bodies, professional councils, health training institutions, and health service providers;

(ii) Aligning curricula, training capacity, clinical placement planning, and assessment systems with national workforce plans and health priorities;

(iii) Harmonising regulatory and quality assurance requirements to reduce duplication and conflict between education and health regulators;

(iv) Reviewing compliance, inspection findings, and performance reports, and initiating corrective or enforcement actions within its mandate; and

(v) Providing technical advice on financing, data systems, monitoring and evaluation, and capacity development.

(c) Composition of NETH Technical Steering Committee

1265. NETH Technical Steering Committee is composed of senior technical officers (Permanent Secretaries, Directors, Commissioners, Registrars of professional Councils or their designated equivalents) from key ministries and agencies, including those responsible for Education and Sports, Health, Finance, Planning and Economic Development, Public Service, National Council Higher Education, the TVET Council, professional councils namely: Uganda Health Professions Assessment Board (UHPAB); Uganda Medical and Dental Practitioners Council (UMDPC); Uganda Nurses and Midwives Council (UNMC); The Allied Health Professionals Council (AHPC); and the Pharmaceutical Society of Uganda (PSU) and other relevant statutory bodies.

1266. Membership to NETH Technical Steering Committee is defined to ensure that participating institutions have both the technical competence and delegated authority to make binding technical decisions on behalf of their organisations. The Committee may establish specialised sub-committees or working groups to address specific thematic areas such as quality assurance, clinical training, workforce planning, data and information systems, or financing.

(d) Authority and Accountability

1267. NETH Technical Steering Committee shall operate with defined authority under the policy and its implementation standards. Its decisions, are binding on participating institutions, and its outputs—such as approved implementation plans, coordination directives, and technical guidelines—form the basis for compliance and enforcement actions.

1268. The committee reports regularly to the ministerial steering committee, ensuring upward accountability and policy coherence.

1269. A strong institutionalised technical steering committee, ensures that NETH is governed not only by political intent but also by sustained technical coordination, evidence-based decision-making, and disciplined implementation across the system.

1270. Membership: This typically includes the:

(i) Permanent Secretary, Education and Sports — Chairperson,
(ii) Permanent Secretary, Health — Co-Chairperson,
(iii) Permanent Secretary, Finance, Planning and Economic Development — Member,
(iv) Permanent Secretary, Public Service — Member,
(v) Permanent Secretary, Health Service Commission— Member,
(vi) Solicitor General — Member.
(vii) Executive Director, TVET Council — Member,
(viii) Executive Director, NCHE— Member,
(ix) Executive Secretary, UHPAB— Member,
(x) Executive Secretary, Uganda Medical and Dental Practitioners Council — Member,
(xi) Executive Secretary, Uganda Nurses and Midwives Council (UNMC)— Member,
(xii) Executive Secretary, The Allied Health Professionals Council (AHPC) — Member
(xiii) Executive Secretary, The Pharmaceutical Society of Uganda (PSU) — Member
(xiv) Director General of Health Services, (MoH) — Member
(xv) Commissioner, Health Education and Training (MoES) — Member
(xvi) Commissioner, Education Policy Analysis and Research (MoES) — Member,
(xvii) Commissioner, Clinical Services (MoH) — Member
(xviii) Commissioner, Institutional Capacity Building and Human resource Development (MoH);
(xix) Coordinators for Health Training from Medical Bureaus (UCMB, UMMB, and UPMB)
(xx) (20) Any other relevant department in MoES and MoH

1271. The NETH Technical Steering Committee may co-opt Ministers with a relevant statutory or policy role as members. Membership shall be structured to ensure balanced representation and collective ownership.

(e) Leadership

1272. The NETH Technical Steering Committee shall be chaired by the Permanent Secretary, MoES and co-chaired by the Permanent Secretary, Ministry of Health.

(f) Support

1273. The NETH Technical Steering Committee secretariat and technical support shall be provided by officials from the MoES — Departments of Health Education and Training and Education Policy Analysis and Research and officials from the MoH — Departments of Clinical Services and the Policy Analysis Unit to ensure continuity, documentation of decisions, follow-up on resolutions, and linkage with technical and implementation-level governance structures.

G20.3.3 NETH Technical Working Group

1274. The NETH Technical Working Group (TWG) is the core operational and expert-driven mechanism that supports detailed, day-to-day implementation of the National Education and Training for Health Policy.

1275. It functions as the primary technical engine of the governance framework, providing analytical depth, specialist input, and practical solutions to implementation challenges identified at policy and technical steering levels.

(a) Purpose of NETH Technical Working Group (TWG)

1276. The TWG exists to translate policy decisions and technical steering directives into implementable instruments, guidelines, tools, and actions.

1277. Its purpose is to undertake detailed technical work that requires subject-matter expertise, cross-institutional collaboration, and continuous engagement with data, standards, and operational realities of education, training, and health service delivery.

(b) Functions of NETH Technical Working Group (TWG)

1278. Key functions of the TWG include:

(i) Developing draft implementation guidelines, standards, protocols, and operational tools arising from the Policy and directives of the Steering Committees;

(ii) Conducting technical analyses on curricula, competency frameworks, training capacity, clinical placement models, assessment systems, and quality assurance processes;

(iii) Supporting harmonisation of education, training, accreditation, and professional regulation requirements;

(iv) Reviewing institutional compliance data, inspection findings, and performance indicators, and proposing corrective or improvement measures;

(v) Supporting monitoring, evaluation, and reporting through data collection, validation, and technical interpretation; and

(vi) Providing rapid technical advice on emerging issues affecting NETH.

(c) Composition of NETH Technical Working Group (TWG)

1279. The NETH Technical Working Group is composed of specialists and practitioners drawn from relevant Ministries, regulatory bodies, professional councils, training institutions, health service providers, and, where appropriate, development partners and experts.

1280. Members are selected based on technical competence, functional relevance, and practical experience rather than institutional rank. Participation may be full-time or part-time, depending on the scope of work, and may be organised into thematic sub-groups (e.g. quality assurance, clinical training, workforce planning, data systems, financing).

1281. Membership will typically include the:

(i) Commissioner, Health Education and Training (MoES)— Chair,
(ii) Director General of Health Services, (MoH)— Co-Chair,
(iii) Commissioner, Finance, Planning and Economic Development — Member,
(iv) Commissioner, HRM, Ministry of Public Service — Member,
(v) Commissioner, HRM, Health Service Commission— Member,
(vi) Deputy Solicitor General — Member.
(vii) Manager Health Education, TVET Council — Member,
(viii) Manager, NCHE— Member,
(ix) Manager, Uganda Health Professions Assessment Board (UHPAB)— Member,
(x) Manager, Uganda Medical and Dental Practitioners Council — Member,
(xi) Manager, Uganda Nurses and Midwives Council (UNMC)— Member,
(xii) Manager, The Allied Health Professionals Council (AHPC) — Member
(xiii) Manager, The Pharmaceutical Society of Uganda (PSU) — Member
(xiv) Principal Policy Analyst, (MoH) — Member
(xv) Assistant Commissioner, HET (MoES) — Member
(xvi) Principal Policy Analyst MoES — Member

(xvii) Assistant Commissioner, Commissioner Clinical Services (MoH) — Member
(xviii) Public Health Training Institutions representatives — Member
(xix) Private Health Training Institutions representatives — Member
(xx) Representative of Public Training hospitals (teaching hospitals) — Member, and
(xxi) Representative of Private Training hospitals (teaching hospitals) — Member
(xxii) Observers: Chair Development Partners Group (where applicable)
(xxiii) Any other senior official from relevant departments in MoES and MoH

(d) Authority and reporting of NETH Technical Working Group (TWG)

1282. While the TWG does not exercise policy-level authority, its technical outputs carry institutional weight. Its recommendations, draft instruments, and analyses are submitted to the technical steering committee for review, endorsement, and onward transmission to the ministerial steering committee where required. TWG outputs form the technical basis for binding decisions, standards, and enforcement actions.

(e) Value of NETH Technical Working Group (TWG) to the System

1283. By institutionalising a dedicated technical working group, the policy ensures that implementation is evidence-based, technically sound, and responsive to operational realities.

1284. The TWG reduces reliance on ad hoc consultations, strengthens institutional memory, and ensures continuity in technical problem-solving, thereby enhancing the effectiveness, coherence, and sustainability of Education and Training for Health governance.

G20.4.Affiliation and Partnership Agreements for NETH

1285. Affiliation and partnership agreements matters: These agreements are foundational to the effectiveness, safety, and credibility of NETH because they operationalise the link between academic instruction and real-world health service delivery.

1286. Health professional training cannot be delivered in isolation; it requires structured access to clinical environments, specialised expertise, and supervised practice settings that reflect the realities of the health system.

1287. These agreements ensure training relevance and workforce alignment. By formally linking HTIs to training hospitals, district health facilities, specialised centres, and other approved partners, affiliations ensure that curricula, competencies, and learning experiences are aligned with national health priorities, disease burden, and service delivery models. This alignment reduces skills mismatches and strengthens workforce readiness.

1288. They safeguard quality and patient safety. Regulated affiliation agreements define supervision, assessment, scope of practice, and ethical responsibilities, ensuring that learners are appropriately guided and that patients are protected. Without such agreements, clinical exposure risks becoming informal, inconsistent, or unsafe, undermining both educational outcomes and public trust.

1289. Affiliation and partnership agreements clarify accountability and regulatory responsibility. They prevent ambiguity over who is responsible for teaching quality, assessment decisions, learner welfare, and compliance with standards. Critically, they affirm that academic and regulatory responsibility remains with the Health Training Institution, regardless of where training occurs.

1290. They expand training capacity without compromising standards. Through controlled and approved partnerships, institutions can access additional training sites and expertise, supporting scale-up

of priority health cadres while maintaining quality assurance and oversight. This is particularly important in resource-constrained settings where no single institution can independently provide all required training environments.

1291. They prevent system fragmentation and regulatory arbitrage. Formal, approved agreements reduce duplication, conflicting mandates, and the misuse of affiliations to bypass accreditation or staffing requirements. They promote coherence across education regulators, professional councils, and health authorities.

1292. Affiliation and partnership agreements matter because they are not merely administrative conveniences; they are essential governance instruments that enable high-quality, safe, accountable, and system-aligned Education and Training for Health, protecting learners, patients, and the public interest while strengthening the health workforce pipeline.

G20.4.1. Definition and Scope of Affiliation and Partnership Agreements

1293. Affiliation agreements are legal contracts that define roles and responsibilities of a healthcare organisation and an educational institution for the purpose of providing practice education to students (or learners). Practice education is that part of a student's education which takes place in the workplace and may involve direct patient/client care.

1294. Affiliation agreements address the risks in the relationship for both organisations and their employees, patients and students. The agreement defines the roles and responsibilities of both organisations and addresses risks to staff, patients and students.

1295. Healthcare organisations require a current affiliation agreement to be in place with sponsoring education institutions before students engage in practice education activities in healthcare organisations programmes or facilities

1296. All HTIs shall establish formal affiliation and partnership agreements with training hospitals, clinical placement sites, and other relevant institutions to support effective delivery of education and training for health.

1297. Affiliation and partnership agreements are mandatory legal instruments, not informal understandings. Their purpose is to: (i) secure access to approved clinical and practice environments; (ii) clarify institutional responsibilities for supervision, assessment, and learner welfare; (iii) protect patient safety and service delivery; and (iv) ensure accountability across education and health service actors.

1298. Whether one or multiple students, no practicum or education experience/training should take place prior to the execution of the affiliation agreement. No clinical training, internship, residency, or supervised practice shall occur without a valid, approved affiliation agreement.

1299. Affiliation and partnership agreements, use clear wording with respect to each party's daily oversight, supervision and training of the students.

1300. In the affiliation and partnership agreements, educational facilities should be required and ensure students have the necessary immunisation, training and experience requirements and police checks before placement.

1301. Affiliation and partnership agreements are formal, regulator-approved arrangements through which HTIs collaborate with external entities to support education, training, supervision, and service-linked learning.

1302. These arrangements are designed to expand training capacity, enhance clinical exposure,

and ensure alignment between education and health service delivery, while preserving clear accountability for quality, safety, and compliance.

1303. Affiliation agreements must be documented, time-bound, and approved by the relevant authorities. They do not transfer regulatory responsibility from the HTI; the institution remains fully accountable for academic standards, learner welfare, and compliance with all applicable policies and standards.

G20.4.2. Purpose and Regulatory Rationale

1304. Affiliation and Partnership Agreements serve a deliberate regulatory and system-building purpose within NETH. Their primary purpose is to enable HTIs to deliver NETH that is clinically grounded, workforce-relevant, and aligned with national health system needs, while maintaining clear accountability, quality assurance, and public protection.

1305. These agreements provide lawful mechanisms through which HTIs access accredited training environments, specialised expertise, and service delivery platforms that may not be fully available within a single institution. They support clinical training, internships, community-based learning, specialised rotations, and shared academic delivery, ensuring that learners acquire competencies that reflect real-world health service demands.

1306. The regulatory rationale for formalising affiliation and partnership arrangements is rooted in risk management and system coherence. NETH is a high-risk public interest activities with direct implications for patient safety, professional competence, and health system performance.

1307. Unregulated collaborations can result in fragmented supervision, unclear responsibility for assessment, inconsistent training quality, and exposure of learners and patients to harm. Formal agreements mitigate the risks by clearly defining authority, roles, responsibilities, and accountability.

1308. Affiliation and partnership agreements also prevent misuse of external relationships as substitutes for institutional capacity. Regulation ensures that institutions do not rely on affiliations to bypass accreditation requirements, staffing standards, infrastructure obligations, or quality assurance systems. The HTI retains full academic and regulatory responsibility for programmes delivered under any affiliation, regardless of the partner involved.

1309. At system level, regulated affiliations promote coordination between education, training, and service delivery, enabling rational planning of training capacity, clinical placements, and workforce outputs. They support equitable distribution of training opportunities, integration of public and approved non-state actors, and alignment with national workforce strategies.

1310. In essence, the purpose and regulatory rationale of Affiliation and Partnership Agreements are to balance flexibility with control: allowing collaboration and capacity-sharing where necessary, while preserving academic integrity, regulatory clarity, learner protection, and public trust in the Education and Training for Health system.

G20.4.3. Core Principles Governing Affiliations and Partnerships

1311. Affiliations and partnerships in Education and Training for Health are governed by a set of core principles designed to ensure that collaboration enhances training quality and system coherence without diluting accountability, academic integrity, or public protection.

1312. These principles apply uniformly to all forms of affiliation and partnership, regardless of the type of institution or partner involved.

(a) Institutional Accountability and Non-Transferability of Responsibility

1313. Affiliation does not transfer or dilute regulatory or academic responsibility. The Health Training Institution remains fully accountable for compliance with all applicable laws, standards, and policies, including curriculum quality, assessment integrity, learner welfare, and ethical conduct, irrespective of where training is delivered.

(b) Quality Assurance and Academic Integrity

1314. All affiliations must be embedded within the institution's quality assurance and academic governance systems.

1315. Teaching, supervision, assessment, and certification under an affiliation must meet approved standards, be subject to internal and external review, and be protected from undue administrative, commercial, or political influence.

(c) Learner and Patient Safety

1316. The protection of learners and patients is paramount. Affiliations ensure adequate supervision, defined scope of practice, ethical safeguards, and safe learning environments.

1317. No partnership may expose learners or patients to avoidable risk in pursuit of training capacity or convenience.

(d) Transparency, Documentation, and Traceability

1318. Affiliations and partnerships must be formal, documented, and approved. Informal or undocumented arrangements are prohibited.

1319. Clear records must exist to demonstrate authority, roles, decision-making, and accountability, enabling effective oversight and audit.

(e) Purpose-Specific and Time-Bound Arrangements

1320. Affiliations must have a clearly defined purpose, scope, and duration. Open-ended or vague partnerships undermine accountability and are not permitted.

1321. Renewal or extension is subject to review and continued compliance.

(f) Equity and System Coherence

1322. Affiliations should support equitable access to quality training opportunities and contribute to coherent national workforce development.

1323. They must not entrench disparities, distort training markets, or fragment the education and health systems.

(g) Regulatory Approval and Oversight

1324. All affiliations are subject to prior approval, ongoing monitoring, and, where necessary, enforcement by the competent authorities.

1325. Compliance with conditions of approval is mandatory, and breaches may result in suspension or

termination of the affiliation.

1326. Together, these core principles ensure that affiliations and partnerships function as disciplined, accountable, and quality-assured instruments for strengthening NETH, rather than as mechanisms for regulatory avoidance or institutional convenience.

G20.4.4. Types of Affiliation and Partnership Agreements

1327. The principal types of affiliation and partnership agreements include, but are not limited to the ones listed below:

(1) HTI – Training Hospital Affiliations

1328. These affiliations link HTIs with accredited training hospitals to provide structured clinical training, internships, residencies, and supervised practice.

1329. They define roles in supervision, assessment, patient safety, and use of facilities, ensuring that clinical training is integrated with academic programmes and conducted in approved environments.

(2) HTI – District Health Facility Partnerships

1330. Partnerships with district health facilities support decentralised and community-based training, enabling learners to gain exposure to primary health care, public health, and rural service delivery contexts.

1331. These agreements clarify supervision arrangements, scope of practice, learner numbers, and quality assurance responsibilities at the sub-national level.

(3) HTI – Specialised Institute or Centre Partnerships

1332. Affiliations with specialised institutes or centres of excellence (such as research institutes, referral centres, or specialised training units) provide access to advanced competencies, technologies, and niche expertise.

1333. These partnerships enhance depth of training in specialised fields while maintaining academic oversight by the HTI.

(4) HTI – Private/ Private Not for Profit Facility Affiliations

1334. Where approved by the regulator, HTIs may affiliate with private or Private Not for Profit (PNFP) health facilities to supplement training capacity.

1335. Such affiliations are subject to stringent approval to ensure equivalence of standards, supervision quality, ethical safeguards, and patient safety, and to prevent commercial interests from compromising training integrity.

G4.4.4.5 Inter-Institutional Academic Partnerships for Shared Delivery

1336. These partnerships involve collaboration between two or more accredited institutions for joint or shared delivery of curricula, teaching, assessment, or supervision.

1337. Agreements must clearly specify academic responsibility, credit allocation, quality assurance mechanisms, and award authority to prevent ambiguity or dilution of standards.

1338. Together, these affiliation and partnership arrangements support a coordinated and capacity-responsive Education and Training for Health system.

1339. By regulating their form and function, the framework ensures that partnerships strengthen training quality and system alignment without fragmenting accountability or compromising learner and patient protection.

1340. Each affiliation and partnership agreement shall be fit-for-purpose and aligned to the institution's classification and approved programmes.

G20.4.5. Mandatory and Standard Content of Affiliation and Partnership Agreements

1341. The affiliation agreement includes:

(a) Definitions

(b) Insurance requirements for both third party liability and personal accidents

(c) Start and end dates of the agreement

(d) Responsibilities of the healthcare organisation related to practice education (e.g. to provide staff and students with reasonable access to facilities)

(e) Constraints on the healthcare organisation that may limit its ability to support practice education (e.g. operational requirements, a need to ensure the safety and care of patients, or a lack of resources)

(f) Responsibilities of the educational institution (e.g. to design and deliver student learning programmes, and take reasonable steps to ensure that students comply with healthcare organisation policies and standards of workplace behaviour)

(g) Designating representatives and mechanisms to facilitate communication on behalf of each organisation

(h) Reporting requirements for health and safety incidents

(i) Circumstances under which the institution's students or staff may be required to withdraw from the practice education experience

(j) Clarifying post-secondary students and staff involved in practice education are not healthcare employees, and are not entitled to employment benefits of the organisation.

(k) Provisions to protect privacy and confidentiality

(l) Conditions under which the agreement may be terminated

(m) Mutual indemnification clauses which protect the health authority and the educational institution against third party liability arising from the negligence of the other

(n) Terms relating to how the agreement may be applied, along with authorised signatures

1342. The affiliation agreement does not cover observation visits to the health authority by individuals who are not sponsored by an education institution.

(a) Supervision and Training Accountabilities

1343. The contract should use clear wording with respect to: (i) How each party will be involved in daily oversight supervision and training of students, including each party's authority, roles and responsibilities where supervision and training is shared between the two parties; (ii) Responsibilities for ensuring student familiarity and compliance with healthcare organization policies/ procedures.

1344. Both parties must agree to designate representatives/liaisons to facilitate communications and planning with respect to the educational experience/training.

(b) Obligations and Responsibilities – Healthcare Organisation

1345. The contract should: (i) Offer 'reasonable' access (versus full/guaranteed access) to the healthcare organization's facilities and supplies. (ii) Require the healthcare organisation to orient their own employees and appointed staff to their obligations under contract.

(c) Obligations and responsibilities – Education Facility

1346. The contract must include the educational facility's agreement to:

(i) Assign staff to monitor and evaluate the students' performance during the programme;

(ii) Require and ensure that students:

(a) Have the necessary immunisation, training and experience requirements, as defined by the healthcare organisation, before placement;

(b) Provide proof of police record check for vulnerable population, before placement;

(c) Are duly registered and in good standing at the college/university as necessary for participation in the programme.

(iii) Orient their employees and appointed staff to their obligations under contract, including compliance with health and safety, intellectual property, privacy and confidentiality and clinical and administrative policies, procedures and guidelines, including an acknowledgement of the consequences for non-compliance.

(iv) Additionally, the contract should include the educational facility's agreement:

(a) To immediately notify the healthcare organisation of any incident or event involving a student or education facility staff (e.g. incident compromises patient or staff safety, privacy and health/ safety breaches);

(b) The possible constraints on the healthcare organisation to perform its obligations under the agreement (i.e. availability of resources, operation and administrative needs and the safety of patients); and thud, the healthcare organisation's discretion to change, substitute or terminate any programme or practice education experience to meet these needs; and

(c) Healthcare organisation's statutory roles and responsibilities (e.g. public safety Act).

(d) Complaints/Dispute Resolution and Suspension of Students/Staff

1347. The contract should include: (i) A clear process for reporting and resolving unprofessional / disruptive behaviours, disputes and complaints of discrimination, harassment or violence; and (ii) Acknowledgement by the educational facility that the healthcare organisation can – 'at anytime' - temporarily or permanently remove or suspend one or more students or educational facility staff (e.g. unprofessional or unsafe behaviour).

(e) Privacy and Confidentiality

1348. The contract should include: (i) Clear breach of privacy reporting practices, including disciplinary steps; and (ii) acknowledgement by the educational facility that no student or educational facility staff will be granted access to personal health information unless they have signed a confidentiality agreement approved by the healthcare organisation.

(f) Insurance and Indemnification

1349. If the healthcare organisation is contracting practitioners (e.g. physicians) to conduct training/ clinical instruction, the practitioner should provide proof of liability protection.

G20.4.6. Approval and Registration Requirements for Affiliations and Partnerships

1350. Approval and registration requirements are central regulatory controls governing affiliation and partnership agreements in education and training for health.

1351. Their purpose is to ensure that all collaborative arrangements are lawful, transparent, quality-assured, and aligned with national education and health system objectives before any training activity is undertaken.

(a) Prior Approval as a Mandatory Condition

1352. No affiliation or partnership agreement may take effect unless it has received prior approval from the competent regulatory authorities.

1353. Approval is required before the learners are placed, training commences, or academic credits are awarded under the arrangement.

1354. Prior approval requirement prevents the emergence of informal or retrospective affiliations that bypass quality assurance, patient safety, and accountability safeguards.

(b) Submission and Assessment Requirements

1355. Institutions seeking approval must submit the proposed agreement together with supporting documentation demonstrating:

(a) Legal status and accreditation of all parties;
(b) Specific purpose, scope, and duration of the affiliation;
(c) Roles and responsibilities for teaching, supervision, assessment, and learner welfare;
(d) Quality assurance, reporting, and risk management arrangements;
(e) Capacity limits, including learner numbers and supervision ratios; and
(f) Ethical, safety, and liability provisions.

1356. Regulatory authorities must assess applications against approved standards, workforce priorities, and system capacity to ensure that the proposed affiliation strengthens, rather than undermine, education and training quality.

(c) Registration of Approved Agreements

1357. Once approved, affiliation and partnership agreements must be formally registered in an official register maintained by the relevant authority.

1358. Registration must provide a public and regulatory record of the authorised training arrangements, and enable traceability, monitoring, and coordination across institutions, regulators, and service delivery units.

(d) Conditions, Duration, and Renewal

1359. Approvals must be granted subject to conditions and for a defined period.

1360. Renewal or variation of an agreement is not automatic and requires review of performance, compliance history, and continued relevance to the training and workforce needs.

1361. Material changes to an approved agreement must be disclosed and approved before they are implemented.

(e) Oversight and Consequences of Non-Compliance

1362. Approved and registered affiliations must be subject to the ongoing monitoring, reporting, and inspections.

1363. Operating under an unapproved, expired, or materially altered agreement constitutes non-compliance and may trigger enforcement actions, including suspension of training activities, sanctions, or withdrawal of institutional or programme approvals.

1364. Through these approval and registration requirements, the regulatory framework ensures that affiliation and partnership agreements are disciplined instruments of system coordination, expanding training opportunities while safeguarding academic standards, learner welfare, patient safety, and public trust.

G20.4.7 Governance and Oversight of Affiliation and Partnership Agreements

1365. Governance and oversight of affiliation and partnership agreements is key in ensuring that collaborative arrangements in NETH operate lawfully, effectively, and in public interest.

1366. These mechanisms ensure that affiliations strengthen training quality and system coherence without diffusing accountability or compromising academic integrity, learner welfare, or patient safety.

(a) Institutional Governance Responsibilities

1367. Health Training Institutions retain primary responsibility for governing all activities conducted under affiliation or partnership agreements.

1368. Governing bodies and executive management must formally approve affiliations and ensure they align with institutional mandate and capacity, and integrate them into institutional planning, risk management, and quality assurance systems.

1369. Academic organs must exercise oversight over curricula, supervision, assessment, and certification associated with affiliated training activities.

(b) Operational Oversight and Coordination

1370. Institutions must designate accountable officers responsible for day-to-day management of affiliation arrangements.

1371. Operational oversight includes; coordinating learner placements, monitoring supervision and training quality, managing communication with partners, and ensuring compliance with approved terms and conditions.

1372. Under Operational oversight, regular performance reviews and reporting are mandatory.

(c) Regulatory Oversight

1373. Affiliation and partnership agreements are subject to oversight by relevant education and health regulators, professional councils, and other competent authorities.

1374. Regulators review approvals, monitor compliance, conduct inspections, and verify that affiliations are functioning within their authorised scope.

1375. Oversight focuses on quality assurance, learner protection, patient safety, and alignment with national workforce and service delivery priorities.

(d) Reporting and Accountability Mechanisms

1376. Institutions are required to submit periodic reports on the performance and compliance of affiliations, including learner numbers, training outcomes, supervision adequacy, incidents, and corrective actions.

1377. Significant risks, breaches, or changes must be reported promptly. Clear documentation and record-keeping enable traceability and accountability at all levels.

(e) Enforcement and Corrective Action

1378. Where deficiencies are identified, governance and oversight mechanisms require timely corrective action.

1379. Regulators may impose conditions, suspend or terminate specific affiliations, or apply broader institutional sanctions where systemic failure is evident.

1380. Institutions remain responsible for implementing remedial measures and protecting affected learners.

1381. Through robust governance and oversight, affiliation and partnership agreements are transformed from informal collaborations into accountable, quality-assured instruments of Education and Training for Health.

1382. This ensures that partnerships contribute positively to workforce development while upholding public trust, regulatory integrity, and professional standards.

G20.4.8. Quality Assurance and Risk Management of Affiliations and Partnerships

1383. Quality assurance and risk management are integral to the design, approval, and operation of affiliation and partnership agreements in education and training for health.

1384. They ensure that collaborative arrangements enhance training quality and system capacity without introducing academic, clinical, ethical, or operational risks that could compromise learners, patients, or public trust.

(a) Embedded Quality Assurance Mechanisms

1385. All affiliation and partnership agreements must be embedded within the Health Training Institution's quality assurance and academic governance systems.

1386. Teaching, supervision, assessment and certification through affiliated sites must meet similar standards, procedures and review processes as institution-based activities.

1387. This includes curriculum alignment, assessment moderation, supervision standards, feedback mechanisms, and periodic programme review.

(b) Shared but Accountable Supervision and Assessment

1388. While training partners may provide clinical or technical supervision, HTIs remain responsible for ensuring that supervisors are qualified, oriented to academic requirements, and operating within approved scopes of practice.

1389. Assessment standards, decisions, and certification authority remain under the institution's academic governance structures, preventing dilution of academic integrity.

(c) Risk Identification and Mitigation

1390. Affiliation arrangements must be supported by systematic risk identification and management processes.

1391. Institutions are required to assess and document potential academic, clinical, financial, safety, and reputational risks associated with each partnership.

1392. Mitigation measures such as supervision ratios, learner caps, safety protocols, insurance and liability provisions, and escalation procedures must be defined and implemented.

(d) Patient and Learner Safety Safeguards

1393. Given the direct interface with service delivery, affiliations must prioritise patient and learner safety.

1394. Agreements must specify ethical standards, infection prevention and control measures, incident reporting systems, and mechanisms for managing adverse events.

1395. Learners must be protected from unsafe practice environments and exploitation, and patients from unqualified or unsupervised care.

(e) Monitoring, Review, and Continuous Improvement

1396. Affiliated training activities are subject to ongoing monitoring, periodic review, and audit.

1397. Institutions must collect data on training quality, supervision effectiveness, learner outcomes, and incidents, and use this information to drive improvement.

1398. Underperforming or high-risk affiliations must be corrected, restricted, or terminated.

(f) Regulatory Assurance

1399. Quality assurance and risk management information arising from affiliations must be available to regulators and professional councils.

1400. Failure to manage risks or maintain quality under an affiliation constitutes a compliance breach and may attract enforcement action against both the individual and the institution.

1401. By embedding rigorous quality assurance and risk management, affiliation and partnership agreements function as controlled, accountable extensions of institutional training capacity supporting high-quality, safe, and ethically grounded NETH.

G20.4.9. Prohibited and Non-Compliant Affiliation and Partnership Agreement Practices

1402. Prohibited and non-compliant affiliation and partnership practices are those that undermine regulatory authority, compromise academic integrity, endanger learners or patients, or distort the education and training for health system.

1403. To safeguard quality, accountability, and public trust, the regulatory framework expressly disallows the following practices.

(a) Informal or Undocumented Affiliations

1404. Any affiliation or partnership that operates without a formally executed, regulator-approved, and registered agreement is prohibited.

1405. Informal arrangements, whether based on convenience, personal relationships, or retrospective justifications, lack accountability and are incompatible with quality assurance, patient safety, and audit requirements.

(b) Use of Affiliation to Bypass Accreditation or Institutional Requirements

1406. Affiliations may not be used to circumvent licensing, accreditation, staffing, infrastructure, or quality assurance standards.

1407. An institution that lacks capacity in a required domain cannot rely on an external partner to mask or substitute for that deficiency. Such practices constitute regulatory avoidance and misrepresentation.

(c) Sale, Leasing, or Franchising of Academic Authority

1408. The commercialisation of academic authority through sale, leasing, franchising, or “renting” of accreditation, programme approval, or award powers is strictly prohibited.

1409. Academic authority is non-transferable and must be exercised only by duly accredited institutions within their approved mandate.

(d) Unapproved Private or Commercial Exploitation of Training Activities

1410. Affiliations that prioritise commercial interests over educational quality, learner welfare, or patient safety are non-compliant.

1411. This includes arrangements that exploit learners as labour, impose inappropriate fees, or place

trainees in unsafe or unsupervised environments.

(e) Misrepresentation of Training Sites, Supervision, or Capacity

1412. Institutions must not misrepresent the existence, status, or quality of affiliated training sites or supervisors.

1413. Inflating capacity, falsifying supervision records, or claiming access to facilities or expertise that are not genuinely available constitutes serious misconduct.

(f) Operating Beyond Approved Scope or Duration

1414. Affiliations must operate strictly within their approved purpose, scope, learner numbers, and timeframes.

1415. Continuing an affiliation after expiry, materially altering its terms without approval, or expanding activities beyond what was authorised is non-compliant.

(g) Failure to Monitor, Report, or Implement Corrective Actions

1416. Neglecting oversight responsibilities, failing to report incidents or performance issues, or ignoring corrective directives renders an affiliation non-compliant, even where the original approval was valid.

1417. Engagement in any of these prohibited practices may trigger enforcement actions, including suspension or termination of the affiliation, sanctions against the institution, enrolment freezes, or withdrawal of approvals.

1418. By clearly defining and enforcing prohibited practices, the regulatory framework ensures that affiliation and partnership agreements strengthen, rather than weaken, the integrity and effectiveness of Education and Training for Health.

G20.4.10. Compliance, Enforcement, and Sanctions under Affiliations and Partnerships

1419. Compliance, enforcement, and sanctions form the accountability backbone governing affiliation and partnership agreements in Education and Training for Health.

1420. They ensure that collaborative arrangements operate strictly within approved parameters, uphold academic and professional standards, and protect learners, patients, and public.

(a) Compliance Obligations

1421. Health Training Institutions and their partners are required to comply fully with the terms and conditions of approved affiliation and partnership agreements, as well as with all applicable laws, policies, standards, and regulatory directives.

1422. Compliance includes adherence to approved scope, learner numbers, supervision arrangements, quality assurance procedures, reporting requirements, and ethical and safety safeguards.

1423. Institutions must actively monitor affiliated activities and maintain verifiable records demonstrating ongoing compliance.

(b) Regulatory Monitoring and Enforcement

1424. Regulatory authorities exercise continuous oversight over affiliations through inspections, audits, performance reviews, and analysis of submitted reports.

1425. Where non-compliance is identified, regulators may issue directives requiring corrective action within specified timelines.

1426. Failure to comply with such directives escalates the matter from routine oversight to formal enforcement.

(c) Sanctions

1427. Sanctions are applied proportionately to the nature, severity, and persistence of non-compliance and may include:

(a) Conditional continuation or renewal of the affiliation subject to remedial actions;

(b) Restriction or reduction of learner numbers or training activities under the affiliation;

(c) Suspension of the affiliation pending correction of identified deficiencies;

(d) Termination of the affiliation where risks cannot be mitigated; and

(e) Broader institutional sanctions, including enrolment freezes or withdrawal of programme or institutional approvals where systemic failure is evident.

(d) Learner Protection Measures

1428. Enforcement actions are accompanied by measures to protect affected learners. These may include teach-out arrangements, transfer to alternative accredited sites, recognition of completed training, and preservation of academic records.

(e) Accountability and Escalation

1429. Persistent or serious breaches, mainly those involving patient safety, misrepresentation, or regulatory avoidance, may be escalated to higher authorities or investigative bodies. Accountability rests primarily with the HTI, regardless of the role of partners.

1430. Through disciplined compliance requirements, credible enforcement, and proportionate sanctions, the framework ensures that affiliation and partnership agreements function as accountable, quality-assured instruments of NETH rather than as mechanisms for evading regulation or responsibility.

G20.4.11. Transition and Harmonisation under Affiliations and Partnerships

1431. Transition and harmonisation provisions are designed to ensure continuity, legal certainty, and system coherence as new or revised standards governing affiliation and partnership agreements for education and training for health come into effect.

1432. Their purpose is to manage the orderly alignment of existing arrangements with the new regulatory framework while safeguarding learners, institutions, and service delivery.

(a) Transition of Existing Affiliation and Partnership Agreements

1433. Affiliations and partnerships that were established prior to the commencement of the new

standards are not invalidated automatically.

1434. Instead, they are subject to a defined transition period within which institutions must review, regularise, and align existing agreements with the current requirements.

1435. During this period, institutions are required to submit existing agreements for review, identify gaps, and implement necessary amendments to achieve full compliance.

(b) Timelines and Conditions for Regularisation

1436. The transition framework must specify clear timelines for submission, review, amendment, and re-approval of existing affiliations.

1437. Continued operation during transition is conditional upon good-faith compliance efforts, transparency, and absence of serious risk to learners or patients.

1438. Agreements that cannot be brought into compliance within the prescribed timelines must be modified, suspended, or terminated.

(c) Learner Protection during Transition

1439. Transition provisions prioritise learner protection. Where an existing affiliation is found to be non-compliant or unsuitable, regulators must demand interim measures such as supervised continuation, transfer of learners, or alternative placements to ensure that learners are not disadvantaged or exposed to unsafe or substandard training environments.

(d) Harmonisation across Laws, Policies, And Regulators

1440. Harmonisation provisions ensure that affiliation and partnership requirements are applied consistently across the education, health, and professional regulation landscape.

1441. They promote alignment between this framework and related policies, standards, and legal mandates, reducing duplication, conflicting requirements, and regulatory ambiguity.

1442. Where overlaps or inconsistencies exist, competent authorities are required to coordinate and issue clarifications or joint guidance.

(e) Institutional and System-Level Coherence

1443. Structured transition and harmonisation mechanisms, helps to avoid regulatory shock, supports institutional adjustment, and strengthens system-wide coherence.

1444. Institutions must have a clear pathway to compliance, while regulators retain the authority to intervene decisively where risks persist.

1445. Transition and harmonisation provisions must ensure that affiliation and partnership agreements evolve in an orderly, fair, and coordinated manner protecting the learners, preserving legitimate collaborations, and reinforcing the integrity and effectiveness of Education and Training for Health governance.

G20.4.12. Outputs and Records under Affiliation and Partnership Agreements

1446. Mandatory outputs and records are formal and verifiable evidence through which HTIs demonstrate lawful operation, effective governance, and continuous compliance of the affiliation

and partnership agreements in NETH.

1447. They transform affiliations from informal arrangements into accountable, auditable, and quality-assured instruments of the education and health system.

(a) Approved and Registered Affiliation and Partnership Agreements

1448. Institutions must maintain copies of all affiliation and partnership agreements that have been formally approved and registered by the competent authorities.

1449. Approved and registered affiliation and partnership agreements constitute the legal basis for all training activities conducted under the affiliation and must reflect the approved scope, duration, conditions, and responsibilities of each party.

(b) Affiliation and Partnership Register

1450. Institutions are required to maintain a central, up-to-date register of all active, expired, suspended, or terminated affiliations and partnerships.

1451. The register records key details such as partner identity, purpose, training sites, learner numbers, duration, approval status, and conditions.

1452. Affiliation and partnership registers enable traceability, oversight, and coordination at both institutional and regulatory levels.

(c) Periodic Performance and Compliance Reports

1453. Institutions must submit periodic reports detailing the operation and performance of each affiliation. These reports typically cover learner placements and numbers, supervision adequacy, training outcomes, incidents, quality assurance findings, and compliance status.

1454. Periodic performance and compliance reporting enables continuous monitoring and early identification of risk.

(d) Quality Assurance and Supervision Records

1455. Documentation must be maintained on supervision arrangements, assessor qualifications, assessment outcomes, moderation activities, and feedback from learners and supervisors.

1456. These records demonstrate that academic standards and clinical supervision requirements are being met consistently across affiliated sites.

(e) Incident, Risk, and Corrective Action Records

1457. Institutions must document all material incidents, identified risks, and corrective actions related to affiliated training activities.

1458. This includes safety incidents, ethical breaches, service delivery disruptions, and regulatory findings, together with evidence of investigation, mitigation, and closure.

(f) Learner Protection and Progression Records

1459. Records must be maintained to show learner placement, attendance, progression, completion, transfers, or teach-out arrangements where applicable.

1460. Records are essential for safeguarding learner rights and ensuring continuity of training.

1461. Collectively, the mandatory outputs and records provide regulators with reliable evidence, support institutional accountability, and protect learners and patients.

1462. They ensure that affiliation and partnership agreements operate transparently, responsibly, and in full alignment with the standards governing NETH.

G20.4.13 Conclusion: Affiliations as System-Building Instruments

1463. Affiliation and partnership agreements are not peripheral administrative arrangements; they are core system-building instruments within NETH.

1464. When properly designed, approved, and governed, affiliations create the functional linkages that integrate education, training, regulation, and health service delivery into a coherent and responsive system.

1465. Through regulated affiliations, HTIs are able to align academic programmes with real service environments, expand training capacity in priority areas, and expose learners to the full spectrum of competencies required by the health system.

1466. There must be clear rules on approval, governance, quality assurance, and accountability ensure that collaboration does not fragment responsibility or dilute standards.

1467. Institutionalising affiliations as regulated instruments, shifts partnerships away from impromptu, personality-driven, or convenience-based arrangements towards predictable, transparent, and auditable relationships. This strengthens system planning, enables coordinated workforce development, and enhances credibility of qualifications awarded.

1468. Affiliations function as safeguards for the public interest. They ensure that learners are trained in safe, supervised, and quality-assured environments, that patients are protected, and that regulators retain clear lines of oversight and enforcement.

1469. Where affiliations fail to meet these expectations, the system provides clear mechanisms for correction, sanction, or termination. Thus, affiliations and partnerships are enablers of system resilience rather than sources of risk.

1470. Properly governed, they reinforce institutional accountability, promote coherence, and contribute directly to a sustainable, high-quality, and trustworthy Education and Training.

G21.0 INTERNSHIP, RESIDENCY, AND FELLOWSHIP TRAINING

G21.1 Purpose and Rationale

1471. Internship, residency, and fellowship training constitute the critical transition from pre-service education to independent professional practice in the health sector. Their governance is thus a matter of public interest, patient safety, and health system integrity.

1472. The purpose of regulating these training phases is to ensure that graduates acquire supervised, competency-based experience in approved service environments, under clearly defined academic, professional, and ethical standards.

1473. The regulatory rationale recognises that post-qualification training occurs at the interface of education and service delivery. Without clear governance, this interface is prone to fragmentation, exploitation of trainees as labour, unsafe clinical practice, and inconsistent professional outcomes.

1474. Governance frameworks therefore exist to protect learners, patients, training institutions, and the health system by ensuring that training is structured, supervised, assessed, and aligned with national workforce needs.

G21.2 Scope and Definitions

1475. The governance framework applies to all internship, residency, and fellowship programmes conducted under the Education and Training for Health system.

(i) Internship training refers to a mandatory, time-bound period of supervised practice following completion of an accredited pre-service qualification, required for full professional registration.

(ii) Residency training refers to structured postgraduate specialist training combining advanced academic instruction with supervised clinical practice, leading to specialist recognition.

(iii) Fellowship training refers to advanced post-specialisation training in highly specialised or sub-specialised areas, typically undertaken in accredited centres of excellence.

1476. The governance framework applies across health professions as determined by policy and law and defines the continuum of professional formation from graduate to specialist and super-specialist.

G21.3 Core Governance Principles

1477. Governance of internship, residency, and fellowship training is anchored on the following principles:

(i) Patient and learner safety is paramount and overrides institutional or service convenience.

(ii) Accountability is non-transferable: each actor remains responsible within its mandate.

(iii) Training is competency-based, not time-served or labour-substituted.

(iv) Academic judgment and service delivery are distinct but coordinated functions.

(v) Equity, transparency, and merit govern admission, placement, and progression.

(vi) Alignment with national workforce priorities guides training scale and distribution.

1478. These principles apply uniformly across all training levels and sites.

G21.4 Multi-Level Governance Architecture

(a) National (Policy Level) Governance

1479. At national level, internship, residency, and fellowship training are governed through ministerial and inter-ministerial structures responsible for education, health, finance, and public service.

1480. These structures provide strategic direction, approve national training priorities and numbers, and ensure alignment with health workforce plans and fiscal frameworks.

1481. Policy-level governance ensures that training pipelines respond to population health needs, disease burden, and service delivery models, and that public resources are deployed in a coordinated and sustainable manner.

(b) National (Technical and Regulatory Level) Governance

1482. At technical and regulatory level, governance is exercised by the Ministries responsible for Education and Health, education and training regulators, and professional councils. These bodies are responsible for: (i) setting standards for training, supervision, and assessment; (ii) accrediting training programmes and sites; (iii) coordinating between education and service delivery systems; and (iv) monitoring compliance and performance.

1483. This level translates policy intent into enforceable standards and operational guidance.

(c) Sub-National Governance

1484. Sub-national governance is exercised through regions, local governments, and health authorities responsible for managing service delivery platforms where training occurs.

1485. Their role is to: (i) coordinate allocation of trainees to facilities; (ii) ensure supervision capacity and service-training balance; and (iii) operationalise national policies within local contexts.

1486. Sub-national governance ensures that training is feasible, equitable, and responsive to local health needs.

(d) Institutional Governance

1487. At institutional level, governance responsibilities are shared between Health Training Institutions and accredited training hospitals or facilities.

1488. Institutions are responsible for academic oversight, curriculum alignment, assessment, and certification, while training facilities are responsible for supervised clinical practice, patient safety, and ethical service delivery.

1489. Clear internal committees and coordinators must be designated to manage internship, residency, and fellowship training.

(e) Accreditation and Designation of Training Sites

1490. All internship centres, residency training hospitals, and fellowship centres must be formally designated and accredited by the competent authorities.

1491. Designation is based on defined criteria including service capacity, case mix, staffing, infrastructure, supervision competence, and ethical standards.

1492. Approvals are time-bound and subject to renewal, inspection, and performance review. No training may occur in undesignated or expired sites.

G21.5 Roles and Responsibilities of Key Actors

G21.5.1 Health Training Institutions

1493. HTIs are the primary academic custodians of internship, residency, and fellowship training.

Their role is to ensure that post-qualification training is academically sound, competency-based, quality-assured, and delivered in a manner that protects learners, patients, and the integrity of qualifications awarded. HTIs remain accountable for training outcomes irrespective of where supervised practice occurs.

(i) Academic Authority and Programme Ownership:

1494. HTIs retain full academic authority over internship, residency, and fellowship programmes within their mandate. This includes programme design, curriculum approval, learning outcomes, assessment frameworks, progression rules, and certification. Academic decisions must be exercised through lawful academic organs (e.g. Senates or Academic Boards) and insulated from undue administrative or service pressures.

(ii) Curriculum Design and Competency Alignment:

1495. HTIs are responsible for developing and maintaining curricula that are competency-based, aligned with professional council standards, national health priorities, and approved qualifications frameworks.

1496. Curricula must integrate supervised practice requirements, assessment modalities, and progression milestones appropriate to internship, residency, and fellowship levels.

(iii) Accreditation, Approval, and Compliance:

1497. HTIs must ensure that all internship, residency, and fellowship programmes and associated training arrangements are accredited and approved by the relevant education regulators and conducted in compliance with applicable laws, policies, and standards.

1498. HTIs must not commence, expand, or modify programmes without requisite approvals.

(iv) Training Site Selection and Affiliation Management:

1499. Where training is delivered in service settings, HTIs are responsible for identifying suitable training sites and entering into approved affiliation or partnership agreements. They must verify that sites meet required standards for supervision, case mix, infrastructure, safety, and ethics, and ensure that affiliations are documented, approved, registered, and periodically reviewed.

(v) Supervision Standards and Academic Oversight:

1500. HTIs must ensure that trainees are supervised by qualified, appropriately registered supervisors who are oriented to academic requirements. While day-to-day clinical supervision may be provided by training facilities, HTIs retain responsibility for academic oversight, including supervision standards, learning plans, and assessment integrity.

(vi) Assessment, Progression, and Certification:

1501. HTIs design and administer assessment systems for internship, residency, and fellowship training, including workplace-based assessments, logbooks, examinations, and moderation processes. They determine progression, remediation, completion, and certification in accordance with approved standards and in coordination with professional councils.

(vii) Learner Welfare, Ethics, and Protection:

1502. HTIs must safeguard trainee welfare, rights, and ethical treatment throughout training. This

includes grievance and appeals mechanisms, protection from exploitation or unsafe practice, and support for remediation or transfer where training environments become unsuitable. Learner protection obligations persist even where training occurs off-campus.

(viii) Quality Assurance and Continuous Improvement:

1503. HTIs are required to embed internship, residency, and fellowship training within their internal quality assurance systems. This includes routine monitoring, feedback collection, academic review, and corrective action. Training outcomes and risks must be analysed to drive continuous improvement.

(ix) Data Management, Reporting, and Accountability:

1504. HTIs must maintain accurate records of trainees, supervisors, placements, assessments, progression, and completion. They are responsible for timely submission of academic and compliance reports to regulators and for cooperating fully with inspections, audits, and reviews.

(x) Coordination with Ministries and Professional Councils:

1505. HTIs work in close coordination with MoH, MoES, education regulators, and Professional Councils to ensure coherent governance. They participate in national and technical coordination mechanisms, align training numbers with approved capacity, and implement directives arising from joint oversight.

(xi) Compliance and Risk Management:

1506. HTIs must identify and manage academic, clinical, financial, and reputational risks associated with post-qualification training. Where deficiencies are identified—whether internally or by regulators—HTIs are responsible for implementing corrective actions promptly and transparently.

1507. HTIs are the academic backbone of internship, residency, and fellowship training. By exercising academic authority, assuring quality, managing affiliations, protecting learners, and coordinating with service and regulatory actors, HTIs ensure that advanced health training produces competent, ethical, and system-ready professionals.

G21.5.2 Training Hospitals and Facilities

1508. Training hospitals and health facilities are the primary service-delivery environments in which internship, residency, and fellowship training are operationalised. Their role is to provide safe, supervised, and ethically governed clinical settings that enable trainees to acquire practical competencies while contributing to health service delivery.

1509. In doing so, training hospitals and facilities function as integral partners within the NETH system, operating under defined accountability and regulatory oversight.

(i) Provision of Accredited Training Environments

1510. Training hospitals and facilities are responsible for maintaining service environments that meet the standards required for designation as internship, residency, or fellowship training sites. This includes adequate case mix, service volume, infrastructure, equipment, and learning resources appropriate to the level and scope of training.

1511. Facilities must operate strictly within the limits of their approved designation, including learner numbers and training scope.

(ii) Clinical Supervision and Mentorship:

1512. Training hospitals and facilities must provide qualified, registered, and experienced supervisors, preceptors, or consultants to oversee trainees.

1513. Supervisors are responsible for day-to-day clinical guidance, mentorship, and formative assessment, ensuring that trainees practise within approved scopes and progressively acquire competence.

1514. Supervision ratios and availability must meet prescribed standards at all times.

(iii) Patient Safety, Ethics, and Clinical Governance:

1515. Patient safety and ethical practice are paramount. Training hospitals and facilities must ensure that trainees are integrated into clinical teams in a manner that safeguards patients, respects informed consent, protects confidentiality, and complies with national clinical governance standards.

1516. Facilities must enforce infection prevention and control measures, ethical codes, and professional conduct requirements applicable to trainees and supervisors alike.

(iv) Service–Training Balance:

1517. Training hospitals and facilities must maintain an appropriate balance between service delivery and training. Trainees must not be used as substitutes for employed staff or deployed beyond their competence for service convenience.

1518. Clinical exposure must be structured as a learning experience, with clear learning objectives, supervision, and feedback, rather than as unsupervised labour.

(v) Participation in Assessment and Feedback:

1519. Facilities support assessment processes by facilitating workplace-based assessments, maintaining supervision records and logbooks, and providing structured feedback on trainee performance.

1520. While academic authority rests with HTIs, the clinical judgments and documented inputs of training hospitals and facilities are essential to fair and valid assessment.

(vi) Compliance with Affiliation and Training Agreements:

1521. Training hospitals and facilities must comply fully with the terms of approved affiliation or partnership agreements entered into with HTIs.

1522. Compliance with affiliation and training agreements includes adherence to agreed roles, reporting requirements, quality assurance processes, and corrective actions. Informal or undocumented training arrangements are prohibited.

(vii) Reporting, Data, and Record-Keeping:

1523. Facilities are responsible for maintaining accurate records of trainee placement, attendance, supervision, incidents, and completion of rotations. They must submit required reports to HTIs and relevant authorities and cooperate with inspections, audits, and monitoring activities.

(viii) Incident Reporting and Risk Management:

1524. Training hospitals and facilities must operate functional systems for reporting and managing clinical incidents, ethical breaches, or safety concerns involving trainees. Such incidents must be investigated promptly, reported through prescribed channels, and addressed through corrective and preventive actions, in coordination with training institutions and regulators.

(ix) Cooperation with Oversight and Enforcement:

1525. Facilities must cooperate fully with oversight by MoES, MoH, education regulators, and Professional Councils. Where deficiencies are identified, facilities are required to implement corrective actions within specified timelines. Persistent non-compliance may result in suspension or withdrawal of training site designation.

(x) Learner Protection and Continuity of Training:

1526. In situations where a facility can no longer safely or lawfully host trainees, it must cooperate in implementing learner protection measures, including supervised continuation, transfer to alternative accredited sites, or teach-out arrangements, ensuring minimal disruption to training progression.

1527. Training Hospitals and Facilities are the clinical backbone of internship, residency, and fellowship training. By providing safe service environments, qualified supervision, ethical governance, and disciplined cooperation with academic and regulatory partners, they ensure that post-qualification health training is effective, accountable, and firmly anchored in the public interest.

G21.5.3 Professional Councils

1528. Professional Councils are the statutory custodians of professional standards, competence, ethics, and public protection for regulated health professions. Within internship, residency, and fellowship training, their role is pivotal in ensuring that post-qualification training produces practitioners who are competent, ethical, and fit to practise, while operating coherently within the broader education and health governance framework.

(i) Setting and Enforcing Professional Competency Standards

1529. Professional Councils define the competency standards, scopes of practice, and ethical requirements applicable at internship, residency, and fellowship levels. These standards inform curricula, supervision expectations, assessment tools, and progression criteria, ensuring that training outcomes meet professional and public safety benchmarks.

(ii) Regulation of Registration, Licensure, and Progression:

1530. Councils regulate provisional and full registration, internship licences, specialist registration, and subspecialist recognition, as prescribed by law. They determine eligibility for entry into internship, approve completion of internship for full licensure, and recognise successful completion of residency and fellowship training for specialist and super specialist status.

(iii) Approval and Oversight of Supervision Standards:

1531. Professional Councils prescribe minimum qualifications, experience, and registration status for supervisors, preceptors, and trainers involved in internship, residency, and fellowship programmes. They ensure that supervision is adequate, ethical, and aligned with approved scopes of practice, and may participate in verification of supervision capacity at designated

training sites.

(iv) Participation in Assessment and Certification Processes:

1532. Where provided for in law or policy, Professional Councils participate in or validate assessment processes, including workplace-based assessments, logbooks, exit evaluations, and examinations. This role ensures consistency, fairness, and credibility of decisions that confer professional recognition or advancement.

(v) Ethical Oversight and Professional Conduct:

1533. Councils enforce codes of professional ethics and conduct applicable to trainees and supervisors. They investigate complaints, address misconduct, and apply disciplinary measures where breaches occur during internship, residency, or fellowship training. This function is central to patient protection and maintenance of public trust.

(vi) Accreditation Input and Training Site Assurance:

1534. While primary designation of training sites may rest with sector ministries or education regulators, Professional Councils provide professional input into the suitability of sites for training, particularly regarding scope of practice exposure, supervision adequacy, and ethical practice environments.

(vii) Monitoring, Data, and Reporting:

1535. Professional Councils maintain registers of interns, residents, fellows, supervisors, and specialists, and require periodic reporting on training progress and completion. These records support workforce planning, regulatory oversight, and coordination with ministries and education regulators.

(viii) Coordination with Education and Health Authorities:

1536. Councils work in close coordination with the MoES, MoH, Education and TVET regulators to ensure harmonised governance across education, training, service delivery, and professional regulation. They participate in joint committees, inspections, and technical forums where mandates intersect.

(ix) Enforcement and Learner Protection:

1537. Where serious deficiencies are identified, such as unsafe practice, inadequate supervision, or misrepresentation of training, Professional Councils may impose professional sanctions, restrict practice, or withhold recognition of training outcomes.

1538. In doing so, they coordinate with other authorities to ensure learner protection through remediation, transfer, or supervised continuation.

(x) Transition and Standards Harmonisation:

1539. Professional Councils support the orderly transition of legacy internship, residency, and fellowship arrangements to updated standards, harmonising professional rules with evolving education and health sector policies while safeguarding the validity of training outcomes.

1540. Professional Councils serve as the professional integrity anchor for internship, residency, and fellowship training. By setting standards, regulating progression, enforcing ethics, and coordinating with education and health authorities, they ensure that advanced health training

results in practitioners who are competent, accountable, and worthy of public trust.

G21.5.4 Ministry of Health (MoH) shall:

1541. MoH is the lead Ministry responsible for stewarding the service-delivery dimension of internship, residency, and fellowship training.

1542. Its mandate ensures that post-qualification training is clinically relevant, safely delivered, ethically grounded, and aligned with national health system priorities, while remaining integrated with education-sector governance and professional regulation.

(i) National Stewardship and Workforce Alignment

1543. MoH provides strategic leadership to ensure that internship, residency, and fellowship training outputs align with national health priorities, disease burden, service delivery models, and health workforce plans. It determines priority cadres and specialties, advises on national training numbers, and ensures equitable distribution of training opportunities across regions and levels of care.

(ii) Designation and Oversight of Training Sites

1544. MoH leads the designation, approval, and periodic review of training hospitals, district health facilities, and specialised centres used for internship, residency, and fellowship training. This includes verifying service capacity, case mix, infrastructure, supervision capability, infection prevention and control, and patient safety systems. Designations are time-bound and subject to inspection, renewal, or withdrawal where standards are not maintained.

(iii) Clinical Governance, Patient Safety, and Ethics

1545. MoH ensures that all training conducted within service delivery settings adheres to national clinical governance standards. It enforces patient safety, ethical practice, and professional conduct, including supervision adequacy, defined scopes of practice for trainees, incident reporting, and management of adverse events. Patient protection is treated as paramount in all training arrangements.

(iv) Coordination of Placement and Allocation

1546. MoH coordinates national and sub-national placement and allocation mechanisms for interns, residents, and fellows in collaboration with education regulators and professional councils. It ensures transparent, merit-based allocation that reflects facility capacity and supervision availability, and it prohibits informal or self-placement arrangements.

(v) Supervision and Service–Training Balance

1547. MoH sets and enforces minimum supervision standards within health facilities, ensuring that trainees receive appropriate mentorship without being used as substitutes for employed staff. It monitors service–training balance to prevent exploitation of trainees as labour and to preserve the integrity of both service delivery and learning outcomes.

(vi) Financing and Employment Interface

1548. MoH advises on and administers, where applicable, financing arrangements related to internship, residency, and fellowship training within the health sector, including stipends or remuneration. It ensures that financial arrangements are transparent, sustainable, and compliant with public

finance rules, while maintaining the distinction between trainee status and employed health workers.

(vii) Monitoring, Data, and Reporting

1549. MoH maintains and utilises health-sector data on trainees, training sites, supervision capacity, and completion outcomes. It integrates this data into health workforce information systems to support planning, monitoring, and accountability, and requires regular reporting from designated training sites.

(viii) Inter-Ministerial and Inter-Regulatory Coordination

1550. MoH works jointly with MoES, education regulators, and professional councils to ensure coherent governance across education, training, and service delivery. It participates in joint inspections, issues harmonised guidance, and resolves boundary issues where mandates intersect.

(ix) Compliance, Enforcement, and Learner Protection

1551. Where non-compliance, unsafe practice, or sustainability risks are identified within training sites, MoH initiates or supports enforcement actions, including enrolment caps, suspension of site designation, or withdrawal of approval.

1552. All enforcement actions are accompanied by learner protection measures, such as supervised continuation, transfer, or teach-out arrangements.

(x) Transition and System Strengthening

1553. MoH oversees the transition of legacy internship, residency, and fellowship arrangements to updated standards, ensuring continuity of training while strengthening system coherence, quality, and public trust.

1554. MoH anchors internship, residency, and fellowship training within the health service delivery system. It ensures clinical relevance, patient safety, ethical practice, and workforce alignment—while coordinating education sector actors and professional councils to deliver a coherent, quality-assured continuum of professional formation.

G21.5.5 Ministry of Education and Sports (MoES) shall:

(a) Policy Stewardship and System Coherence

1555. MoES provides overarching education policy stewardship for post-qualification health training, ensuring alignment with national education policies, qualifications frameworks, and cross-subsector standards. It coordinates with the MoH and other MDAs to maintain coherence between pre-service education, supervised practice, and advanced training.

(b) Oversight of Academic Governance and Quality Assurance:

1556. MoES ensures that the academic components of residency and fellowship programmes are governed through lawful academic organs (e.g., Senates/Academic Boards) and embedded within institutional quality assurance systems. It supports and enforces standards for curriculum approval, assessment integrity, moderation, progression, and awards, thereby protecting academic credibility.

(c) Regulation through Statutory Education Agencies:

1557. Through its statutory agencies (including higher education and TVET regulators, as applicable), MoES: (a) accredits institutions and programmes that host or award residency and fellowship training; (b) assures compliance with institutional requirements (governance, staffing, infrastructure, QA); and (c) participates in inspections and audits where academic risk or institutional fitness is implicated.

(d) Qualifications Framework Alignment and Recognition:

1558. MoES ensures that internship, residency, and fellowship learning outcomes align with the national qualifications framework and relevant descriptors. This guarantees clarity of level, portability, recognition, and progression across education and professional systems, including articulation between TVET and higher education pathways where relevant.

(e) Institutional Capacity and Sustainability Assurance:

1559. MoES verifies that institutions involved in advanced health training possess sustainable academic capacity—qualified faculty, learning resources, research support (for residencies / fellowships), and stable governance—so that training quality is not compromised by institutional weakness.

(f) Data, Reporting, and Public Accountability:

1560. MoES requires timely submission of academic and compliance reports from institutions, maintains education-sector records relevant to advanced training, and supports integrated data systems that inform national planning, transparency, and accountability.

(g) Inter-Ministerial Coordination and Boundary Clarity:

1561. MoES co-leads (with Health) boundary management between education regulation and service delivery governance. It issues joint guidance where mandates intersect, prevents regulatory overlap or gaps, and ensures that affiliations and training arrangements do not bypass education standards.

(h) Compliance, Enforcement, and Learner Protection:

1562. Where academic non-compliance or institutional unfitness is identified, MoES supports proportionate enforcement, conditional approvals, enrolment controls, suspension of academic authority, or withdrawal of programme approval, while ensuring learner protection through teach-out or transfer arrangements.

(i) Transition and Harmonisation:

1563. MoES oversees the orderly transition of legacy training arrangements to current standards, harmonising education laws, regulations, and policies with health sector requirements and professional council rules.

1564. MoES anchors internship, residency, and fellowship training within Uganda's education governance architecture. It protects academic standards, ensures institutional fitness, enables qualifications recognition, and coordinates with the health sector actors to deliver a coherent, quality-assured continuum of professional formation.

1565. Admission, placement, and allocation mechanisms are the operational instruments through which equity, quality, workforce relevance, and patient safety are realised in internship, residency, and fellowship training.

1566. Because these training phases occur at the interface of education and service delivery, their governance must be transparent, merit-based, centrally coordinated, and capacity-constrained.

1567. Informal, discretionary, or market-driven approaches are incompatible with public interest training.

G22.1 Purpose and Governance Logic:

1568. The primary purpose of regulated admission and allocation mechanisms is to ensure that: (i) trainees enter programmes based on merit and eligibility; (ii) placements reflect accredited capacity and supervision availability; and (iii) national and sub-national health workforce priorities are met.

1569. These mechanisms prevent congestion at training sites, protect patient safety, reduce inequities, and avoid the exploitation of trainees as labour. They also enable system-wide planning and accountability.

G22.2 Eligibility and Admission Criteria:

1570. Internship admission is limited to graduates who have successfully completed an accredited pre-service programme and meet professional council requirements for provisional registration.

(a) Residency admission requires completion of internship, full professional registration, and satisfaction of programme-specific academic and professional criteria.

(b) Fellowship admission is restricted to recognised specialists who meet subspecialty entry requirements and demonstrate readiness for advanced training.

1571. Eligibility criteria must be publicly stated, consistently applied, and verified prior to placement. Discretionary waivers outside approved rules are prohibited.

G22.3 Centralised and Coordinated Placement Systems

1572. Placements for internship, residency, and fellowship training are coordinated through nationally approved systems led by MoH, in collaboration with MoES, education regulators, and Professional Councils.

1573. Central coordination ensures: (i) alignment with designated training site capacity; (ii) equitable regional distribution; (iii) avoidance of duplication or over-allocation; and (iv) traceability and auditability of decisions.

1574. Self-placement, informal negotiations, or unilateral institutional admissions outside the coordinated system are not permitted.

G22.4 Capacity-Based Allocation

1575. Allocations are strictly constrained by: (i) accredited training site designation; (ii) supervisor availability and ratios; (iii) service case mix and volume; and (iv) infrastructure and safety limits.

1576. Training numbers are approved annually and reviewed periodically. Where capacity changes, allocations must be adjusted accordingly. Over-allocation constitutes a safety and compliance breach.

G22.5 Merit, Equity, and Workforce Considerations

1577. Allocation decisions are informed by a combination of merit-based ranking and workforce planning considerations, including: (i) national and regional staffing gaps; (ii) priority specialties and cadres; (iii) equitable access across gender and regions; and (iv) service delivery needs at different levels of care. This approach balances individual opportunity with system needs, ensuring fair access while strengthening workforce distribution.

G22.6 Placement Duration, Rotation, and Mobility

1578. Placements specify duration, rotation schedules, and approved learning objectives. Mobility between sites is permitted only where formally approved and documented to ensure continuity of supervision and assessment.

1579. Unauthorised movement between facilities undermines governance and is non-compliant.

G22.7 Transparency, Notification, and Acceptance

1580. Placement outcomes must be formally communicated to the trainees and host facilities, with clear start dates, expectations, and reporting lines.

1581. Trainees must formally accept placements and comply with reporting the requirements. Failure to report without proper authorisation may result in forfeiture or deferral.

G22.8 Data Management and Registers

1582. All admissions and placements must be recorded in national and institutional registers, linked to professional council databases and health workforce information systems. Accurate data supports monitoring, evaluation, and long-term planning.

G22.9 Appeals, Deferrals, and Exceptional Circumstances

1583. Structured mechanisms must exist for appeals, deferrals, or re-allocation in clearly defined exceptional circumstances (e.g., health, maternity, national service needs). Such decisions must be documented, time-bound, and authorised by the competent body to preserve fairness and integrity.

G22.10 Compliance and Enforcement:

1584. Non-compliance with admission and placement rules such as unauthorised admissions, informal placements, or capacity breaches, triggers enforcement action. Measures may include nullification of placements, sanctions against institutions or facilities, and non-recognition of training periods by Professional Councils.

1585. Admission, placement, and allocation mechanisms are not administrative conveniences; they

are core governance tools. When centrally coordinated, capacity-based, and transparent, they protect learners and patients, support workforce planning, and ensure that internship, residency, and fellowship training function as an integrated, equitable, and accountable component of Education and Training for Health.

G23.0 SUPERVISION, ASSESSMENT, AND PROGRESSION

1586. Supervision, assessment, and progression constitute the core quality-control mechanisms that ensure internship, residency, and fellowship training produce competent, ethical, and safe health professionals.

1587. Because these training phases occur in live service environments, governance in this area must be explicit, competency-based, and enforceable.

1588. Weakness in supervision or assessment directly translates into patient risk and professional failure.

G23.1 Purpose and Governance Logic

1589. The governance of supervision, assessment, and progression serves four interrelated objectives: (i) to protect patients and learners by ensuring trainees practise only within demonstrated competence; (ii) to guarantee that training outcomes meet academic and professional standards; (iii) to ensure fair, transparent, and defensible progression decisions; and (iv) to align post-qualification training with national professional and workforce requirements.

1590. Accordingly, supervision and assessment are treated as regulatory obligations rather than discretionary pedagogical practices.

G23.2. Supervision Framework:

G23.2.1 Supervision as a Mandatory Requirement:

1591. All internship, residency, and fellowship training must occur under continuous, qualified supervision.

1592. No trainee may practise independently or beyond their approved scope of practice. Supervision is a condition of patient safety and a prerequisite for recognition of training.

G23.2.2 Supervisor Qualifications and Approval

1593. Supervisors must: (i) be fully registered and in good standing with the relevant Professional Council; (ii) possess appropriate experience and, where applicable, specialist or subspecialist status; (iii) be formally designated by the training hospital or facility; and (iv) be oriented to the academic requirements of the training programme.

1594. Supervisor eligibility and ratios are prescribed by cadre and training level and are subject to inspection.

G23.2.3 Levels and Intensity of Supervision:

1595. Supervision intensity varies by training stage: (i) Internship requires close, direct, and continuous supervision. (ii) Residency allows graduated responsibility under defined limits. (iii) Fellowship

involves advanced mentorship with high-level oversight.

1596. Progressive autonomy is permitted only upon demonstrated competence and documented approval.

G23.2.4 Supervisor Responsibilities:

1597. Training must be conducted under qualified supervisors with defined responsibilities. Supervisors are responsible for: (i) direct clinical oversight and mentorship; (ii) verification of competencies and procedures performed; (iii) formative feedback and remediation; (iv) maintenance of supervision logs and assessments; and (v) immediate intervention where patient safety is at risk.

1598. Failure to supervise adequately constitutes professional misconduct.

G23.3 Assessment Framework

G23.3.1 Competency-Based Assessment:

1599. Assessment must be competency-based and aligned with the: (i) Approved curricula; (ii) professional council standards; and (iii) the national qualifications descriptors. The assessment frameworks must be competency-based, standardised, and moderated. Progression depends on demonstrated competence, not mere time completion.

1600. Time served on internship, residency, and fellowship training without demonstrated competence is insufficient for progression.

G23.3.2 Assessment Tools and Methods

1601. Assessment methods may include: (i) Workplace-based assessments (WBAs); (ii) procedure logs and portfolios; (iii) structured clinical evaluations; (iv) written, oral, or practical examinations; and (v) multisource feedback.

1602. Assessment tools must be standardised, documented, and periodically reviewed.

G23.3.3 Moderation and Academic Oversight

1603. Health Training Institutions retain academic authority over assessment. Moderation processes must be in place to ensure fairness, consistency, and validity across sites and supervisors. Assessment decisions must be defensible and auditable.

G23.3.4 Role of the Professional Councils:

1604. Where prescribed, Professional Councils validate assessment outcomes, approve internship completion, and recognise specialist or subspecialist status. Their involvement ensures alignment with professional standards and public protection.

G24.1 Progression Criteria

1605. Progression from one stage to the next is based on: (i) demonstrated competence; (ii) satisfactory professional conduct; (iii) completion of required rotations; and (iv) compliance with assessment requirements. Automatic progression is prohibited.

G24.2 Remediation and Support

1606. Trainees who fail to meet progression requirements must be offered structured remediation, including targeted supervision, additional training, or extended rotations. Remediation plans must be documented, time-bound, and reviewed.

G24.3 Appeals and Due Process

1607. Clear and fair appeals mechanisms must exist and be available for the assessment and progression decisions, remediation, appeals, and academic review.

1608. Appeals are considered through academic governance structures, with procedural fairness and documentation.

G24.4 Completion and Certification:

1609. Completion of internship, residency, or fellowship requires formal certification by the HTI and, where applicable, confirmation by the Professional Council.

1610. Certification attests to competence, ethical conduct, and readiness for independent or advanced practice.

G24.5 Documentation and Records

1611. Institutions and training sites must maintain comprehensive records, including: (i) Supervisor approvals and logs; (ii) assessment results and moderation records; (iii) progression and remediation decisions; and (iv) completion and certification documents.

1612. Incomplete or falsified records invalidate training periods.

G24.6 Compliance, Risk Management, and Enforcement

1613. Failure to meet supervision or assessment standards triggers enforcement action, including: (i) Restriction of trainee scope of practice; (ii) suspension of training site designation; (iii) non-recognition of training periods; or (iv) professional disciplinary action against supervisors.

1614. Regulators and Professional Councils intervene where patient safety or academic integrity is compromised.

G24.7 System Outcomes

1615. Effective governance of supervision, assessment, and progression ensures that: (i) trainees advance only when competent; (ii) patients are protected from unsafe practice; (iii) qualifications retain credibility; and (iv) the health system gains professionals' fit for purpose status.

1616. Supervision, assessment, and progression are the backbone of internship, residency, and fellowship training. When rigorously governed, they transform service-based learning into a disciplined, ethical, and quality-assured pathway of professional formation under Education and Training for Health.

G25.0 FINANCING AND EMPLOYMENT STATUS

1617. Financing and employment status arrangements for internship, residency, and fellowship training are critical governance dimensions that determine sustainability, equity, trainee welfare, and the integrity of post-qualification training.

1618. Because these training phases occur within service delivery settings while remaining educational in purpose, their financing and employment treatment must be clearly defined, transparent, and legally compliant.

G25.1. Purpose and Governance Logic

1619. The governance of financing and employment status serves four core objectives: (i) to protect trainees from exploitation or financial insecurity; (ii) to preserve the educational character of training distinct from routine service employment; (iii) to ensure lawful, transparent, and sustainable use of public and institutional resources; and (iv) to support national health workforce planning and retention.

1620. Ambiguity in financing or employment status undermines training quality, distorts service delivery incentives, and exposes institutions to legal and fiscal risk.

G25.2 Trainee Status: Education First, Service Second

1621. Interns, residents, and fellows are trainees, not substitute employees. Their primary relationship to the system is educational and professional formation, even though training occurs in service environments and contributes to service delivery.

(a) Interns are provisionally registered trainees completing mandatory supervised practice.

(b) Residents are postgraduate trainees undergoing structured specialist training.

(c) Fellows are advanced trainees undertaking subspecialist development.

1622. Any service contribution by trainees must be supervised, proportionate to competence, and framed as part of learning objectives—not as independent service labour.

G25.3 Employment Relationships and Legal Treatment

1623. Employment Status: The employment status of trainees must be explicitly defined by policy and applicable law. Possible arrangements include: (i) stipend-based training appointments; (ii) fixed-term training contracts; or (iii) public service training placements.

1624. Legal Treatment: Regardless of the model adopted, trainees must not be treated as permanent staff, and their terms must reflect their training status, supervision requirements, and limited scope of practice.

G25.4 Clarity of Authority and Responsibility

1625. Contracts or appointment letters must clearly state:

(a) training objectives and duration;

(b) supervision and assessment arrangements;

(c) remuneration or stipend terms;

(d) leave, insurance, and welfare provisions where applicable; and

(e) disciplinary and grievance procedures.

1626. Informal or undocumented arrangements are prohibited.

G26.0. FINANCING MODELS

G26.1 Public Financing

1627. Where funded through public resources, financing for internship, residency, and fellowship training must be aligned with approved budgets and workforce plans.

1628. Public financing may support: (i) trainee stipends or salaries; (ii) training site costs related to supervision and infrastructure; and (iii) programme administration and quality assurance.

1629. Public funds must be used strictly for approved purposes and in compliance with public finance laws.

G26.2 Institutional and Partner Contributions

1630. Universities, training hospitals, and affiliated partners may contribute resources in accordance with approved agreements.

1631. Such contributions must be transparent, documented, and subject to audit to prevent cost-shifting, double-charging, or conflicts of interest.

G26.3 Prohibited Financing Practices

1632. The following practices are non-compliant: (i) charging trainees for mandatory training placements; (ii) requiring payment to secure placement or supervision; (iii) using trainee labour to offset staffing costs without supervision; or (iv) commercialising training slots.

G26.4 Remuneration, Stipends, and Welfare

G26.4.1 Remuneration Principles

1633. Where stipends or remuneration are provided, they must: (i) be predictable and timely; (ii) reflect trainee status rather than independent practice; (iii) comply with applicable labour and public service rules; and (iv) be sufficient to support basic welfare and safe participation in training.

G26.4.2 Welfare and Protection

1634. Financing arrangements must support trainee welfare, including: (i) occupational safety and health coverage; (ii) professional indemnity or insurance where applicable; (iii) access to leave and reasonable working hours; and (iv) protection from financial penalties linked to training outcomes.

G26.5 Distinction Between Training and Service Labour

1635. A clear firewall must exist between training and routine service employment. Indicators of non-compliance include: (i) unsupervised clinical duties; (ii) excessive workloads unrelated to learning objectives; (iii) substitution for absent staff; or (iv) performance evaluation based solely on service output.

1636. Such practices undermine patient safety and invalidate training outcomes.

G26.6 Accountability, Reporting, and Audit

1637. All financing and employment arrangements must be documented, reported, and auditable. Institutions and training sites must maintain records of: (i) funding sources and expenditures; (ii) trainee contracts or appointment letters; (iii) stipend or salary payments; and (iv) welfare and insurance coverage.

1638. Failure to account for funds or misclassification of trainees shall trigger enforcement action.

G26.7 Risk Management and Sustainability

1639. Financing models must be sustainable and aligned with training capacity. Over-expansion of trainee numbers without secured financing creates systemic risk, disrupts training quality, and exposes trainees to hardship.

1640. Risk assessments must consider: (i) funding continuity; (ii) inflation and cost pressures; (iii) supervision capacity; and (iv) contingency planning for funding interruptions.

G26.8 Compliance and Enforcement

1641. Non-compliance in financing or employment status may result in: (i) suspension of training placements; (ii) enrolment caps; (iii) withdrawal of training site designation; (iv) non-recognition of training periods; or (v) referral to audit and investigative authorities.

1642. Enforcement actions must prioritise trainee protection and system integrity.

G26.9 System Outcomes

1643. Properly governed financing and employment arrangements ensure that: (i) trainees are supported and protected; (ii) training remains educational in purpose; (iii) public resources are safeguarded; and (iv) the health system develops competent professionals sustainably.

1644. Financing and employment status are not administrative afterthoughts but central pillars of governance in internship, residency, and fellowship training. Clear, lawful, and transparent arrangements preserve the integrity of Education and Training for Health while protecting trainees, patients, and the public interest.

1645. Quality assurance (QA) and risk management are the central governance mechanisms through which internship, residency, and fellowship training are rendered safe, credible, and fit for purpose.

1646. Given that these training phases occur within live clinical environments and directly affect patient outcomes, quality assurance and risk management are treated as mandatory, system-wide obligations rather than discretionary institutional practices.

G27.1 Purpose and Governance Logic

1647. The governance of quality assurance and risk management serves four interdependent objectives:

(a) to protect patients and trainees from unsafe practice;
(b) to ensure that training outcomes meet academic and professional standards;
(c) to detect and correct failures before harm occurs; and
(d) to preserve public trust in health professional training and certification.

1648. Without robust quality assurance and risk management, post-qualification training becomes variable, unsafe, and legally indefensible.

G27.2 Integrated Quality Assurance Framework

G27.2.1 Quality Assurance Across the Training Continuum:

1649. Quality Assurance applies continuously across internship, residency, and fellowship training and covers: (i) curriculum alignment and learning outcomes; (ii) supervision quality and adequacy; (iii) assessment validity and moderation; (iv) training environment suitability; and (v) trainee welfare and ethical safeguards.

1650. Quality assurance frameworks must be aligned with institutional academic governance systems and professional council standards.

G27.2.2 Institutional Quality Assurance Responsibilities

1651. Health Training Institutions are responsible for embedding internship, residency, and fellowship training within their internal Quality Assurance systems. This includes routine monitoring, structured feedback, periodic academic review, and formal reporting to regulators.

G27.2.3 Training Site Quality Assurance

1652. Training hospitals and facilities must maintain service-level quality assurance systems that interface with academic quality assurance processes. Clinical governance, morbidity and mortality reviews, and supervision audits are integral to training quality.

G27.3 Risk Identification and Classification:

1653. Institutions and training sites must systematically identify and classify risks associated with post-qualification training, including:

(a) Clinical risks: unsafe procedures, inadequate supervision, patient harm.

(b) Academic risks: compromised assessment integrity, inconsistent standards.

(c) Operational risks: overcrowding, infrastructure failure, staff shortages.

(d) Ethical and welfare risks: exploitation, harassment, burnout.

(e) Financial risks: funding interruptions, mismanagement affecting continuity and reputational and legal risks: litigation, loss of public confidence.

1654. Risk identification must be proactive, documented, and regularly updated. Institutions and facilities must identify and manage academic, clinical, ethical, and safety risks.

G27.4 Risk Mitigation and Control Measures

1655. For each identified risk, institutions must implement proportionate mitigation measures, such as: (i) defined supervision ratios and scopes of practice; (ii) caps on trainee numbers based on capacity; (iii) standardised assessment tools and moderation; (iv) duty hour limits and welfare protections; (v) incident reporting and escalation protocols; and (vi) contingency and business continuity plans.

1656. Mitigation measures must be operationalised and monitored, not merely documented.

G27.5 Incident Reporting and Management

1657. Mandatory Reporting: All adverse events, near-misses, ethical breaches, or safety concerns involving trainees must be reported through established clinical governance and academic structures and channels.

1658. Investigation and Corrective Action: Reported incidents must be investigated promptly, with findings documented and corrective actions implemented. Where incidents indicate systemic failure, broader institutional or regulatory intervention is required.

1659. Protection from Retaliation: Trainees and supervisors who report concerns in good faith must be protected from retaliation. Whistle-blower protections are integral to effective risk management.

G27.6 Monitoring, Review, and Continuous Improvement

1660. Quality Assurance and risk management systems must include: (i) regular audits of training sites and supervision quality; (ii) analysis of assessment outcomes and progression data; (iii) trainee and supervisor feedback mechanisms; and (iv) periodic review of risk registers and mitigation plans.

1661. Findings must inform continuous improvement and policy adjustment.

G27.7 Regulatory Oversight and External Assurance

1662. Education regulators, health authorities, and Professional Councils conduct inspections, audits, and reviews to verify institutional Quality Assurance and risk management.

1663. Institutions must cooperate fully and provide access to records, sites, and personnel.

1664. External assurance validates internal Quality Assurance systems and provides an independent safeguard for the public interest.

G27.8 Enforcement and Escalation

1665. Where Quality Assurance or risk management failures are identified, enforcement actions may include: (i) restrictions on trainee numbers or scope of practice; (ii) suspension of training site designation; (iii) non-recognition of training periods; (iv) mandated corrective action plans; or (v) withdrawal of programme approval.

1666. Escalation is guided by risk severity and persistence, with patient and learner protection as the overriding consideration.

G27.9 System Outcomes

1667. Effective Quality Assurance and risk management ensure that: (i) trainees develop competence progressively and safely; (ii) patients receive care from appropriately supervised practitioners; (iii) training standards are consistent nationwide; and (iv) the health system retains public confidence.

1668. Quality assurance and risk management are the safety net and control system of internship, residency, and fellowship training. When rigorously implemented and enforced, they transform service-based learning into a disciplined, ethical, and accountable continuum of professional formation under Education and Training for Health.

1669. Quality assurance systems must cover all training phases and sites. Incident reporting, investigation, and corrective action are mandatory.

G28.0. DATA, REPORTING, AND ACCOUNTABILITY

1670. Data, reporting, and accountability constitute the transparency and control mechanisms through which internship, residency, and fellowship training are planned, monitored, and regulated in the public interest.

1671. Because these training phases involve public resources, patient safety, and professional certification, robust information systems and clear accountability are indispensable to effective governance.

G28.1 Purpose and Governance Logic

1672. The governance of data, reporting, and accountability serves five core objectives: (i) to enable evidence-based planning of training numbers and capacity; (ii) to monitor training quality, safety, and outcomes in real time; (iii) to ensure compliance with legal, academic, and professional standards; (iv) to protect learners and patients through early detection of risk; and (v) to uphold public trust through transparency and answerability.

1673. Weak data systems or opaque reporting undermine oversight and expose the system to preventable harm.

G28.2. Data Domains and Coverage

1674. Institutions and authorities must collect and maintain accurate data across the full training lifecycle, including:

(a) Trainee data: admissions, placements, demographics, registration status, progression, completion, deferrals, and attrition.

(b) Training site data: designation status, capacity, supervision ratios, case mix, and infrastructure.

(c) Supervision and assessment data: supervisor credentials, assessment outcomes, moderation records, and remediation actions.

(d) Quality and safety data: incidents, near-misses, ethical breaches, and corrective actions.

(e) Financing data: stipends, funding sources, expenditures, and continuity risks.

1675. Data must be disaggregated where necessary to support equity and workforce planning.

G28.3.0 Reporting Obligations

G28.3.1 Institutional Reporting

1676. Health Training Institutions and training sites are required to submit periodic academic and compliance reports to regulators and coordinating authorities.

1677. Reports must be accurate, complete, and timely and typically cover: (i) training numbers and placements; (ii) supervision adequacy; (iii) assessment outcomes and progression; (iv) incidents and risk management actions; and (v) compliance status and corrective measures.

G28.3.2 National and Inter-Agency Reporting

1678. National authorities must compile institutional data into consolidated reports to inform key policy decisions, workforce planning, and budgetary processes.

1679. Inter-agency data sharing ensures coherence between education, health, and professional regulation.

G28.3.3 Registers and Information Systems

1680. Mandatory registers must be maintained at institutional and national levels, including: (i) internship, residency, and fellowship registers; (ii) supervisor and training site registers; and (iii) completion and certification records.

1681. The registers must be integrated with professional council databases and health workforce information systems to ensure traceability and avoid duplication or misrepresentation.

G28.3.4 Accountability and lines of responsibility

1682. Accountability is established through defined reporting lines:(i) institutions are accountable for academic governance and data integrity; (ii) training facilities are accountable for service-level data and supervision records; (iii) professional councils are accountable for registration and certification data; and (iv) regulators are accountable for system oversight and enforcement.

1683. Accountability is collective but not diffuse: each actor remains answerable within its mandate.

G28.3.5 Audit, Verification, and Inspections

1684. Data and reports are subject to audit and verification through inspections, desk reviews, and

cross-checks.

1685. Regulators may verify records on-site and reconcile data across institutions and agencies.

1686. Misreporting, falsification, or obstruction constitutes serious non-compliance.

G28.3.6 Public Accountability and Transparency

1687. Where appropriate, aggregated information on training numbers, accredited sites, and compliance status may be made public to inform learners, employers, and the public.

1688. Transparency reinforces trust and deters malpractice while protecting personal and sensitive data.

G28.3.7 Risk management and Early Warning

1689. Robust data and reporting systems function as early warning mechanisms. Trends such as declining supervision ratios, high attrition, repeated incidents, or delayed completion trigger regulatory review and intervention before systemic failure occurs.

G28.3.8 Enforcement and Consequences of Non-Compliance

1690. Failure to submit required reports, maintain accurate data, or cooperate with audits triggers enforcement actions, including sanctions, public compliance notices, non-recognition of training periods, or withdrawal of approvals.

G28.3.9 System Outcomes

1691. Effective data, reporting, and accountability systems ensure that: (i) training capacity is planned realistically; (ii) quality and safety are monitored continuously; (iii) public resources are safeguarded; and (iv) professional formation is transparent and defensible.

1692. Data, reporting, and accountability are the nervous system of internship, residency, and fellowship governance. When properly designed and enforced, they enable NETH to operate as an evidence-driven, transparent, and accountable system that protects learners, patients, and the public interest.

1693. Institutions and training sites must submit regular reports on trainee numbers, progression, supervision, and incidents.

G29.0 COMPLIANCE, ENFORCEMENT, AND SANCTIONS

1694. Compliance, enforcement, and sanctions constitute the regulatory backbone that ensures internship, residency, and fellowship training are delivered lawfully, safely, and to the approved standards.

1695. Given the high public-interest stakes, patient safety, professional competence, and use of public resources, this framework operates on the principle that compliance is continuous, enforceable, and non-negotiable.

G29.1 Purpose and Governance Logic

1696. The compliance and enforcement framework serves five core objectives namely to:

(a) Protect patients and trainees from unsafe or unethical practice;

(b) Ensure training outcomes meet approved academic and professional standards;

(c) Uphold the integrity and credibility of professional certification;

(d) Deter regulatory avoidance, misrepresentation, and exploitation; and

(e) to preserve public trust in Education and Training for Health.

1697. Enforcement is not punitive by default; it is corrective where possible and protective where necessary.

G29.2 Compliance Obligations

G29.2.1 Institutional and Site-Level Compliance

1698. All actors involved in internship, residency, and fellowship training, including HTIs and designated training hospitals or facilities must comply with:
(a) approved programme and site designations;
(b) admission, placement, and allocation rules;
(c) supervision, assessment, and progression standards;
(d) quality assurance and risk management requirements;
(e) financing and employment-status provisions; and
(f) data, reporting, and audit obligations.

1699. Compliance applies throughout the training lifecycle and across all training sites, including affiliated and decentralised facilities.

G29.2.2 Individual Professional Compliance

1700. Supervisors, trainers, and trainees are required to comply with professional scopes of practice, ethical standards, and supervision conditions.

1701. Practising beyond approved scope or without adequate supervision constitutes non-compliance.

G29.3 Monitoring and Detection of Non-Compliance

1702. Non-compliance may be identified through:
(a) routine reporting and data analysis;
(b) inspections and audits (academic, clinical, or financial);
(c) incident and adverse event reporting;
(d) complaints from trainees, patients, or staff; and
(e) cross-agency verification of records.

1703. Failure to report, obstruction of oversight, or provision of misleading information is treated as a serious breach in its own right.

G29.4 Graduated Enforcement Approach

1704. Enforcement is applied in a graduated manner, proportionate to risk severity, persistence, and impact.

G29.4.1 Corrective Directives

1705. Where deficiencies are remediable, authorities may issue binding directives requiring corrective action within defined timelines.

1706. Institutions must submit evidence of implementation and verification.

G29.4.2 Conditional Approvals and Restrictions

1707. Approvals for programmes, sites, or placements may be made conditional, including:
(a) Enrolment Caps;
(b) Enhanced Supervision Requirements;
(c) Increased Reporting Frequency; or
(d) Temporary Scope Limitations. These measures stabilise risk while corrective actions are undertaken.

G29.4.3 Suspension

1708. Where risks are significant or immediate, authorities may suspend: (i) training site designation; (ii) admissions or placements; or (iii) specific training activities. Suspension remains in force until compliance is restored and verified.

G29.5. Sanctions:

1709. Where non-compliance is serious, persistent, or wilful, sanctions may be imposed, including:
(a) Non-Recognition of training periods where supervision, assessment, or site approval requirements were breached.
(b) Withdrawal of training site designation for facilities that fail to meet standards.
(c) Withdrawal of programme approval for institutions that are institutionally unfit or repeatedly non-compliant.
(d) Professional sanctions against supervisors or trainees for ethical or scope-of-practice breaches.
(e) Referral to audit or investigative authorities in cases involving financial mismanagement, fraud, or criminal conduct.

1710. Sanctions are documented, reasoned, and subject to due process.

G29.6. Learner and Patient Protection Measures

1711. All enforcement actions are accompanied by measures to protect learners and patients, including:
(a) Supervised continuation of training where safe;
(b) transfer to alternative accredited sites;
(c) teach-out arrangements to enable completion; and
(d) preservation and recognition of valid training already completed.

1712. Learner protection is a principal consideration and may override institutional convenience.

G29.7 Escalation and Inter-Agency Coordination

1713. Serious or systemic non-compliance triggers escalation and coordinated action among education authorities, health authorities, and professional regulators.

1714. Escalation ensures that enforcement addresses root causes rather than isolated symptoms.

G29.8 Due Process and Appeals

1715. Institutions and individuals subject to enforcement or sanctions are entitled to procedural fairness.

1716. Decisions must be communicated in writing, with reasons, timelines, and avenues for appeal clearly stated.

1717. Appeals do not suspend urgent measures required to protect patients or learners.

G29.9 Deterrence and System Integrity

1718. Consistent enforcement and credible sanctions serve a deterrent function, signalling that:
(a) Informal or unsafe training practices will not be tolerated;
(b) Regulatory approval carries enforceable obligations; and
(c) public interest overrides institutional or individual expediency.

G29.10 System Outcomes

1719. An effective compliance, enforcement, and sanctions framework ensures that: (i) only accredited sites and programmes deliver training; (ii) trainees progress based on demonstrated competence; (iii) patients are protected from unsafe practice; and (iv) Education and Training for Health operates as a disciplined, trustworthy system.

1720. Compliance, enforcement, and sanctions are the assurance mechanisms that convert policy and standards into real-world protection. When applied proportionately and consistently, they sustain quality, safeguard the public, and preserve confidence in internship, residency, and fellowship training as integral components of Education and Training for Health.

1721. Failure to comply with governance requirements may result in sanctions including but not limited to conditional approvals, suspension of site designation, enrolment freezes, or withdrawal of training authority.

1722. Enforcement actions against breach of governance requirements must prioritise learner and patient protection.

G30.0 TRANSITION AND HARMONISATION PROVISIONS

1723. Transition and harmonisation provisions provide the legal and operational bridge between legacy arrangements and the current governance framework for internship, residency, and fellowship training.

1724. Their purpose is to ensure continuity, equity, and system coherence while bringing all post-qualification training into full compliance with updated standards that protect learners, patients, and the public interest.

G30.1 Purpose and Governance Logic

1725. Transition and harmonisation provisions serve five interrelated objectives:

(a) to prevent disruption to trainees already enrolled in training pathways;

(b) to regularise existing programmes, sites, and arrangements that predate current standards;

(c) to align education, health, and professional regulation into a coherent system;

(d) to eliminate regulatory gaps, overlaps, and contradictions; and

(e) to strengthen long-term quality, safety, and accountability.

1726. These provisions recognise that reform must be orderly and fair, while remaining firm on non-negotiable requirements related to patient safety and training quality.

G30.2 Treatment of Existing Training Arrangements:

1727. Internship, residency, and fellowship programmes, training sites, and affiliation arrangements that were established prior to the commencement of the current framework are not invalidated automatically. Instead, they are subject to transitional review and regularisation.

1728. During the transition period: (i) existing programmes and sites must be identified, documented, and submitted for review; (ii) compliance gaps against current standards must be assessed; and (iii) corrective measures must be agreed and implemented within defined timelines.

1729. Continuation during transition is conditional upon demonstrated good faith, transparency, and absence of serious risk to learners or patients.

G30.3 Timelines and Conditional Continuation

1730. Transition provisions specify clear timelines for: (i) submission of legacy programmes and site information; (ii) completion of regulatory reviews; (iii) implementation of corrective actions; and (iv) re-approval, modification, or discontinuation.

1731. Where risks are low and remediable, conditional continuation may be granted subject to enrolment caps, enhanced supervision, or additional reporting. Where risks are high or persistent, immediate restrictions or suspension may be required.

G30.4 Harmonisation across policies, laws, and regulators

1732. Harmonisation provisions ensure that internship, residency, and fellowship governance is applied consistently across: (ii) education and health sector policies and service delivery rules; (i) education and health sector laws and regulations; and (iii) professional council standards for licensure and specialist recognition.

1733. Through harmonisation: (a) academic authority is aligned with education law and institutional governance; (b) service-delivery oversight is aligned with clinical governance requirements; and (c) professional certification processes are aligned with validated training outcomes.

1734. Joint guidance, coordinated inspections, and shared data systems are used to resolve overlaps and prevent regulatory fragmentation.

G30.5 Alignment of Standards, Terminology, and Levels

1735. Transition provisions also standardise: (i) definitions of internship, residency, and fellowship; (ii) competency frameworks and assessment language; (iii) supervision standards and progression

rules; and (iv) recognition and certification outcomes.

1736. This alignment ensures portability, comparability, and transparency across institutions, professions, and jurisdictions.

G30.6 Learner protection during transition

1737. Learner protection is the paramount consideration during transition. Measures include: (i) recognition of valid training already completed; (ii) supervised continuation where safe; (iii) transfer to alternative accredited sites where necessary; and (iv) teach-out arrangements for programmes or sites that must close or be withdrawn.

1738. No learner should be disadvantaged due to the regulatory reforms undertaken in the public interest.

G30.7 Data Migration and Record Integrity

1739. Transition requires consolidation and validation of historical records, including: (i) trainee registers; (ii) supervision and assessment logs; (iii) completion and certification data.

1740. Records must be migrated into approved systems to ensure continuity, auditability, and future verification of professional status.

G30.8 Capacity Building and Institutional Adjustment

1741. Recognising varied institutional readiness, transition provisions may be accompanied by: (i) technical guidance and implementation manuals; (ii) phased compliance requirements for complex standards; and (iii) capacity-building support for institutions and training sites. However, capacity-building does not suspend core safety and ethical requirements.

G30.9 Enforcement during Transition

1742. Transition does not imply regulatory restraint. Failure to; engage in regularisation, disclose material information, or implement agreed corrective actions shall trigger enforcement measures, including: (i) enrolment caps; (ii) suspension of placements; (iii) non-recognition of the training periods; or (iv) withdrawal of the approval. Transition is a pathway to compliance, and is not an exemption from it.

G30.10 System Outcomes

1743. Effective transition and harmonisation ensure that: (i) reform strengthens rather than destabilises training pipelines; (ii) learners and patients are protected throughout change; (iii) institutions operate under clear, unified rules; and (iv) internship, residency, and fellowship training function as an integrated continuum of professional formation.

1744. Transition and harmonisation provisions are the instruments that convert reform into stability. By managing change in an orderly, coordinated, and learner-centred manner, they secure the legitimacy, coherence, and long-term effectiveness of internship, residency, and fellowship training under Education and Training for Health.

1745. Existing internship, residency, and fellowship arrangements must be reviewed and regularised within clearly prescribed timelines.

1746. Learners must be protected during transitions through teach-out or transfer arrangements.

G31.0 MANDATORY OUTPUTS AND RECORDS

1747. Mandatory outputs and records are the concrete, formal, auditable artefacts through which the governance, compliance, quality assurance, and accountability for internship, residency, and fellowship training are demonstrated.

1748. They convert policy and standards, approvals, and supervision requirements into verifiable evidence, ensuring that post-qualification training is lawful, transparent, and defensible in the public interest and are indispensable for learner protection, patient safety, and regulatory confidence.

G31.1 Purpose and Governance Logic

1749. The governance of mandatory outputs and records serves five essential purposes: (i) to demonstrate compliance with education, health, and professional regulation requirements; (ii) to assure the quality and safety of training and service delivery; (iii) to support learner progression, certification, and professional recognition; (iv) to enable monitoring, audit, and enforcement; and (v) to preserve institutional and system memory over time.

1750. Without complete and reliable records, training periods cannot be validated and regulatory oversight collapses.

G31.2 Programme and Site Approval Records

1751. Institutions and authorities must maintain up-to-date records of: (i) approved internship, residency, and fellowship programmes; (ii) designated and accredited training hospitals and facilities; (iii) conditions, scope, capacity limits, and approval periods; and (iv) renewals, suspensions, or withdrawals of approval. These records establish the legal authority under which training is conducted.

G31.3. Designation Instruments for Training Centres

1752. Designation instruments are the formal legal documents that authorise hospitals, health facilities, and centres of excellence to host internship, residency, or fellowship training. Also, they specify the scope of training, approved cadres and specialties, capacity limits, supervision requirements, and validity period of the designation.

1753. The instruments establish the lawful basis for all training activities conducted at a site. Training undertaken in the absence of a valid designation or beyond its approved scope or capacity is non-compliant and may be invalidated.

1754. Designation instruments also provide a reference for inspections, renewals, conditional approvals, or withdrawal where standards deteriorate.

G31.4 National Placement Allocation Schedules

1755. National placement allocation schedules are the authoritative records that map who is placed where, when, and for what level of training. They operationalise merit-based admission, capacity-constrained allocation, and workforce-aligned distribution of trainees across designated sites.

1756. These schedules ensure transparency and equity, prevent over-concentration of trainees, and protect supervision and patient safety standards. They also serve as the definitive reference for verifying lawful placement, entitlement to stipends or support, and recognition of training periods.

1757. Informal or off-schedule placements are prohibited and unenforceable.

G31.5 Training Log Books

1758. The log books are vital for demonstrating that training is conducted under apt supervision and within approved scopes of practice.

1759. Inadequate, missing, or falsified supervision records constitute a serious breach and may result in non-recognition of training periods or professional sanctions.

1760. Training log books shall be guided by qualified supervisors, showing their credentials and registration status, supervision ratios, and ongoing supervisory engagement with trainees.

1761. The training log books must include records of mentorship, feedback, competency sign-offs, and supervisor development activities.

G31.6 Trainee Registers

1762. Mandatory trainee registers must be maintained at institutional and national levels, capturing: (i) trainee identity and professional registration status; (ii) admission and placement details; (iii) training level, site, and duration; (iv) progression, deferrals, or interruptions; and (v) completion or exit outcomes.

1763. Registers must be accurate, current, and integrated with professional council databases.

G31.7 Supervision and Trainer Records

1764. Records must be maintained for: (i) approved supervisors and trainers, including credentials and registration status; (ii) supervision assignments and ratios; (iii) supervision logs, mentoring notes, and sign-offs; and (iv) supervisor orientation and development activities.

1765. Inadequate supervision records invalidate training periods.

G31.8 Assessment and Progression Records

1766. Institutions must maintain comprehensive assessment documentation, including: (i) workplace-based assessments and portfolios; (ii) examination results and moderation records; (iii) remediation plans and outcomes; (iv) progression decisions and approvals; and (v) appeals and review outcomes.

1767. The above stated records must be the basis for fair and defensible progression and certification.

G31.9 Trainee Assessment and Completion Records

1768. Assessment and completion records capture the competency-based evaluations, progression decisions, remediation actions, and formal completion outcomes for each trainee. They include workplace-based assessments, portfolios, examinations, moderation records, and certification or attestation of completion.

1769. The above records provide the evidentiary basis for progression to the next training stage, full licensure, specialist recognition, or subspecialist certification. They must be accurate, complete, and auditable; absence or inconsistency undermines the validity of awards and exposes institutions to enforcement action.

G31.10 Incident and Welfare Reports

1770. Incident and welfare reports document clinical incidents, near-misses, ethical breaches, harassment or exploitation concerns, and trainee welfare issues, together with investigations, corrective actions, and outcomes. They are central to patient safety, learner protection, and continuous quality improvement.

1771. Timely reporting and resolution of incidents demonstrate functional risk management and ethical governance. Failure to report, investigate, or act on incidents is treated as non-compliance and may trigger restrictions, suspension of site designation, or other sanctions.

G31.11 Quality Assurance and Risk Management Records

1772. Mandatory quality assurance and risk records include: (i) training site audits and inspection reports; (ii) incident and adverse event reports; (iii) risk registers and mitigation actions; and (iv) corrective and preventive action records. These records demonstrate proactive management of quality and safety.

G31.12 Financing and Employment Records

1773. Institutions and training sites must retain: (i) trainee appointment letters or contracts; (ii) stipend or remuneration records; (iii) funding sources and expenditures related to training; and (iv) insurance and welfare coverage documentation.

1774. Financial opacity or missing records triggers enforcement action.

G31.13 Reporting and Compliance Records

1775. Mandatory reporting records include: (i) periodic academic and compliance reports submitted to regulators; (ii) correspondence on directives, conditions, and enforcement actions; and (iii) evidence of implementation and verification of corrective measures. These records establish institutional accountability and responsiveness.

G31.14 Completion, Certification, and Licensure Records

1776. Upon completion of training, records must include: (i) institutional completion certificates or attestations; (ii) professional council confirmations or registrations; (iii) fellowship or specialist recognition documents; and (iv) dates and scopes of certification. These records are essential for professional practice and career progression.

G31.15 Retention, Accessibility, and Data Protection

1777. Records must be retained for prescribed periods, be accessible for audit and verification, and be protected in accordance with data protection and confidentiality requirements.

1778. Loss, falsification, or unauthorised alteration of the above stated records constitutes serious non-compliance.

G31.17 System Outcomes

1779. Robust mandatory outputs and records ensure that: (i) training is verifiable and credible; (ii) learners' rights and achievements are protected; (iii) regulators can intervene early and effectively; and (iv) public confidence in health professional training is sustained.

1780. Mandatory outputs and records are the evidentiary foundation of internship, residency, and fellowship governance. When rigorously maintained and audited, they uphold legality, quality, and accountability across NETH, protecting learners, patients, and public interest.

G31.18 Conclusion: Governance as a Continuum of Professional Formation

1781. Governance of internship, residency, and fellowship training must be understood not as a series of isolated regulatory interventions, but as a continuous and integrated framework guiding professional formation from graduation to advanced and super specialist practice.

1782. This continuum-based approach reflects the reality that competence, professional judgment, and ethical practice are progressively developed through structured learning, supervised experience, and accountable assessment over time.

1783. Internship establishes the foundational transition from theoretical knowledge to supervised clinical practice, embedding patient safety, professional conduct, and basic competence.

1784. Residency builds on this foundation by deepening expertise through structured specialist training, increasing responsibility under controlled supervision, and integrating advanced academic judgment with service delivery.

1785. Fellowship represents the apex of professional formation, focusing on subspecialisation, leadership, innovation, and the highest standards of practice within centres of excellence.

1786. Governance across these stages must therefore be coherent, cumulative, and mutually reinforcing. A continuum approach ensures that academic authority, service governance, and professional regulation are aligned rather than fragmented.

1787. Education authorities must safeguard curriculum integrity, assessment standards, and institutional fitness; health authorities must ensure safe, ethical, and relevant service environments; while professional councils must protect the public through competency standards, licensure, and discipline. Each of these key actors must exercise a distinct but coordinated mandate, preventing gaps in oversight and ensuring that responsibility is never diffused or ambiguous.

1788. This governance model also embeds quality assurance, risk management, and accountability at every stage of professional development. Supervision intensity, assessment rigour, and autonomy are calibrated to training level and demonstrated competence, ensuring that progression is earned rather than assumed.

1789. Data, reporting, and enforcement mechanisms provide continuous feedback, enabling early intervention and system learning.

1790. Governance as a continuum places learner and patient protection at the centre of professional formation. Transitions between training stages are managed deliberately to preserve continuity, recognise valid learning, and prevent disruption. Where institutions or sites fail to meet these standards, enforcement actions must prioritise safe continuation, transfer, or teach-out rather than abrupt termination.

1791. In treating internship, residency, and fellowship training as a single, governed continuum, NETH moves beyond episodic compliance towards a system of sustained excellence. This approach

produces health professionals who are not only technically competent, but ethically grounded, accountable, and responsive to national health system needs. Ultimately, governance as a continuum of professional formation strengthens public trust, workforce capability, and the resilience of the health system itself.

G32.0 EDUCATION AND TRAINING STANDARDS

G32.1 Programme Design and Delivery

1792. Programme design and delivery is about how programmes must be conceived, structured, delivered, and reviewed. Compliance under this standard ensures that programmes produce practice-ready graduates, protect patient safety, and remain responsive to evolving health system needs.

1793. Therefore, all programmes must be designed and delivered in line with the mandatory design principles for NETH (non-negotiable). The five core design principles are:

(i) Competency-based education and training (CBET);

(ii) Labour-market and health-system responsiveness;

(iii) Integrated theory–practice delivery;

(iv) Ethical, professional, and patient-centred orientation; and

(v) Alignment with national and international standards.

1794. The mandatory design principles for programmes (non-negotiable) establish the minimum pedagogical, professional, and system-alignment requirements for all NETH programmes. These principles are binding and non-negotiable: no programme may be approved, accredited, delivered, reviewed, or renewed unless it demonstrably complies with all five.

1795. Together, they ensure that health training produces competent, ethical, employable professionals who are responsive to Uganda's health system needs and aligned with international best practice.

1796. Compliance must be evidenced through programme design documents, curricula, assessment frameworks, and delivery arrangements.

G32.1.1. Purpose of Programme Design and Delivery Standards

1797. The programme design and delivery standards operationalise the core objective of the NETH Policy, 2025: to produce competent, ethical, practice-ready health professionals aligned with Uganda's health system needs.

1798. The operational intent is to ensure that what is taught, how it is taught, where it is taught, and how competence is verified are all deliberately structured, regulated, and quality-assured. Programme design and delivery are therefore treated not as internal academic choices, but as public-interest functions with direct implications for patient safety, workforce quality, and health system performance.

G32.1.2. Programme Design as a Regulatory and System Function

1799. Under the Policy, programme design is not merely curriculum drafting; it is a regulated system-design activity. Its operational intent is to ensure that every approved programme: (i) Is competency-driven, not content-heavy or time-served; (ii) Is mapped to nationally recognised qualification levels; (iii) Is anchored in Uganda's disease burden, service delivery realities, and workforce gaps; and (iv) Produces graduates who are deployable without remedial retraining.

1800. Thus, programme design must begin with defined competencies, not course lists. Learning outcomes, teaching methods, assessment strategies, and clinical exposure are all downstream of the competency framework.

G32.1.3. Competency-Based Orientation: The Core Design Logic

1801. The Policy establishes competency-based education and training (CBET) as the organising principle of all National Education and Training for Health programmes.

"All Education and Training for Health Programmes programmes shall be designed and delivered using a competency-based education and training model".

1802. The operational intent is to: (i) Shift from "knowledge accumulation" to demonstrated ability to perform safely and effectively. (ii) Ensure that graduates can apply knowledge, skills, and professional judgement in real clinical and community settings and (iii) to enable regulators and employers to trust qualifications as indicators of actual competence.

1803. This practically implies that: (i) Each programme must define: (a) core professional competencies derived from occupational standards and professional council requirements; (b) supporting technical and transversal competencies; and (c) levels of autonomy and responsibility expected at graduation. (ii) Modules, credits, and clinical rotations must be explicitly mapped to these competencies. (iii) Progression through the programme must reflect competency acquisition, not merely attendance or time completion. (iv) Learning outcomes must specify observable knowledge, skills, and professional behaviours and (v) Assessment systems must verify demonstrated competence, not time served or content coverage.

1804. The competency-based education and training model is non-negotiable because it; ensures that graduates are practice-ready, reduces variability in outcomes, and aligns training with service delivery realities and patient safety expectations.

G32.1.4. Labour-Market and Health-System Responsiveness

1805. Programme design and delivery must be responsive to current and projected health system needs, rather than static or supply-driven."Programmes must be explicitly responsive to current and projected health workforce needs".

1806. The operational intent is to: (i) Align training outputs with national workforce plans, priority cadres, and geographic needs. (ii) Avoid overproduction of graduates in saturated cadres while shortages persist elsewhere and (iii) Ensure relevance to Uganda's epidemiological profile, service delivery models, and health reforms.

1807. This practically implies that: (i) Programmes must be periodically reviewed using; (a) Ministry of Health workforce data; (b) disease burden and service utilisation trends and (c) employer and facility feedback. (ii) Regulators may impose: (a) enrolment ceilings; (b) targeted programme adjustments; or (c) conditional approvals where misalignment is evident.

1808. This should be based on: (i) Evidence of alignment with national health workforce plans and service delivery priorities. (ii) Engagement with employers, service providers, and Professional

Councils in programme design and review and (iii) on clear mechanisms for periodic updating to reflect epidemiological trends, technology, and service models.

1809. This may be non-negotiable because training disconnected from labour-market demand leads to skills mismatches, unemployment, and inefficient use of public and private resources.

G32.1.5. Integrated Theory–Practice Design

1810. The Policy treats theory and practice as inseparable components of professional formation.

"Programmes shall integrate theoretical instruction and practical/clinical training in a coherent, sequenced manner".

1811. The operational intent is to: (i) Prevent the production of graduates with strong theoretical knowledge but weak clinical competence. (ii) Ensure early, progressive, and supervised exposure to real service environments and (iii) Embed learning within the realities of Uganda's health facilities and communities.

1812. This requires; structured progression from foundational theory to applied practice, adequate and approved clinical, practicum, or simulation-based learning, and supervised practice with documented feedback and assessment. This is non-negotiable because health professions require applied competence. Fragmented or purely theoretical training undermines professional readiness and patient safety.

1813. This practically implies that: (i) Programmes must include: (a) structured clinical placements; (b) skills laboratories and simulation where appropriate; and (c) clearly defined learning objectives for each practice phase. (ii) Clinical exposure must be: (a) approved; (b) supervised; and (c) proportionate to programme level and cadre. (iii) Practice-based learning must be assessed, not merely observed.

G32.1.6. Ethical, Professional, and Patient-Centred Orientation

1814. Programme design and delivery are explicitly linked to patient safety, ethics, and professional conduct.

"All programmes must embed ethics, professionalism, and patient-centred values throughout training".

1815. The operational intent is to: (i) Ensure that technical competence is matched with ethical judgement, professionalism, and respect for patients. (ii) Protect patients from harm arising from poorly supervised or ethically unprepared trainees; and (iii) Reinforce public trust in health training institutions and qualifications.

1816. This requires; explicit instruction in ethics, professional conduct, and scope of practice; safeguards for patient safety, dignity, and informed consent during training and codes of conduct and disciplinary frameworks for learners. This is non-negotiable because clinical competence without ethical grounding poses serious risk to patients, institutions, and the health system.

1817. This practically implies that: (i) Ethics, professionalism, and patient safety must be: (a) embedded across the curriculum, not confined to standalone courses; and (b) reinforced during clinical training and assessment. (ii) Programmes must include: (a) clear codes of conduct; (b) disciplinary and grievance mechanisms; and (c) learner orientation on consent, confidentiality, and scope of practice.

G32.1.7. Alignment with National and International Standards

1818. Programme design and delivery must be nationally coherent and internationally credible. “Programmes must align with recognised national and international frameworks”.

1819. The operational intent is to: (i) Ensure portability and recognition of Ugandan health qualifications. (ii) Support regional and global mobility without compromising local relevance and (iii) Benchmark quality against recognised best practice.

1820. This practically implies that: (i) Programmes must align with: (a) the Uganda Qualifications Framework (UQF); (b) applicable ‘Technical and vocational education and training’ (TVET) qualifications framework or the higher education qualifications framework; (c) The International Standard Classification of Education (ISCED) 2011 classification — the official framework used to facilitate international comparisons of education systems; and (d) relevant international guidance (e.g. The World Health Organisation (WHO) education standards) and (ii) benchmarking must be substantive, evidenced, and periodically reviewed.

G32.1.8. Programme Delivery as a Controlled, Quality-Assured Process

1821. Delivery is treated as a regulated operational process, not an informal instructional activity.

1822. The operational intent is to: (i) Ensure consistency between approved programme design and actual delivery. (ii) Prevent dilution of standards through ad hoc teaching, overcrowding, or unsafe practices and (iii) Enable regulators to verify that approved programmes are delivered as authorised.

1823. This practically implies that: (i) Teaching methods must match approved curricula and competencies. (ii) Enrolment must not exceed approved capacity. (iii) Trainers, preceptors, and supervisors must be qualified and sufficient in number and (iv) deviations from approved delivery arrangements require regulatory approval.

G32.1.9. Accountability and Continuous Improvement

1824. Programme design and delivery are subject to continuous monitoring, evaluation, and improvement.

1825. The operational intent is to: (i) Treat programmes as evolving systems responsive to evidence and feedback. (ii) Detect and correct weaknesses before they affect graduate competence or patient safety and (iii) ensure public accountability for education and training outcomes.

1826. This practically implies that: (i) Institutions must: (a) collect data on learning outcomes and graduate performance; (b) respond to monitoring and evaluation findings; and (c) implement corrective actions where gaps are identified. (ii) Persistent failure in programme design or delivery may lead to: (a) enrolment caps; (b) conditional accreditation; or (c) withdrawal of programme approval.

G32.1.10. Why Programme Design and Delivery Matter

1827. Under NETH Policy, 2025, programme design and delivery are the critical bridge between policy intent and health system performance. The operational intent is to ensure that: (i) qualifications reliably signal competence; (ii) graduates are safe, ethical, and deployable; (iii) public investment in training yields health system value; and (iv) education and training for health serve the public interest, not institutional convenience.

1828. Thus, programme design and delivery is a core regulatory concern, a professional responsibility, and a national development priority. Programme design and delivery is not discretionary; it is a condition for accreditation, continuation, and graduate recognition.

G32.1.11. Mandatory Outputs Supporting the Core Design Principles

1829. The mandatory outputs listed below constitute the documented evidence that an Education and Training for Health programme complies with the five non-negotiable design principles. These outputs are not ancillary documents; they are regulatory artefacts that must be produced, reviewed, approved, and retained as part of programme accreditation, renewal, inspection, and enforcement.

1830. Absence, inconsistency, or obsolescence of any output constitutes programme-level non-compliance, regardless of teaching quality claims or historical practice.

(a) Competency Framework and Mapping Matrix

1831. This output demonstrates full compliance with Competency-Based Education and Training (CBET). The content and purpose of CBET include: (i) A programme-specific competency framework derived from: (a) national occupational standards; (b) Professional Council competency requirements; and (c) health service delivery expectations. (ii) A mapping matrix showing alignment between: competencies; learning outcomes; curriculum modules; teaching methods; and assessment tools.

1832. This enables regulators and Professional Councils to verify that training leads to demonstrable competence and provides an auditable basis for assessment validity and graduate readiness. Thus, without a validated competency framework and mapping matrix, programme approval or renewal cannot be granted.

(b) Labour-Market Needs Assessment Reports

1833. This output evidences labour-market and health-system responsiveness. The content and purpose include: (i) Analysis of: (a) national and sub-national health workforce gaps; (b) employer demand and service delivery priorities; (c) alignment with MoH workforce plans and sector strategies. (ii) Documentation of stakeholder engagement (employers, facilities, councils).

1834. This prevents supply-driven programme proliferation and supports admissions capacity decisions and programme relevance. Consequently, programmes lacking current labour-market justification may face capacity caps or non-approval.

(c) Theory–Practice Integration Plans

1835. This output demonstrates integrated theory–practice delivery. The content and purpose include: (i) Structured plan showing: (a) sequencing of classroom, laboratory, simulation, and clinical learning; (b) approved practicum and clinical placement sites; (c) supervision ratios and responsibilities; (d) assessment of practical competence. (ii) Timetables and rotation schedules where applicable.

1836. This verifies that practical training is planned, supervised, and assessed, not ad hoc and enables inspection of clinical readiness and site adequacy. Accordingly, absence of an integration plan invalidates clinical training approvals and placements.

(d) Ethics and Professionalism Integration Evidence

1837. This output confirms ethical, professional, and patient-centred orientation. The content and purpose include: (i) Curriculum components on: (a) professional ethics; (b) scope of practice; (c) patient rights and safety; (d) codes of conduct. (ii) Evidence of: (a) learner induction on ethics; (b) disciplinary and grievance mechanisms; (c) safeguards in clinical training environments.

1838. This ensures that professional values are embedded across training, not treated as peripheral topics and supports Professional Council oversight and public trust. Consequently, ethical gaps trigger corrective action and may suspend clinical training.

(e) International Benchmarking and External Review Reports

1839. This output demonstrates alignment with national and international standards. The content and purpose include: (i) Benchmarking against: (a) Uganda Qualifications Framework; (b) ISCED 2011; and (c) WHO or discipline-specific international guidelines. (ii) Reports from: (a) external reviewers; (b) peer institutions; or (c) recognised applicable international bodies.

1840. This confirms comparability, portability, and credibility of qualifications and supports international recognition and mobility of graduates. Thus, education and training for heath programmes lacking benchmarking evidence may be denied approval or renewal.

1841. Enforcement may be triggered by any of the following: Absence of competency-based design; Misalignment with health priorities; Insufficient clinical exposure; Ethical or patient-safety violations; and Failure to meet national or international benchmarks.

1842. This may attract the following sanctions: Conditional accreditation, enrolment caps, suspension of programme delivery, or withdrawal of approval.

G32.2 Teaching, Learning, and Assessment Guidelines

G32.2.1 Core Teaching, Learning, and Assessment Sub-Standards (Mandatory)

1843. The five core sub-standards constitute the minimum, non-negotiable quality threshold for all Education and Training for Health (ETH) programmes. They apply universally, regardless of qualification level, provider type, or delivery modality, and collectively ensure that teaching and assessment lead to demonstrable competence, ethical practice, and patient safety.

1844. Compliance with all five sub-standards is a condition for programme approval, continuation, and renewal. Failure in any one sub-standard constitutes programme-level non-compliance.

G32.2.2 Teaching and Learning Methodologies

1845. Programmes shall employ appropriate, evidence-informed teaching and learning methodologies aligned to competency-based education and training (CBET).

1846. This methodology requires: (a) Use of learner-centred, outcomes-based pedagogies. (b) Integration of lectures, problem-based learning, skills laboratories, simulation, and supervised clinical practice. (c) Teaching methods matched to learning outcomes and learner level. (d) Delivery by qualified instructors, trainers, and clinical supervisors.

1847. This is mandatory because methodologies determine how competence is formed. Inappropriate or purely didactic approaches undermine skill acquisition, professional judgment, and safe practice.

G32.2.3 Learning Environment and Resources

1848. Programmes must be delivered within safe, adequate, and supportive learning environments.

1849. This requires: (a) Fit-for-purpose classrooms, laboratories, skills labs, and libraries. (b) Access to accredited clinical and practice sites with adequate case mix. (c) Learning resources proportionate to enrolment and programme scope. (d) Compliance with health, safety, infection prevention, and environmental standards.

1850. This is obligatory because learning environments directly affect learning quality and safety. Resource deficiencies compromise competence and expose learners and patients to risk.

G32.2.4 Assessment Design and Integrity

1851. Assessment systems shall be valid, reliable, fair, and secure, and aligned to defined competencies.

1852. This requires: (a) Assessment blueprints mapped to learning outcomes and competencies. (b) Balanced use of formative and summative assessments. (c) Secure examination processes and controls against malpractice. (d) Moderation and verification mechanisms, internal and external where required.

1853. This is mandatory because assessment determines who is certified as competent. Weak integrity undermines public trust and professional credibility.

G32.2.5 Clinical and Practical Assessment

1854. Programmes shall directly assess clinical and practical competence in real or simulated settings.

1855. This requires: (a) Use of appropriate methods such as: (i) workplace-based assessments; (ii) kills demonstrations; (iii) case-based evaluations; and (iv) Objective Structured Clinical Examinations (OSCEs) where clinically relevant. (b) Standardised assessment criteria and trained assessors. (c) Documentation of competence attainment.

1856. This is mandatory because clinical competence cannot be inferred from written tests alone. Direct assessment is essential to patient safety and professional readiness.

G32.2.6 Feedback, Progression, Remediation, and Appeals

1857. Programmes shall operate transparent and fair learner progression systems.

1858. This requires: (a) Timely, constructive feedback on performance. (b) Clear progression rules linked to competence achievement. (c) Structured remediation pathways for learners who fall short. (d) Formal appeals mechanisms consistent with principles of natural justice.

1859. This is mandatory because fair progression and remediation arrangements, protects learners' rights, promotes improvement, and upholds academic and professional integrity.

G32.2.7 Conclusions

1860. The above five sub-standards operate as an integrated quality assurance framework: Accordingly, (a) none of the standards may be waived or substituted;(b) all must be demonstrated through documented evidence and practice; and (c) failure in one undermines the validity of programme outcomes.

1861. These core sub-standards define the minimum conditions under which teaching, learning, and

assessment can legitimately certify competence in the health professions.

G32.2. The Teaching, Learning, and Assessment (TLA) Guidelines

1862. The Teaching, Learning, and Assessment (TLA) guidelines operationalise the Teaching, Learning, and Assessment standards by setting out how institutions design curricula, deliver instruction, assess learners, and verify competence. These guidelines are binding administrative instruments: failure to comply constitutes non-compliance with the Standards, triggering corrective action or sanctions.

1863. The guidelines apply to all NETH programmes, regardless of the qualification level or provider type.

G32.2.1 Curriculum Design and Approval

1864. Curricula shall be competency-based, outcomes-oriented, and mapped explicitly to: (a) approved occupational and professional competencies; (b) UQF levels and descriptors; and (c) programme scope and authorised cadre.

1865. Institutions shall establish formal procedures for: (a) curriculum development and approval; (b) periodic review and updating; and (c) change control (no material changes without approval). This ensures that curricula are lawful, coherent, and responsive, and prevent ad-hoc or unapproved programme drift.

G32.2.2. Teaching and Learning Delivery Modalities

1866. Teaching and learning shall integrate theory, skills development, and supervised practice using appropriate modalities, including: (a) classroom and laboratory instruction; (b) simulation-based learning; and (c) workplace and clinical learning.

1867. Institutions shall ensure: (a) adequate supervision ratios; (b) qualified instructors and preceptors; and (c) structured learning plans for clinical and practical components. This Guarantees that learning delivery produces practice-ready graduates and does not compromise patient safety.

G32.2.3. Learner Assessment and Competence Verification

1868. Assessment systems shall: (a) measure achievement of defined competencies; (b) combine formative and summative approaches; and (c) include direct assessment of clinical and practical competence.

1869. Assessment tools must be: (a) valid, reliable, and fair; (b) aligned to learning outcomes; and (c) appropriate to the qualification level. This shall shift assessment from time-served or content-tested models to demonstrated competence.

G32.2.4. Assessment Governance and Integrity

1870. Institutions shall establish robust assessment governance, including: (a) internal moderation and peer review; (b) external verification where required; (c) secure handling of examination materials; and (d) controls to prevent malpractice and conflicts of interest.

1871. Clear separation shall be maintained between: (a) teaching, (b) assessment setting and marking, and (c) certification or award decisions. This is intended to protect the credibility of qualifications and ensure defensible assessment outcomes.

G32.2.5. Recognition of Prior Learning (RPL) and Credit Transfer

1872. Where applicable, institutions shall implement regulated RPL and credit transfer mechanisms that: (a) assess prior learning against programme competencies; (b) limit RPL to allowable proportions; and (c) maintain full documentation and audit trails.

1873. RPL decisions shall not compromise minimum competence or professional standards. This promotes access and mobility while safeguarding qualification integrity.

G32.2.6. Use of Digital and Innovative Learning Technologies

1874. Digital delivery and assessment shall be: (a) pedagogically appropriate to the programme; (b) quality-assured and accessible; and (c) compliant with data protection and learner privacy requirements.

1875. Simulation and e-assessment may supplement, but not improperly replace, required clinical exposure. This enables innovation without diluting learning outcomes or assessment rigour.

G32.2.7. Continuous Improvement, Review, and Feedback

1876. Institutions shall operate continuous improvement systems that include: (a) regular programme and assessment reviews; (b) learner, employer, and supervisor feedback; and (c) documented corrective actions.

1877. Findings shall inform curriculum updates, staff development, and delivery improvements. This ensure that teaching and assessment remain current, relevant, and effective.

G32.2.8. Mandatory Records and Outputs

1878. Institutions shall maintain and produce, on demand: (a) approved curricula and mapping matrices; (b) assessment blueprints, tools, and moderation reports; (c) learner progression, competence, and completion records; and (d) external verification and audit reports.

1879. This Provide an auditable evidence base for accreditation, inspection, and enforcement.

G32.2.9. Governance and Regulatory Rationale

1880. Together, these guidelines: (a) ensure consistency and comparability across programmes and institutions; (b) protect learners from poor-quality or invalid assessment; (c) safeguard patient safety and professional standards; and (d) enable regulators to make clear, defensible decisions.

G32.2.10. Governance and Regulatory Consequence

1881. The Teaching, Learning, and Assessment Guidelines convert the Standards into a workable regulatory operating system, ensuring that what is approved on paper is delivered, assessed, and verified in practice across the NETH system.

1882. The mandatory outputs under these guidelines include: (i) Teaching and learning strategy; (ii) Resource adequacy and inspection reports; (iii) Assessment blueprints and moderation reports; (iv) Clinical assessment (OSCE/logbook) records; (v) Feedback, remediation, and appeals records.

1883. The absence of fair progression and appeals systems triggers regulatory sanctions. The

Sanctions may include: conditional accreditation, enrolment caps, suspension of assessments, repeat examinations, or withdrawal of programme approval.

G32.3 Trainers, Preceptors, and Staff Guidelines

G32.3.1 Core Standards for Trainers, Preceptors, and Staff (Mandatory Domains)

1884. Human resources for training are the single most critical determinant of education quality and patient safety. No programme, placement, or internship may operate without adequate numbers of qualified, licensed, and prepared trainers and preceptors.

1885. Trainers, preceptors, and faculty involved in education and training for health shall be appropriately qualified, registered, competent, and supported to deliver quality education, ensure patient safety, and uphold professional and ethical standards.

1886. The five core standards define the minimum, non-negotiable human-resource quality requirements for all Health Training Institutions (HTIs) and approved training sites. They establish who may teach, supervise, and assess learners; under what conditions; and with what accountability.

1887. Compliance across all five domains is mandatory for institutional approval, programme accreditation, clinical placement authorisation, and continued operation.

1888. Failure in any one domain constitutes material non-compliance and triggers corrective action or enforcement, regardless of programme level or institutional history.

G32.3.2. Qualification and Professional Registration

1889. HTIs and training sites shall ensure that all trainers, faculty members, and preceptors possess appropriate academic qualifications and valid professional registration, where applicable.

1890. This requires: (i) Academic qualifications aligned to the level of training delivered under the Uganda Qualifications Framework (UQF). (ii) Current registration, licensure, or recognition by the relevant Professional Council for all personnel involved in teaching or supervising regulated clinical practice. (iii) Demonstrated discipline-specific experience appropriate to the scope and risk of training activities.

1891. This is mandatory because training quality and patient safety depend on instructors who are credibly qualified and lawfully authorised. Unqualified or unregistered personnel undermine competence certification and expose learners and patients to risk.

G32.3.3. Pedagogical Preparation and Teaching Competence

1892. Personnel shall demonstrate competence in education practice, not merely subject expertise.

1893. This requires: (a) Formal preparation in competency-based education and training (CBET). (b) Ability to design and deliver learner-centred instruction. (c) Competence in assessment design, marking, moderation, and feedback.

1894. This is mandatory because effective learning requires educators who can translate knowledge into competence development. Subject expertise without pedagogical skill leads to inconsistent outcomes and weak assessment validity.

G32.3.4. Clinical Supervision and Preceptorship Capacity

1895. Training sites and institutions shall demonstrate adequate clinical supervision and preceptorship capacity.

1896. This requires: (a) Designated, trained preceptors for all clinical placements. (b) Clear supervision roles, responsibilities, and escalation pathways. (c) Capacity to provide safe, supervised exposure across required competencies and case mix.

1897. This is mandatory because clinical training without effective supervision compromises learner development and endangers patient safety. Preceptorship capacity is therefore a core safety requirement.

G32.3.5. Trainer–Learner and Preceptor–Trainee Ratios

1898. HTIs and training sites shall maintain approved ratios appropriate to the learning context.

1899. This requires: (a) Defined maximum learner-to-trainer ratios for classrooms, skills labs, and simulations. (b) Defined maximum trainee-to-preceptor ratios in clinical settings. (c) Adjustments for programme complexity, risk, and learner level.

1900. This is mandatory because excessive ratios dilute supervision, reduce feedback quality, and increase safety risks. Ratios are a direct control on training quality and risk exposure.

G32.3.6 Performance Management, CPD, and Accountability

1901. Institutions and sites shall operate formal performance management and professional development systems.

1902. This requires: (a) Regular appraisal of teaching and supervision performance. (b) Mandatory continuing professional development (CPD) for all trainers and preceptors. (c) Mechanisms for addressing under-performance through mentoring, retraining, or removal from teaching or supervisory roles.

1903. This is mandatory because training quality is not static. Continuous performance management and CPD ensure educators remain current, competent, and accountable.

G32.3.7 Integrated Compliance Logic

1904. The five domains function as a single human-resource quality assurance framework: (i) They are non-substitutable—strength in one cannot offset failure in another; (ii) they apply to both institutions and training sites; and they are assessed at approval, review, and inspection stages.

G32.3.8 Governance Rationale

1905. By enforcing these core standards, the Education and Training for Health framework: (a) ensures that only qualified, prepared, and accountable personnel shape future health professionals; (b) protects learners and patients from unsafe training environments; (c) strengthens credibility of qualifications and professional practice; and (d) provides regulators with clear, defensible benchmarks for oversight and enforcement.

1906. These standards ensure that competence is taught, supervised, and assessed by people who are themselves competent, current, and accountable, forming the human-resource backbone of a safe and credible health training system.

G32.4. Trainers, Preceptors, and Faculty Guidelines

G32.4.1 Purpose and Legal Effect

1907. These guidelines operationalise the trainers, preceptors, and faculty standards by defining who may teach, supervise, and assess, under what conditions, and with what accountability. They are binding administrative instruments: non-compliance constitutes a breach of the Standards and triggers corrective action, capacity restrictions, or sanctions.

1908. The guidelines apply to all NETH programmes, across TVET and higher education pathways, and to all learning environments, including classrooms, skills labs, simulation centres, and clinical/workplace sites.

G32.4.2. Role Definitions and Scope of Responsibility

1909. Institutions shall formally define and separate roles to prevent ambiguity and risk through : (a) Trainers/Instructors deliver classroom and skills-based instruction aligned to CBET. (b) Faculty provide academic leadership, curriculum stewardship, scholarship, and assessment governance. (c) Preceptors/Supervisors oversee workplace and clinical learning, ensuring safe practice and competence development. This ensures accountability, prevents role confusion, and aligns responsibilities to competence and risk.

G32.4.3. Minimum Qualifications and Professional Standing

1910. All personnel must meet minimum academic and professional thresholds appropriate to their role and programme level through: (a) Academic qualifications aligned to UQF level of delivery. (b) Current professional registration/licensure where teaching or supervising regulated practice. (c) Relevant discipline-specific experience, particularly for clinical supervision. This guarantees credibility of instruction and safety of supervision.

1911. Therefore, Trainers and faculty shall possess academic qualifications at least one level higher than the programme taught (unless otherwise approved); Preceptors and clinical supervisors shall be professionally registered and in good standing; and Specialist training shall be supervised by appropriately credentialed specialists.

1912. Unqualified or unregistered trainers trigger: immediate removal from teaching or supervision; or suspension of affected modules or placements or both.

G32.4.4. Appointment, Credentialing, and Authorisation

1913. Institutions shall implement transparent appointment and authorisation processes through: (a) Verification of credentials and licensure prior to appointment. (b) Formal letters of appointment specifying role, scope, and limits. (c) Maintenance of authorised staff registers distinguishing who may teach, assess, or supervise. This prevents unauthorised teaching or assessment and ensure defensible approvals.

G32.4.5. Staffing Levels, Ratios, and Deployment

1914. Trainer–Learner and Preceptor–Trainee Ratios. Ratios as capacity control mechanisms: This requires; Compliance with prescribed trainer–student and preceptor–intern ratios, and Ratio compliance linked to approved enrolment and placement ceilings.

1915. Institutions shall ensure adequate staffing and safe ratios through: (a) Defined learner-to-trainer/preceptor ratios appropriate to learning context. (b) Continuous supervision coverage in clinical settings. (c) Controls on workload, dual roles, and over-extension. This protects learning quality

and patient safety; support effective supervision.

1916. Ratio breaches trigger: enrolment caps; placement reductions; suspension of clinical training activities.

G32.4.6. Pedagogical and Assessment Competence

1917. Teaching competence as a quality requirement. Thus, trainers shall have training in pedagogy, curriculum delivery, and assessment; Preceptors shall be oriented in supervision and mentoring; and Continuous professional development (CPD) in education methods is mandatory.

1918. Personnel shall demonstrate competence in education practice, not only subject expertise through: (a) Training in CBET pedagogy and learner-centred methods. (b) Competence in assessment design, marking, and moderation. (c) Readiness to conduct clinical assessments, including OSCEs where applicable. This ensures assessments validly certify competence.

1919. Lack of pedagogical preparation results in conditional accreditation and mandatory training.

G32.4.7. Continuing Professional Development (CPD)

1920. All trainers, faculty, and preceptors shall undertake mandatory CPD through: (a) Regular updating of pedagogical skills. (b) Maintenance of clinical currency for supervisors. (c) Documented CPD plans and verified participation. This keeps teaching and supervision current with evolving practice and standards.

G32.4.8. Ethics, Professional Conduct, and Safeguards

1921. Institutions shall enforce ethical standards and safeguards through: (a) Codes of conduct covering boundaries, confidentiality, and professionalism. (b) Zero tolerance for harassment, exploitation, or abuse and (c) through clear reporting and protection mechanisms for learners and patients. This protects dignity, safety, and public trust.

G32.4.9. Performance Management and Quality Assurance

1922. Institutions shall operate performance and QA systems through: (a) Regular appraisal of teaching and supervision effectiveness. (b) Peer review and learner feedback. (c) Corrective action plans, mentoring, or retraining where gaps are identified. This drives continuous improvement and accountability.

1923. Performance Management, CPD, and Accountability. Continuous competence and accountability require: Performance appraisal of trainers and preceptors; Mandatory CPD participation; and Mechanisms for addressing poor performance or misconduct.

1924. Persistent non-performance or CPD non-compliance leads to: removal from teaching or supervision roles; and/or referral to Professional Councils.

G32.4.10. Joint Governance with Clinical Sites

1925. Clinical Supervision and Preceptorship Capacity. Supervision as a patient-safety safeguard. This requires: (a) Designated supervisors for all learners in clinical settings; (b) Clear supervision responsibilities and scopes; (c) Availability of supervisors throughout training periods.

1926. Where learning occurs in clinical settings: (a) there shall written agreements defining preceptor roles and supervision standards. (b) there shall be joint planning of rotations, supervision, and

assessment. (c) there shall be clear escalation pathways for safety or performance concerns. This aligns institutional and site responsibilities and prevents supervision gaps.

1927. Inadequate supervision leads to: (a) immediate placement suspension; and re-assignment of learners.

G32.4.11. Mandatory Records and Outputs

1928. Institutions shall maintain and produce: (a) Authorised staffing registers (trainers, faculty, preceptors); (b) credential verification files and appointment instruments; (c) CPD logs and appraisal reports; (d) supervision logs and clinical assessment records. This provides an auditable evidence base for accreditation, inspection, and enforcement.

G32.4.12. Governance Rationale

1929. Together, these guidelines: ensure that only qualified, authorised, and supported personnel teach and supervise; protect learners and patients from unsafe or unqualified practice; strengthen assessment credibility and professional standards; and enable regulators to apply consistent, defensible oversight.

1930. Accordingly, the Trainers, Preceptors, and Faculty Guidelines establish the human-capital backbone of the NETH system—ensuring that competence, ethics, and safety are formed by people who are themselves competent, ethical, and accountable.

1931. The mandatory outputs under these guidelines include: (a) Verified trainer and preceptor registers; (b) Pedagogical training and induction records; (c) Supervision assignment schedules and logs; (d) Ratio compliance matrices; (e) Performance appraisal and CPD records.

1932. Use of unqualified or unregistered trainers; Inadequate supervision in clinical settings; Breach of trainer–learner or preceptor–trainee ratios; and Absence of CPD or performance management systems shall trigger sanctions. The sanctions shall include: conditional accreditation, enrolment and placement caps, suspension of training activities, or withdrawal of programme approval among others.

G32.5 Clinical Training and Practice-Based Learning Guidelines

1933. Mandatory sub-standards for clinical and practice-based learning

1934. Clinical training and practice-based learning shall be structured, supervised, safe, and aligned with approved programmes, competency frameworks, and national health system needs.

1935. The six mandatory sub-standards define the minimum conditions under which clinical and practice-based learning may lawfully and safely occur within the Education and Training for Health (ETH) framework.

1936. They apply to all forms of practicum, clinical rotations, internships, residencies, and fellowship training, regardless of qualification level or provider type. Compliance with all six sub-standards is non-negotiable and is a condition for placement authorisation, learner progression, and recognition of training outcomes.

1937. Clinical training is a regulated educational activity, not informal exposure or ad hoc service participation. All practice-based learning must be: intentionally planned; competency-driven; adequately supervised; and conducted only in approved environments.

1938. Failure in any one sub-standard constitutes clinical training non-compliance and triggers immediate corrective action or enforcement.

G32.5.1 Approved and Designated Clinical Training Sites

1939. Clinical learning shall take place only at sites formally approved and designated for training.

1940. This requires (a) Written designation by the competent authority (MoH and/or relevant Professional Council, in coordination with regulators). (b) Verification of site readiness, including service capacity, case mix, staffing, infrastructure, and safety systems. (c) Time-bound approval subject to periodic review and renewal.

1941. Site approval as a safety and quality gate: Clinical training shall occur only at sites: formally affiliated to an HTI; and approved or designated by the competent authority.

1942. Sites must demonstrate adequate: case mix and service scope; infrastructure and equipment; staffing and supervision capacity; patient safety systems.

1943. This is mandatory because unapproved sites lack assurance of supervision, safety, and learning value. Designation ensures that patient care and learner training are compatible and safely managed.

1944. Use of non-approved sites results in immediate suspension of placements and possible programme sanctions.

G32.5.2 Structured Clinical Learning Objectives and Schedules

1945. Clinical learning shall be planned, structured, and outcomes-driven, not ad hoc.

1946. This requires: (i) clearly defined clinical learning objectives aligned to programme competencies and learner level; (ii) approved rotation schedules specifying duration, departments, and activities and; (iii) progressive exposure from observation to supervised practice.

1947. This is mandatory because structure ensures that clinical exposure translates into competence development and prevents random or unsafe task allocation.

1948. Structure as competence assurance requires: (a) Defined clinical learning outcomes linked to programme competencies; (b) structured rotation schedules and duration; and (c) clear expectations for learner activities and responsibilities.

1949. Unstructured or ad hoc clinical exposure triggers corrective action or placement suspension.

G32.5.3 Supervision, Mentoring, and Oversight

1950. All clinical learning shall occur under authorised supervision.

1951. This requires: (a) Designated preceptors or supervisors with appropriate qualifications and training; (b) Defined supervision models, learner-to-preceptor ratios, and escalation pathways; (c) Regular mentoring, feedback, and oversight of learner performance.

1952. This is mandatory because effective supervision is the primary safeguard against unsafe practice and poor learning outcomes.

1953. Supervision as a patient-safety requires: (a) Designated supervisors/preceptors for all learners;

(b) defined supervision levels (direct, indirect, progressive autonomy); and (c) continuous availability of supervisors during clinical activities.

1954. Inadequate supervision results in immediate restriction of clinical activities.

G32.5.4 Patient Safety, Ethics, and Risk Management

1955. Clinical training shall prioritise patient safety and ethical practice at all times.

1956. This requires: (a) Clear limits on learner scope of practice consistent with training level; (b) Informed consent and respect for patient dignity; (c) Compliance with infection prevention and control (IPC) standards; and (d) Incident reporting, investigation, and response mechanisms.

1957. This is mandatory because training convenience can never override patient safety or ethical obligations.

1958. Patient protection as a non-negotiable standard requires: (a) Compliance with infection prevention and control; (b) Respect for consent, confidentiality, and dignity; (c) Clear incident reporting and response mechanisms; and (d) Learner insurance and indemnity arrangements.

1959. Serious safety or ethical breaches trigger suspension of sites, supervisors, or programmes.

G32.5.5 Documentation, Logbooks, and Competency Tracking

1960. Clinical learning shall be fully documented and auditable.

1961. This requires: (a) Standardised logbooks recording procedures, cases, and supervision; (b) Competency tracking tools linked to learning outcomes; and (c) Supervisor sign-off and verification of competence milestones.

1962. This is mandatory because documentation provides evidence of learning, enables verification, and protects learners, institutions, and regulators.

1963. Evidence of learning and competence requires: (i) Use of approved logbooks or digital tracking tools; (ii) Supervisor validation of competencies achieved; (iii) Secure storage and auditability of records. Incomplete or falsified records invalidate clinical training outcomes.

G32.5.6 Monitoring, Review, and Continuous Improvement

1964. Clinical training arrangements shall be continuously monitored and improved.

1965. This requires: (a) Regular review of site performance, supervision quality, and learner outcomes. (b) Feedback from learners, preceptors, and institutions. (c) Corrective Action Plans (CAPs) where deficiencies are identified; (d) De-designation or suspension of sites where non-compliance persists.

1966. This is mandatory because clinical environments evolve, and continuous oversight is essential to sustain safety and training quality.

1967. Quality improvement as an ongoing obligation requires: (i) Periodic review of clinical training quality; (ii) Learner and supervisor feedback mechanisms; and (iii) Corrective action where gaps are identified.

1968. Persistent quality failures result in withdrawal of site approval or programme sanctions.

G32.5.7 Mandatory Outputs:

1969. The mandatory outputs under these guidelines include: (i) Approved clinical training site list; (ii) Clinical learning plans and schedules; (iii) Supervisor assignment and feedback records; (iv) Patient safety and incident reports; (v) Logbooks and competency tracking records; and (vi) Clinical training review and improvement reports.

G32.5.8 Enforcement:

1970. Training at non-approved sites; Lack of supervision; Patient safety incidents; Absence of documented competencies; and Persistent quality failures shall together trigger sanctions. The sanctions shall include: immediate placement suspension, site de-designation, enrolment caps, or withdrawal of programme approval among others.

G32.5.9 Integrated Logic

1971. The six sub-standards above operate as an integrated clinical governance framework where: (i) each is essential and non-substitutable; (ii) all must be met before, during, and after placements; and (iii) failure in one undermines the integrity of the entire clinical learning arrangement.

G32.5.10 Governance Rationale

1972. By enforcing these sub-standards, the NETH framework: (i) ensures clinical learning is safe, structured, and educationally sound; (ii) protects patients and learners from unmanaged risk; (iii) supports credible certification of clinical competence; and (iv) strengthens public confidence in health professional training.

1973. Thus, these mandatory sub-standards ensure that clinical training serves its true purpose: producing competent, ethical, and patient-centred health professionals without compromising care or safety.

G32.6.0 Clinical Training and Practice-Based Learning Guidelines

G32.6.1 Purpose and Legal Effect

1974. These guidelines operationalise the Clinical Training and Practice-Based Learning Standards by specifying how clinical learning is planned, approved, supervised, assessed, and safeguarded.

1975. They are binding administrative instruments: non-compliance constitutes a breach of the Standards and triggers corrective action or sanctions.

1976. They apply to all NETH programmes requiring clinical, practicum, workplace, internship, residency, or fellowship components, across Technical and Vocational Education and Training (TVET) and higher education pathways.

G32.6.2 Scope, Purpose, and Eligibility for Clinical Training

1977. Clinical training exists to enable learners to apply knowledge, develop skills, and demonstrate professional behaviours in real or simulated practice environments.

1978. Institutions shall define: (i) eligibility prerequisites (academic progression, skills readiness); (ii) authorised clinical activities by programme level; and (iii) boundaries consistent with scope of practice and patient safety. This ensures only prepared learners enter clinical settings and

perform authorised tasks.

G32.6.3. Designation and Approval of Clinical Training Sites

1979. Clinical learning may occur only at designated and approved sites that meet readiness criteria, including: (i) adequate case mix and service capacity; (ii) qualified and authorised preceptors; (iii) safe infrastructure and Infection Prevention and Control (IPC) compliance— “Safe infrastructure” is a fundamental pillar of IPC compliance in healthcare settings, creating an environment where infectious agents are less likely to spread.; and (iv) governance and reporting capability.

1980. Designation is time-bound and subject to review. This prevents unsafe or ad-hoc placements and protect patients and learners.

G32.6.4 Clinical Learning Design and Sequencing

1981. Institutions shall design clinical learning as a progressive pathway including: (i) observation and orientation; (ii) assisted practice under close supervision; (iii) supervised independent tasks appropriate to level.

1982. Clinical learning shall be integrated with theory, skills labs, and simulation. This builds competence progressively and avoid premature exposure to risk.

G32.6.5 Supervision, Preceptorship, and Ratios

1983. All clinical learning shall occur under authorised supervision through: (i) preceptors appointed, credentialed, and trained; (ii) defined supervision models and escalation pathways; and (iii) approved learner-to-preceptor ratios adjusted for risk and complexity. This ensures continuous oversight and safe practice.

G32.6.6 Assessment of Clinical and Practical Competence

1984. Clinical competence shall be assessed using direct, evidence-based methods, including: (i) workplace-based assessments (mini-CEX, DOPS, case logs); (ii) simulations and OSCEs where applicable; and (iii) standardised criteria with trained assessors. This certifies competence based on demonstrated performance, not exposure alone.

G32.6.7 Patient Safety, Ethics, and Risk Management

1985. Institutions and sites shall enforce patient-centred safeguards through: (i) informed consent and respect for dignity; (ii) strict adherence to IPC and safety protocols; (iii) incident reporting, investigation, and learning systems; and (iv) limits on learner scope of practice. This places patient safety above training convenience.

G32.6.8 Learner Welfare, Safety, and Support

1986. Clinical training must protect learner well-being, including: (i) induction and orientation at sites; (ii) reasonable working hours and fatigue management; (iii) access to welfare and counselling services; and (iv) grievance and whistle-blowing protections. This sustains learning quality and prevent harm or exploitation.

G32.6.9 Data, Records, and Reporting

1987. Institutions and sites shall maintain auditable records, including: (i) logbooks and supervision attestations; (ii) attendance and rotation schedules; (iii) assessment outcomes; and (iv) incident

and welfare reports. This enables verification, monitoring, and defensible regulatory decisions.

G32.6.10 Inter-Institutional Coordination and Placement Management

1988. Where placements involve multiple institutions or sites: (i) placement ceilings and calendars shall be coordinated; (ii) information sharing shall be standardised; and (iii) conflicts shall be resolved through agreed protocols. This avoids overcrowding, duplication, and unsafe placements.

G32.6.11 Monitoring, Inspection, and Corrective Action

1989. Regulators shall conduct routine and risk-based inspections of sites and programmes. Where deficiencies arise: (i) CAPs with timelines are required; (ii) placements may be capped or suspended; and (iii) sites may be de-designated for persistent non-compliance. This ensures continuous compliance and rapid risk containment.

G32.6.12 Governance Rationale

1990. Together, these Guidelines: (i) ensure clinical learning is planned, supervised, assessed, and safe; (ii) protect patients and learners from unmanaged risk; (iii) support credible competence certification; and (iv) enable coordinated, defensible regulation.

1991. Accordingly, the Clinical Training and Practice-Based Learning Guidelines convert the Standards into a controlled clinical learning system—one that balances educational value with patient safety, ethical practice, and public trust across the Education and Training for Health ecosystem.

G33.0. MONITORING, EVALUATION, AND REPORTING (MER)GUIDELINES

1992. MER must be institutionalised to ensure accountability, continuous improvement, evidence-based decision-making, and alignment of education and training for health with national health system needs.

1993. MER are mandatory system functions, not optional administrative activities. MER ensures that: (i) policy and standards implementation is tracked against agreed indicators; (ii) risks to quality, safety, and sustainability are detected early; (iii) corrective actions are evidence-based and verifiable; and (iv) decision-makers have reliable data for planning and regulation.

1994. Failure to comply with MER guidelines constitutes systemic non-compliance.

G33.1. Clinical Training Mandatory MER Components

1995. The five mandatory MER components constitute the minimum accountability architecture for NETH system. They apply to all actors; HTIs, clinical training sites, regulators, assessment bodies, and coordinating ministries and ensure that performance, quality, safety, and compliance are systematically measured, transparently reported, and acted upon.

1996. Compliance with all five components is non-negotiable. Failure in any one component undermines the integrity of the MER system and constitutes non-compliance with the Standards.

G33.1.1. Defined Indicators and Performance Metrics

1997. All actors shall operate against a defined set of indicators and performance metrics aligned to their role within the Education and Training for Health system.

1998. This requires: (i) use of nationally prescribed indicators and definitions to ensure comparability. (ii) role-specific indicators covering inputs, processes, outputs, and outcomes; and (iii) clear targets, thresholds, and risk flags linked to regulatory action.

1999. This is mandatory because without defined indicators, monitoring becomes subjective and inconsistent. Standardised metrics enable evidence-based oversight, benchmarking, and defensible decision-making.

2000. Indicators as compliance signals requires: (i) standardised NETH indicators covering: (a) institutional compliance; (b) programme quality; (c) training capacity and outputs; (d) clinical training safety; and (e) graduate progression and outcomes. (ii) Indicators disaggregated by cadre, level, institution type, and region.

2001. Failure to adopt approved indicators triggers reporting non-compliance sanctions.

G33.1.2. Routine Monitoring and Data Collection

2002. Actors shall conduct routine, systematic monitoring and collect data at prescribed intervals.

2003. This requires: (i) Continuous tracking of institutional, programme, and clinical training performance. (ii) Use of standardised data collection tools and formats. (iii) Verification and validation of data at source, with audit trails.

2004. This is mandatory because routine monitoring enables early detection of risk, under-performance, or non-compliance, reducing reliance on crisis-driven inspections.

2005. Monitoring as a continuous obligation requires: (i) Regular collection of accurate, timely, and verifiable data; (ii) Use of approved tools, templates, and digital systems where provided; and (iii) Clear assignment of monitoring responsibilities.

2006. Submission of false, incomplete, or late data leads to sanctions and intensified oversight.

G33.1.3. Periodic Evaluation and Review

2007. Beyond routine monitoring, actors shall undertake periodic evaluations to assess effectiveness and impact.

2008. This requires: (i) Scheduled programme, institutional, and system-level evaluations. (ii) Use of qualitative and quantitative methods; and (iii) Independent or external review where required for objectivity.

2009. This is mandatory because evaluation tests whether interventions are achieving intended outcomes, not just whether activities occurred.

2010. Evaluation as learning and accountability requires: (i) Periodic internal and external evaluations of: (a) programme effectiveness; (b) clinical training quality; (c) governance and compliance; (d) workforce relevance. (ii) Evaluations aligned to policy objectives and Standards.

2011. Failure to participate in evaluations results in conditional approvals or escalated inspections.

G33.1.4. Structured Reporting and Disclosure

2012. Actors must produce structured, timely, and accurate reports based on MER data.

2013. This requires: (i) Mandatory reports submitted according to prescribed timelines and formats. (ii) Exception and incident reporting for safety, ethics, or governance breaches. (iii) Public or sectoral disclosure where required to protect learners and the public.

2014. This is mandatory because Structured reporting ensures transparency, accountability, and informed decision-making across the system.

2015. Reporting as a statutory duty requires: (i) Timely submission of: (a) academic performance reports; (b) compliance and accreditation status; (c) clinical training and safety reports; (d) financial and sustainability information (as required). (ii) Public disclosure of approved information to ensure transparency.

2016. Non-reporting or misreporting triggers sanctions, including but not limited to suspension of approvals.

G33.1.5. Corrective Action, Feedback Loops, and Continuous Improvement

2017. MER must lead to action. Actors must implement structured feedback and corrective mechanisms.

2018. This requires: (i) Formal feedback to institutions, sites, and programmes. (ii) CAPs with clear actions, timelines, and responsibilities. (iii) Follow-up verification and documentation of corrective measures; and (iv) Continuous learning and system improvement.

2019. This is mandatory because monitoring without corrective action perpetuates failure. Feedback loops ensure that MER drives improvement, not compliance theatre.

2020. Closing the accountability loop requires: (i) Mandatory corrective action plans (CAPs) for identified gaps; (ii) Time-bound implementation and verification; (iii) Feedback mechanisms to inform policy and practice improvements.

2021. Failure to implement Corrective Action Plans (CAPs) leads to progressive sanctions up to withdrawal of approval.

G33.1.6. Integrated Logic

2022. The above five components operate as a single accountability cycle where: (i) indicators define what matters; (ii) monitoring collects evidence; (iii) evaluation interprets performance; (iv) reporting ensures transparency; and (v) corrective action closes the loop. Failure in any component breaks the cycle and compromises system integrity.

G33.1.7. Governance Rationale

2023. By mandating these MER components five components, the NETH framework: (i) ensures continuous oversight rather than episodic regulation; (ii) protects learners and patients through early risk detection; (iii) strengthens coordination across institutions and regulators; and (iv) builds public trust through transparent, evidence-based governance.

2024. Thus, the mandatory MER components transform NETH into a measurable, accountable, and continuously improving system, where performance is tracked, problems are corrected, and outcomes are demonstrably aligned with national health workforce needs.

G33.1.8. Mandatory Outputs

2025. The mandatory outputs under these guidelines include: (i) NETH Indicator Framework; (ii) Institutional MER alignment matrices; (iii) Routine monitoring datasets and verification notes; (iv) Evaluation reports; (v) Periodic Education and Training for Health reports and public summaries; (vi) Corrective action plans and verification records.

2026. Persistent non-reporting or data falsification; Failure to participate in evaluations; non-implementation of corrective actions; and obstruction of monitoring or audits triggers sanctions.

2027. The sanctions include: intensified inspections, conditional renewals, enrolment or placement caps, suspension, or withdrawal of approvals.

G33.2. The Monitoring, Evaluation, and Reporting Guidelines

G33.2.1. Purpose, Scope, and Legal Effect

2028. The MER Guidelines operationalise the MERR standards by defining how performance, compliance, quality, and safety are tracked, analysed, and acted upon across the Education and Training for Health system. They are binding administrative instruments: failure to monitor, evaluate, or report as required constitutes non-compliance with the Standards and triggers corrective action or sanctions.

2029. The guidelines apply to all HTIs, programmes, clinical training sites, regulators, and assessment bodies, regardless of qualification level or provider type. This moves NETH governance from episodic inspections to continuous, evidence-based oversight.

G33.2.2. Results Framework and Indicators

2030. MER shall be anchored in a results framework that links: (i) inputs (staffing, infrastructure, sites); (ii) processes (teaching, supervision, assessment); (iii) outputs (enrolments, completions, competencies); (iv) outcomes (employability, licensure, deployment); and (v) impact (health workforce adequacy and quality).

2031. A minimum national indicator set shall be prescribed to ensure comparability across institutions and regulators. This ensures monitoring focuses on outcomes and impact, not activity counts alone.

G33.2.3. Data Collection and Data Quality Assurance

2032. All MER data shall be collected using standardised definitions, templates, and tools.

2033. Requirements for MER include: (i) routine data validation and verification; (ii) traceable audit trails linking data to source records; (iii) controls against manipulation or selective reporting; and (iv) compliance with data protection and confidentiality laws. This ensure MER evidence is credible, auditable, and legally defensible.

G33.2.4. Institutional Monitoring Responsibilities

2034. Each HTI and training site shall operate internal monitoring systems covering: (i) institutional compliance (governance, staffing, infrastructure); (ii) programme delivery and assessment quality; (iii) clinical training safety and supervision; and (iv) learner welfare and incidents.

2035. Institutions must identify risks early and escalate material issues to regulators. This makes institutions the first line of quality and risk control.

G33.2.5. Regulatory and Sector-Level Monitoring

2036. Regulators (TVET Council, NCHE, Professional Councils, MoES, MoH) shall use MER data to conduct: (i) routine and risk-based inspections; (ii) cross-institutional performance analysis; and (iii) coordinated enforcement actions.

2037. MER outputs shall inform approvals, renewals, capacity ceilings, and sanctions. This replaces fragmented oversight with coordinated, data-driven regulation.

G33.2.6. Evaluation and Periodic Review

2038. Beyond routine monitoring, the system shall undertake periodic evaluations, including: (i) programme effectiveness reviews; (ii) institutional performance evaluations; and (iii) system-level reviews of workforce outcomes.

2039. Evaluations may involve external reviewers to ensure objectivity. This tests whether NETH interventions are achieving intended results and inform policy refinement.

G33.2.7. Reporting Requirements and Timelines

2040. Mandatory reporting shall include: (i) periodic institutional performance reports; (ii) enrolment, completion, and placement reports; (iii) incident and exception reports (safety, ethics, governance); and (iv) special reports as directed by regulators.

2041. Clear timelines, formats, and recipients shall be prescribed. This ensures timely information for decision-making and risk containment.

G33.2.8. Feedback, Learning, and Corrective Action

2042. MER is incomplete without actionable feedback. MER requirements include: (i) structured feedback to institutions and sites; (ii) Corrective Action Plans (CAPs) with timelines and responsibilities; (iii) follow-up verification of corrective actions; and (iv) dissemination of lessons learned and good practice.

2043. This converts monitoring into continuous improvement, not punitive reporting alone.

G33.2.9. Information Systems and Interoperability

2044. MoES and MoH shall coordinate the development of a NETH information architecture, ensuring: (i) a single set of core data fields used by all regulators; (ii) interoperability between institutional and regulatory systems; and (iii) avoidance of duplicative data requests.

2045. This reduces the reporting burden while improving data quality and coherence.

G33.2.10. Mandatory Records, Outputs, and Enforcement Linkages

2046. Institutions and regulators must maintain: (i) approved indicators and results frameworks; (ii) verified datasets and reports; (iii) inspection and evaluation reports; (iv) CAPs and verification records; and (v) decision notes linking MER evidence to approvals or sanctions.

2047. MER outputs constitute the primary evidence base for enforcement actions under the Standards. This ensures every regulatory decision is evidence-based and defensible.

G33.2.11. Governance Rationale

2048. Together, the MER Guidelines: (i) embed accountability and transparency across the Education and Training for Health system; (ii) enable early detection of risk and under-performance; (iii) support coordinated regulation and policy coherence; and (iv) ensure that education and training investments translate into safe, competent, and deployable health professionals.

2049. In effect, the MER Guidelines transform the NETH framework into a learning and accountability system—one where performance is continuously measured, problems are corrected early, and public trust is sustained through evidence-based governance.

G34.0 APPLICATION, ENFORCEMENT, TRANSITIONAL ARRANGEMENTS AND DECLARATION

2050. PIGs apply to all entities involved in NETH and shall be enforced in accordance with applicable laws, regulations, and mandates of the competent authorities.

2051. This guideline establishes the administrative and legal force, scope of application, enforcement authority, transition pathway, and formal declaration of the PIGs. This guideline ensures that: (i) Guidelines are binding and universally applicable; (ii) enforcement authority is clear and coordinated; (iii) existing institutions and programmes are transitioned lawfully and safely; and (iv) that the guidelines acquire formal administrative and legal effect upon issuance.

G34.1 Application of Policy Implementation Guideline: Scope and Applicability

2052. Application: These guidelines apply to: (i) all public and private HTIs; (ii) universities, colleges, specialised institutes, and training centres; (iii) training hospitals, clinical placement sites, and internship centres; (iv) Professional Councils, assessment bodies, and affiliated entities; (v) any person or body engaged in education and training for health.

2053. Application is automatic and mandatory; no additional adoption instrument is required at institutional level.

2054. Enforcement: Failure to align institutional operations to the Guidelines constitutes non-compliance and attracts enforcement action.

G34.2 Enforcement Authority and Mechanisms

2055. Enforcement of these Guidelines shall be undertaken by: (i) the Ministry responsible for Education; (ii) the Ministry responsible for Health; (iii) the National Council for Higher Education; (iv) the TVET Council; (v) the relevant Health Professional Councils; and any other authority legally mandated to regulate aspects of Education and Training for Health.

2056. Each authority shall enforce only within its lawful mandate, in coordination with others.

2057. The sanctions framework under these guidelines shall be graduated and proportionate. It shall include: (i) warnings and directives; (ii) conditional approvals; (iii) enrolment or placement caps; (iv) suspension of programmes or sites; (v) withdrawal of accreditation or designation; (vi) nullification of unlawfully offered training; and (vii) referral for legal or professional disciplinary action.

G34.3 Transitional Arrangements

2058. Purpose: Transitional arrangements are intended to: (i) ensure continuity of training; (ii) protect enrolled learners; (iii) allow institutions reasonable time to achieve compliance; and (iv) avoid abrupt disruption to health workforce supply.

2059. Enforcement: Institutions that fail to engage with transition requirements or pose immediate risk may be subject to immediate enforcement notwithstanding the transition period.

G34.4 Supremacy and Interpretation

2060. Interpretive authority: These guidelines shall be interpreted in a manner consistent with: (i) the NEHT Policy, 2025; (ii) NETH Policy implementation Standards; (iii) applicable education, health, and professional laws.

2061. In case of inconsistency in policy implementation instruments, the policy prevails over the Standards. In case of inconsistency in policy implementation instruments, the PISs prevails over the PIGs within their scope, subject to superior law.

G34.5 Declaration and Commencement

G34.5.1 Declaration

2062. These Policy Implementation Guidelines are hereby issued to give full operational effect to the National Education and Training for Health Policy, 2025 and the attached Policy Implementation Standards.

G34.5.2 Commencement

2063. The Policy Implementation Guidelines shall take effect on the date of signature and shall remain in force unless amended or revoked by the issuing authority.

2064. Mandatory outputs under this guideline include: (i) Signed guidelines instrument; (ii) official dissemination circulars; (iii) transitional implementation notice; (iv) transitional compliance plans and reports; and enforcement notices and decisions.

2065. With the issuance of this Guideline, the Policy Implementation Guidelines become fully binding, enforceable, and operational across the Education and Training for Health system in Uganda.

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