THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

ANNUAL HEALTH SECTOR PERFORMANCE REPORT

FINANCIAL YEAR

2017/18

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ACRONYMS

AAA	Automated Attendance Analysis
ACT	Artemisinin Combination Therapies
AfDB	African Development Bank
AHSPR	Annual Health Sector Performance Report
AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Ante Natal Care
ART	Anti-retroviral Therapy
ARVs	Antiretroviral Drugs
Hb	Haemoglobin
CAO	Chief Administrative Officer
CBD	Community Based Distributor
CCHF	Cramean Congo Haemorrhagic Fever
CCM	Country Coordinating Mechanism
CDC	Centres for Disease Control
CDR	Case Detection Rate
CEmNOC	Comprehensive Emergency Neonatal and Obstetric Care
CHEW	Community Health Extension Worker
CHIS	Community Health Insurance Schemes
CHW	Community Health Worker
CLTS	Community Led Total Sanitation
CPHL	Central Public Health Laboratories
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
CYP	Couple Years of Protection
DBS	Dry Blood Sample
DFID	Department for International Development
DHO	District Health Officer
DHT	District Health Team
DHMT	District Health Management Team

DLT	District League Table
DOTS	Directly Observed Treatment, short course (for TB)
DPT	Diphtheria, Pertussis (whooping cough) and Tetanus vaccine
EAC	East African Community
EDC	Effective Development Cooperation
EID	Early Infant Diagnosis
EMHS	Essential Medicines and Health Supplies
CAO	Chief Administrative Officer
CEmOC	Comprehensive Emergency Obstetric Care
CHEW	Community Health Extension Worker
CLTS	Community Led Total Sanitation
CQI	Continuous Quality Improvement
CSO	Civil Society Organization
EID	Early Infant Diagnosis
eMTCT	Elimination of mother-to-child transmission of HIV
FP	Family Planning
FY	Financial Year
GAVI	Global Alliance for vaccines and Immunization
GBV	Gender Based Violence
GFTAM	Global Fund to fight TB, Aids and Malaria
GH	General Hospital
GoU	Government of Uganda
HAART	Highly Active Anti-Retroviral Therapy
HC	Health Centre
HDP	Health Development Partners
HIC	Home Improvement Campaign
HRIS	Human Resource Information System
HMIS	Health Management Information System
HPAC	Health Policy Advisory Committee
HPC	Health Professional Councils
HPV	Human Papilloma Virus

HRH	Human Resources for Health
HRSP	Humand Resource Strengthening Project
HSD	Health Sub-District
HSDP	Health Sector Development Plan
HTI	Health Training Institution
IDSR	Integrated Disease Surveillance and Response
iCCM	Integrated Community Case Management
IEC	Information Education and Communication
iHRIS	Integrated Human Resource Information System
IMAM	Integrated Management of Acute Malnutrition
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IPT	Intermittent Preventive Treatment for malaria
IRS	Indoor Residual Spraying
ITNs	Insecticide Treated Nets
JCRC	Joint Clinical Research Center
JICA	Japan International Cooperation Agency
JMS	Joint Medical Stores
JRM	Joint Review Mission
KCCA	Kampala City Council Authority
KOICA	Korea International Agency for Cooperation
LG	Local Government
MakSPH	Makerere University School of Public Health
MDR	Multi-drug Resistant
MIP	Malaria in pregnancy
MMR	Maternal Mortality Ratio
MoES	Ministry of Education and Sports
MoFPED	Ministry of Finance, Planning and Economic Development
MoGLSD	Ministry of Gender, Labour and Social Development
MoH	Ministry of Health
MoPS	Ministry of Public Service

MOU	Memorandum of Understanding
MPDSR	Maternal Perinatal Death Surveillance & Review
MTEF	Medium Term Expenditure Framework
NCD	Non Communicable Diseases
NCRI	National Chemotherapeutic Research Institute
NDA	National Drug Authority
NDC	National Disease Control
NGOs	Non-Governmental Organizations
NHIS	National Health Insurance Scheme
NHP	National Health Policy
NMCP	National Malaria Control Program
NMR	Neonatal Mortality Rate
NMRL	National Microbiology Reference Laboratory
NMS	National Medical Stores
NPHC	National Population and Housing Census
NSDS	National Service Delivery Survey
NTDs	Neglected Tropical Diseases
NTLP	National Tuberculosis and Leprosy Control Program
ODF	Open Defecation Free
OPD	Out Patients Department
OPM	Office of the Prime Minister
OSH	Occupational Safety and Health
PHC	Primary Health Care
PLWHA	People with HIV/AIDS
PMI	Presidential Malaria Initiative
PMDT	Programmatic Management of Multi-Drug Resistant TB
PMDU	Prime Minister's Delivery Unit
PMTCT	Prevention of Mother to Child Transmission
PNFP	Private Not for Profit
PPFP	Post Partum Family Planning
PPH	Post Partum Haemorrhage

PPPH	Public Private Partnership for Health
PRDP	Peace Recovery and Development Plan
RBF	Results Based Financing
RH	Reproductive Health
RMNCAH	Maternal and Child Health
RRH	Regional Referral Hospital
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender Based Violence
SHRH	Strengthening Human Resources for Health
SLD	Second Line Drugs
SMC	Senior Management Committee
SMER	Supervision, Monitoring, Evaluation and Research
SP	Sulfadoxine/Pyrimethamine
STI	Sexually Transmitted Infection
SUO	Standard Unit of Output
TB	Tuberculosis
TFR	Total Fertility Rate
TMC	Top Management Committee
TPR	Test Positivity Rate
TSR	Treatment Success Rate
TWG	Technical Working Group
UACP	Uganda Aids Control Program
UBOS	Uganda Bureau of Statistics
UBTS	Uganda Blood Transfusion Services
UCI	Uganda Cancer Institute
UDHS	Uganda Demographic and Health Survey
UHC	Universal Health Coverage
UHI	Uganda Heart Institute
UNEPI	Uganda Expanded Program on Immunization
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund

UNMHCP	Uganda National Minimum Health Care Package
UNRHO Uganda	National Health Research Organisation
UPHIA	Uganda Population based HIV Impact Assessment
URHVP	Uganda Reproductive Health Voucher Project
URMCHIP	Uganda Reproductive Maternal Child Health Improvement Project
USAID	United States Agency for International Development
USF	Uganda Sanitation Fund
UVRI	Uganda Virus Research Institute
VHF	Viral Haemorrhagic Fever
VHT	Village Health Team
VL	Viral Load
WHO	World Health Organization

FOREWORD

The health sector has implemented the third year of the Health Sector Development Plan and our goal is ***'To accelerate movement towards Universal Health Coverage with essential health and related services needed for promotion of a healthy and productive life'***. In line with statutory requirements, Government reviews the annual performance of the health sector in order to assess progress on agreed outputs, performance of the health sector and come up with strategies and recommendations on how to improve health care service delivery.

The Annual Health Sector Performance Report for Financial Year 2017/18 reports on the progress of the health sector against the annual work plans as well as the overall health sector performance against the annual targets of the HSDP 2015/16 – 2017/18 key performance indicators. This annual report is the third under the HSDP. This report shall be presented to stakeholders at the 24th Joint Review Mission in which the sector shall specifically review what has been achieved, what has not been achieved and the reasons why the set targets have not been achieved. The review shall guide future planning and programming and help to refocus priorities towards achieving the HSDP and NDP II targets.

The sector will continue to prioritize interventions defined in the five-year HSDP with emphasis on efficiency and effectiveness in health service delivery. The Ministry of Health recognizes the contributions of the relevant Ministries, Departments and Agencies, Health Development Partners, the Civil Society Organizations, the Private Sector and the Community in the achievement of progress in financial year 2017/18.

Improvements in performance were made possible by the commitment of health providers and health workers in the public and private sector, working under sometimes difficult conditions especially in the hard to reach districts in the country. I commend the dedicated and productive health workers and implore and appeal to those who are not dedicated to work ethics in the health sector to improve so that the country health indicators improve to acceptable levels.

The Ministry of Health expressed gratitude to the Ministry of Health Technical Working Groups, divisions, programs and all partners for their contributions in the preparation of this Annual Health Sector Performance Report and co-financing the Joint Review Mission. Special gratitude to the MoH Planning Department that ensured that this annual report was compiled and presented as required.

For God and My Country

Hon. Dr. Jane Ruth Aceng
MINISTER OF HEALTH

EXECUTIVE SUMMARY

The Annual Health Sector Performance Report (AHSPR) highlights progress, challenges, lessons learnt and proposes mechanisms for improvement. The report focuses on the progress in implementation of commitments in the Ministerial Policy Statement, overall sector performance against the targets set for the Financial Year (FY) 2017/18, and trends in performance for selected indicators over the previous FYs. The compilation process of the AHSPR 2017/18 was participatory with involvement of all the 14 Technical Working Groups, Senior Management Committee, Health Policy Advisory Committee and Top Management.

Data

The report focuses on the key indicators for monitoring performance of the HSDP 2015/16 - 2019/20 which are linked with the monitoring of the second National Development Plan (NDP II) and international initiatives such as the Sustainable Development Goals (SDGs). The report is based on the health facility and district reports gathered as part of the routine Health Management Information System (HMIS), administrative sources, program data and surveys. Generation of output indicators for this report largely utilized data from the DHIS2, with timeliness of monthly HMIS 105 reporting at 95% in 2017/18 from 88% in 2016/17 and completeness at 94.3%. Coverage estimates for the routine HMIS indicators uses the UBOS 2017 mid-year population projections to estimate the target populations.

Service coverage

The sector recorded improvement in ART coverage from 73% (964,232 adults and 64,677 children) in 2016/17 to 86% (1,074,000 adults and 66,110 children) in 2017/18; HIV positive pregnant women not on HAART receiving ARVs for elimination of mother-to-child transmission of HIV during pregnancy, labour, delivery and postpartum improved to 95% (95,523/103,670) from 90%.

TB case detection rate increased to 56% from 50% in 2017/18 but still far below the HSDP target of 78% for the year; IPT2 coverage for pregnant women increased by 16% to 63.2% from 54.5% in 2016/17. IPT3 coverage was only 9.4%.

Inpatient malaria deaths decreased significantly by 52% to 9.38 per 100,000 from 20 per 100,000 in 2016/17 but still below the HSDP target of 5 per 100,000 as envisioned in the Malaria Reduction Plan. Similarly, the number of malaria cases per 1,000 persons decreased by 39.5% to 293 per 1,000 from 433 per 1,000 in 2016/17. Upto 72% (7,942,257/11,062,306) patients diagnosed with malaria were Lab. Confirmed compared to 69% (10,922,161/15,857,997) in 2016/17. Reported Test Positivity Rate reduced from 49% in the FY 2016/17 to 39% in FY 2017/18.

In the FY 2017/18, the MoH with support from partners conducted IRS in 1.3 million housing units in 26 districts in eastern and northern Uganda protecting 17% of Uganda's population. However, the level of protection was far below the UMRSP target for this year of at least 30% of the population protected.

During the FY 2017/18 the GoU with support from partners concluded the LLIN mass campaign where a total of 26.5 million LLINs were distributed country wide. Preliminary results from this exercise show high coverage rates of over 95% in all districts. Recent decreases in the incidence and test positivity rate of malaria in Uganda can be attributed largely to increased LLIN coverage following this just concluded mass campaign.

The under-five Vitamin A coverage increased to 35.3% from 25.3% in 2016/17 but still far below the HSDP target of 62%. This is despite the availability of Vitamin A capsules at health facilities. Issues of documentation especially during the Child Days Plus need to be addressed. According to UDHS 2016, 61.9% of children 6 – 59 months were given vitamin A supplements in past 6 months. After adjustment, 9% of children age 6-59 months have vitamin A deficiency (<0.825 µmol/L). This is a substantial decline from 33% in 2011.

$DPT_3HibHeb_3$ coverage in 2017/18 was at 95% achieving the HSDP target of 95%; and measles coverage also increased slightly to 88% from 86.7% in 2016/17 and still below the target of 95%.

Bed Occupancy Rate (BOR) is a measure of utilization of the available bed capacity. BOR was 76% for all hospitals and HC IVs below the target of 85%. National Referral Hospitals had a BOR of 89%, RRHs had BOR of 78%, general hospitals at 50%. BOR at the HC IVs declined to 47% from 54% in 2016/17. There is need to improve the functionality of the HC IVs and general hospitals to decongest the RRHs so that they concentrate on delivering secondary level care.

Average length of stay (ALOS) in hospitals refers to the average number of days that patients spend in hospital and is used as an indicator of efficiency. The ALoS for all hospitals and HC IVs was 4.7 days and the target is 3 days. ALoS for the RRHs reduced to 5.6 in 2017/18 from 6.9 in 2016/17 and also there was a decline from 5.1 to 4.9 in the general hospitals. There was no change in the ALoS for the HC IVs which remained at 3.2 days.

Couple Years of Protection is a measure of family planning use and there was an 18% increase in the Couple Years of Protection (CYP) to 2,540,251 in 2017/18 from 2,156,240 in 2016/17. There was a notable increase in the use of IUDs and implants but a decrease in the users for all other methods.

Antenatal Care four visits increased minimally to 38% in 2017/18 from 37% (677,338/1,830,295) in FY 2016/17 and far below the HSDP target of 42.5%. ANC4+ visits were highest in the districts of Moyo (72.7%), Bushenyi (64.1%), Kabarole (62.1%), Adjumani (61.9%) and Buhweju (57.9%).

Health facility deliveries were increased slightly to 60% from 58% in 2016/17 and still below the HSDP target of 80%. The sector also achieved an increase in the proportion of HC IVs offering Comprehensive Emergency Obstetric Care (i.e. Caesarean section and blood transfusion) from 44.6% (83/186) in 2016/17 to 48% (87/186) in 2017/18, HC IVs conducting Caesarean Sections including without blood transfusion increased from 70.4% (131/186) to 78% (142/186) in 2017/18. This means that a total of 55 out of the 142 HC IVs (39%) are performing C/S without blood transfusion services. There is need to increase blood transfusion services at HC IV level. A total of 17,729 C/S were conducted at the 142 HC IVs and of these following HC IVs performed the highest number of C/S; Mukono Town Council HC IV (1,533), St. Paul HC IV (1,054), Rukunyu HC IV (803), Mpigi HC IV (585), Rwekubo HC IV (534) and Kyegegwa HC IV (506).

Access and Quality of Care

New OPD utilization rate for FY 2017/18 was 1.1 of which per capita utilization for males was 0.9 and females 1.3 indicating that females utilize the OPD services more than males and Hospitals admissions reduced to 3.25 per 100 population from 3.67 per 100 in 2016/17. The HSDP target was 9 per 100 for 2017/18 which seems to be on the high side and needs to be reviewed. The decline in admissions is largely due to the decline in malaria cases.

According to the Uganda National Household Survey, 86% of the population access healthcare within a 5 km radius an increase from 83% in 2012/13 though there are regional variations in access with Acholi region having over 34% of the population having to travel more than 5 km.

Medicines & Health Supplies

The availability of health commodities in the last quarter of FY 2016/17 as measured by a basket of 41 commodities increased to 85% in 2017/18 from 83% in 2016/17, and an average of 57% of health facilities that reported had over 95% availability of the basket of commodities in comparison with 55% in 2016/17. Key commodities such as ACT's were overstocked (> 5 months of stock). However, nutritional commodities, some RMNCH and TB commodities were either low stocked or stocked out. The reduction in malaria cases led to a reduction in ACTs consumed by almost 9.5 million doses in this FY compared to last year resulting in overstock of malaria commodities in many facilities. In respect to stock out of TB commodities, the global shortages of the active pharmaceutical ingredients (rifampicin) resulting into longer lead times depleting the buffer stock and leading to stock out of TB commodities. Accumulation of Depo Provera at facility level initially led to overstock and expiries, this led to NMS suspending the procurement of Depo Provera leading to the current stock out.

UGX 7.4 billion which is 50% of the entire PHC non-wage grant to PNFPs was released to JMS to procure and distribute EMHS for accredited 550 PNFP facilities and the facility order fill rate was 99.4%.

Quality of Care

In respect to quality of care, the facility based fresh still births (per 1,000 deliveries) reduced to 9.4 per 1,000 deliveries from 10.1 per 1,000 in 2016/17 and above the HSDP target of 13/1,000 for the year. The number of maternal deaths among 100,000 health facility deliveries also reduced by 30% to 104 per 100,000 health facility deliveries from 148 per 100,000 in 2016/17. In 2017/18 FY a total of 1,111 maternal deaths were reported through the MoH HMIS compared to 1,118 in 2016/17. Of these only 555 (50%) reviewed/audited compared to 267 (24%) in 2016/17. This is a 108% increase in the number of maternal deaths reviewed and this is largely because of the training conducted and dissemination of the MPDSR guidelines. Haemorrhage (48.5%) and hypertensive disorders of pregnancy (12.5%) were the major casues of maternal deaths.

The rate of under five deaths among 1,000 under 5 admissions increased to 22.4 per 1,000 admissions compared to 20.2 per 1,000. The HSDP target was 16.9 per 1,000

ART retention declined to 76% in 2017/18 from 82% in 2016/17 which is short of the HSDP target of 84% and TB treatment success rate declined to 77% in 2017/18 from 80% in 2016/17 which is still far below the HSDP target of 86% for the year.

The Client Satisfaction Index was not assessed this year however, there was an assessment of the community perspectives on an array of healthcare related services undertaken in the Uganda National Household Survey 2016/17 by UBOS. According to the UNHS 2016/17, the major concerns of the communities in accessing health services at the public health facilities were; unavailability of medicines/supplies (23%), long waiting time (13%), long distance (12%), limited range of services (14%) and understaffing (10%). Whereas, in private facilities, it was found that the services being expensive (39%) ranked top followed by limited range of services (23%) and long distance (9%).

Health Risks and Social Determinants

National Household Survey report of 2016/17 findings show that 83% of households used pit latrines. Only 3% used flush toilets. 84% of households did not have hand washing facilities and of the households that had, 8% had facilities with water only and only 6% had facilities with both soap and water.

The Uganda Sanitation Fund Program was implemented in 40 districts. At least 7,901 of the 11,354 villages targeted by the program have so far been declared ODF, reflecting an overall performance level of 70%. In FY 2017/18; among the USF supported districts, the average latrine coverage now stands at 96%. A total of 30,341 new hand washing facilities constructed across all the 40 USF districts. According to the UNHS 2016/17, overall, 79.8% of households in Uganda had access to improved sources of drinking water compared to 67.7% in 2012/13. 96% of households were within 3 km of the main drinking water source.

There was no significant investment in building the capacity of Village Health Teams (VHTs). Much effort was towards finalizing the Community Health Extension Workers (CHEWs) policy, strategy, training curriculum and resource mobilization. Selection of the CHEW trainees in the 13 pilot districts was conducted and training of the CHEWS shall commence in FY 2018/19. Some HDPs e.g. USAID, UNICEF & WHO have committed to supporting the funding of the training, supplies and tools in the first year.

Health Financing

The health sector received a total of Ug. Shs 1.95 trillion representing 6.7% of the total national budget, and 66% of the budget was released. All votes received about 100% of the revised budget except MoH Headquarter (36%) and Uganda Cancer Institute (48%) who received low disbursements for their donor funded projects largely due to delays in donor approvals and delays in the procurement process resulting from readjustments in the technical aspects of the UCI ADB supported project. The wage component was absorbed up to 96% and the Non-Wage recurrent was absorbed up to 99%.

Except for the PHC wage component that has been rising, to cater for annual salary increments and recruitment of health workers in the LGs the other grants have remained static over the last 8 years. The average PHC Non-wage allocations per level of service are far below what is required to carry out the core functions of management and ensure quality service delivery. In FY 2017/18, the average annual PHC Non-Wage allocation for HC IVs was Ug. Shs. 30,665,866/= and HC IIIs Ug. Shs. 8,898,710/= against a requirement of Ug. Shs. 42,232,000/= and Ug. Shs. 15,592,000/= respectively.

In 2017/18, there were 8 organizations promoting Community Health Insurance Schemes and they supported 12 schemes spread in 20 districts of Western and Central Uganda covering a total of 152,260 people representing 0.4% of the population in Uganda. Depending on the scheme / product, members pay a co-payment at the point of service ranging from Ug. Shs. 1,000/= to 30,000/= per episode. All schemes have a ceiling on the amount the scheme pays per episode ranging between Ug. Shs. 80,000/= to 500,000/=.

A number of health facilities received additional funding through the Results Based Financing approach; the USAID/Uganda Voucher Plus Activity paid out Ug. Shs, 10.93 billion to 156 contracted health facilities in Northern and Eastern Uganda, the PNFP and Institutional Capacity Building Projects supported by (Enabel / Belgium Government) in West Nile and Rwenzori Region paid out Ug. Shs. 7.7 billion and 3.6 billion respective to 82 contracted health facilities.

Human Resource

The health sector staffing improved slightly in 2017/18 to 74% from 73% (45,029/61,796) in 2016/17. The number of health workers per 1,000 population in Uganda is still far below the WHO threshold of 2.5 medical staff (doctors, nurses and midwives) per 1,000 population. In 2017/18 FY the doctors, nurses and midwives ration per 1,000 population was only 0.4 compared to the WHO recommendation of 2.5.

Overall, the stock of qualified health profession available for employment in the health sector increased from 90,412 (2017) to 101,350 (June 2018). This is attributed to increase in production from pre-service training of some cadres e.g. Nurse, Midwives, Laboratory staff and Clinical Officers.

During the FY 2017/2018, the focus was on strengthening the community health workforce through establishment of a motivated cadre of CHWs namely the CHEWs and the development of systems for the management of the community health workforce in general.

A total of 188 scholarships were awarded for training of critical cadres like anaesthetists, anaesthetic assistants, biomedical engineers, among others.

The Integrated Human Resource Information System (iHRIS) has been established in all LGs and central institutions however, functionality is still low. Some of the challenges affecting functionality so far is inability of institutions to update data in the system regularly and low use HRIS data for decision making particularly at district level.

With funding support from DFID, OPM the sector acquired 52 biometric fingerprint readers and 188 Robust phones to facilitate real time reporting and improve the quality of data in in 8 general district hospitals, 29 HC IVs and 183 HC IIIs and 1 HC II. Duty attendance rose from 79% in January 2017 to 87% in May 2018.

Automated Attendance Analysis was rolled out to all districts by February 2018 and by March 2018 the absenteeism without authority had reduced from an average 10% same time in April 2017 to 9%. In addition, absenteeism (with or without approval) reduced from 42% in 2017 to 22% in 2018.

Health Infrastructure

Investments in health infrastructure has continued and this included construction of new and rehabilitation of old infrastructure at various levels, provision of medical equipment and hospital furniture; provision of solar lighting, improvement of operations and maintenance of health infrastructure and general transport in some districts.

Examples of major infrastructure development projects during 2017/18 were; Rehabilitation of Mulago National Referral Hospital, completion of the 450 bed Specialised Women and Neonatal hospital at Mulago; installation of 13 medical oxygen plants completed and access to high quality medical oxygen enhanced in all RRHs; completion of 19 medicines stores and 26 semi-detached staff houses under GAVI, construction of 68 staff housing units in Karamoja region; construction of new warehouse for NMS at Kajjansi commenced; maintenance of solar systems was carried out in 634 / 665 HCs; maintenance of 42 Philips x-ray machines, 6 automatic printers and 49 Philips ultrasound scanners in 10 RRH, 23 GHs & 28 HC IVs by M/s Dash-S Technologies Inc. 22 out 36 x-ray machines maintained are functional. Rehabilitation of Kayunga, Yumbe and Kawolo general hospitals;

renovation of general hospitals / HC IVs in 28 LGs under the PHC Development Grant. In addition, 15 double cabin pick-ups were procured for District Health Offices and procured Medical Equipment and Furniture for distribution to Hospitals and HC IVs.

Monitoring Implementation of the Country Compact and IHP+

Functionality of the HPAC is very crucial in monitoring implementation of the Compact and provision of advice on the implementation of the HSDP and policies. Twelve monthly meetings were held and 10 of these were on the scheduled dates (first Wednesday of the month). Overall average attendance of HPAC members was 49%. Representatives of HDPs, Private sector and Medical bureaus attended above average of 50%. A total of 35 items (17 policy issues and 18 non policy issues) were presented and discussed in these meetings.

11 out of the planned 12 (92%) Senior Management Committee meetings were held during 2017/18 FY and proceedings fed into the HPAC meetings. Only half of the Technical Working Groups held regular monthly meetings from which the policy and strategic issues discussed were synthesized and forwarded to the SMC for further review and appropriate action.

District League Table Performance

There is an improvement in the DLT national average performance by 4% to 69.2% from to 66.2% in 2016/17. Remarkable improvement was registered in the maternal deaths audited to 50% from 23.9% in 2016/17. Among all the 121 LGs and KCCA the top five are Adjumani (86.3%), Moyo (85.6%), Bushenyi (83.4%), Gulu (82.1%) and Kabarole (81.7%). The bottom five LGs in performance are Buliisa (60.1%), Abim (59.6%), Nakapiripirit (59%), Amudat (58%) and Luuka (56.3%). The most improved district between 2016/17 and 2017/18 FY was Amudat with 25% positive change followed by Bulambuli and Kaabong both with a 22% and Buvuma 21% change in score.

Factors like influx of refugees can have a positive or negative effect on service delivery but also on the performance indicators which are based on utilization rates. This is shown by marked improvement in the DLT performance in the refugee host district and therefore there is need to establish clear monitoring mechanism and adjustment of the district population figures for performance assessment.

Regional Referral & Large PNFP Hospital Performance

Beginning this FY 2017/18 the SUO for the referral hospitals has been revised to take into account the core services of a referral hospital in comparison to a general hospital or HC IV which serve as primary referral facilities. Thus, the following outputs ANC, FP, Immunization & postnatal attendances have been replaced with major surgery for computation of the SUO.

The total SUO for the 14 RRHs and 4 Large PNFP Hospitals was 9,834,485 in FY 2017/18 compared to 9,837,521 in 2016/17. There was almost no increase in the number of deliveries at the RRHs. A total of 60,277 major operations were conducted in FY 2017/18. There was a decline in the number of admission and OPD attendances in the RRHs FY 2017/18 and this could be attributed to the overall reduction in the malaria cases as a result of the LLINs distribution. Mbale RRH continues to produce significantly higher SUOs than other RRHs mainly owing to the much higher number of admissions (49,306) compared to other RRHs. Mengo Hospital (263,703) and Masaka (257,091) have the highest total OPD attendances; Masaka (9,594), Naguru (8,312) and Hoima (8,222) have the highest deliveries; and Mbarara (5,868), Mbale (4,781) and Hoima (4,301) conducted the highest number of major operations. The change is the variable for the SUO has not resulted in significant change in the total SUO for the hospitals however, there are observed positive (increase in SUO) and negative (decrease in SUO) changes in the SUO for some of the hospitals ranging from +23% for Mengo to -24% for Mubende RRH.

The total number of Caesarean Sections (C/S) increased to 1,802 in 2017/18 from 1,603 in 2016/17. Mbarara (3,078) and Masaka (2,929) performed the highest number of C/S. Gulu (426) and Moroto (160) had the lowest C/S performed. There was a significant increase in the number of C/S performed by Masaka RRH from 657 in 2016/17 to 2,929 in FY 2017/18. Nsambya hospital had the highest C/S rate of 50.3%, Lubaga 41.6% and Mbarara 39.9%. The lowest C/S rate was in Gulu RRH at 12.3%.

The average number of maternal deaths in the RRHs was 20. Fort Portal (53) and Hoima (52) RRHs had the highest number of maternal deaths during the year and Moroto (1), Gulu (2) and Kabale (2) had the lowest. There was a significant increase in the number of maternal deaths in Mbarara RRH from 24 in 2016/17 to 41 deaths in 2017/18 whereas, Masaka RRH registered a decrease from 45 deaths in 2016/17 to 27 in 2017/18.

Fresh Still Births (FSB) at RRHs also continued to be a major challenge with the highest of 48/1,000 deliveries in Hoima RRH followed by Mubende at 31/1,000, then Fort Portal and Arua RRHs at 29/1,000 and 27/1,000 hospital deliveries respectively. Moroto, Mengo and Nsambya had the lowest FSB rate at 2/1,000 deliveries.

General Hospital Performance

The total SUO for the General Hospitals1 has been revised this FY by inclusion of major surgery as one of the variables to assess performance. The SUO for the 129 General Hospitals whose HMIS data was analysed this FY increased from 17,418,297 to 17,508,504. There was a decline in the total OPD attendances and admissions in the hospitals but a very significant increase in the total immunizations.

Iganga General Hospital has the highest SUO of 523,532 followed by Mityana Hospital with 386,533 SUO. The lowest ranked hospitals are predominantly private hospitals with no or irregular reporting through the national system. Overall improvement was noted mainly in the private hospitals and this is attributed to improved reporting by the private hospitals. Nakesero hospital was the most improved hospital by 56% from SUO 85,101 in 2016/17 to 192,948 in 2017/18 followed by Kibuli (41% change), Mbarara Community (39%), Bethany Women & Family (37%), Rushere Community and Kabasa Memorial (30%).

Apart from the increase in the number of C/S carried out from 48,695 in 2016/17 to 60,071 in 2017/18; and number of major operations to 105,375 from 87,274 in 2016/17, and a slight reduction in the Fresh Still Birth risk from 16/1,000 to 15/1,000 facility deliveries, the rest of the parameters showed that there was no improvement in the quality of services.

The average C/S rate in the general hospitals increased to 28% in 2017/18 from 25% in 2016/17 FY. Nakasero Hospital had the highest C/S rate of 72% (1,069 C/S out of 1,481 deliveries), followed by Bethany Women and Family Hospital at 55%.

Maternal Mortality continues to be a major challenge in the general hospitals as well. St. Mary's Lacor reported the highest number of maternal deaths at 26, followed by Kagadi (15); Kamuli Mission (14); Lubaga (14); Iganga (13) and St. Joseph Kitovu (13).

Health Centre IV Performance

HC IVs generated a total of 13,161,745 SUO in 2017/18 compared to 14,432,943 SUO in FY 2016/17 and 13,780,782 in 2015/16. The reduction is largely due to the reduction on OPD attendances from 4,115,947 in 2016/17 to 3,597,388 in 2017/18 and admissions reducing from 571,653 to 503,888. This can be attributed to the overall reduction in OPD attendances and admissions due to the reduces cases of malaria following distribution of LLINs and IRS in some districts. There is a marked increase in total immunizations from 850,236 in 2016/17 to 2,101,126 in 207/18.

Kisenyi HC IV ranked number one with 291,855 SUO, followed by Mukono T.C, Luwero, Kumi, Budadiri and Budaka HC IVs. Kisenyi HC IV had the highest OPD attendances (83,771), deliveries (9,608), ANC (39,397) and postnatal care attendances (18,747). The highest admissions were in Mukono TC HC IV (10,168) and the highest family planning visits were at Lwengo HC IV (16,342).

The bottom 10 HC IVs using the SUO parameters in 2017/18 are, Bushenyi, Mbarara Municipal Council, Nyamirami, St. Franciscan, Bukwa, Kataraka, Ntuusi, ASTU, Ayira Health Services and Hiima HC IV. Hiima HC IV, Ayira Health Services and ASTU have very low outcomes equivalent to HC III level. Kamukira, Kikuube, ASTU and Mbarara Municipal Council HC IVs did not provide inpatient services.

[1] General Hospital SUO total = ∑ (Outpatients*1 + (Total ANC Visits*0.5 + Postnatal Care attendances + Family Planning) *0.5 + Total Immunizations*0.2 + Deliveries*5 + Inpatients*15 + Major Surgery*20)

Conclusion

The health sector has registered progress in a number of indicators however, still faces so a huge burden of preventable diseases including disease outbreaks, inadequate staffing coupled with inefficient supervision, inadequacy in maintenance of medical equipment, poor health infrastructure, low use of data and inadequate funding for PHC activities.

There is need to invest in health promotion and diseases prevention interventions to reduceon the disease burden, increase funding to address the gaps in health service delivery and promote use of the data generated through the National Health Information System.

1 INTRODUCTION

1.1 Background

The Annual Health Sector Performance Report (AHSPR) is an institutional requirement compiled to highlight progress, challenges, lessons learnt and propose ways of moving the health sector forward in relation to the National Development Plan (NDP), National Health Policy, and the National Health Strategy. The AHSPR Financial Year (FY) 2017/18 is the eighteenth annual report produced by the Ministry of Health (MoH). This report is the third annual report for the Health Sector Development Plan (HSDP) 2015/16 - 2019/20. The report mainly focuses on the progress in implementation of the annual work plans for the different health sector institutions as well as overall health sector performance against the HSDP key performance indicator targets set for the FY 2017/18, performance of the Districts as per the District League Tables and performance of the hospitals and Health Center (HC) IVs using the Standard Unit of Outputs (SUO). The sector performance will be deliberated upon during the 24th Joint Review Mission (JRM) slated for 30th to 31st October 2018. The outcomes of the sector performance review are expected to guide planning and programming for the next FY 2019/20.

1.2 Vision, Mission, Goal and Strategic Objectives of the HSDP 2015/16 – 2019/20

1.2.1 Vision

The vision of Uganda's health sector is to have a healthy and productive population that contributes to economic growth and national development.

1.2.2 Mission

The mission of the sector is to facilitate the attainment of a good standard of health by all people of Uganda in order to promote a healthy and productive life.

1.2.3 Goal

The sector's goal as stipulated in the HSDP is to accelerate movement towards Universal Health Coverage (UHC) with essential health and related services needed for promotion of a healthy and productive life.

1.2.4 Strategic Objectives

The overall strategic direction for the sector is provided by the strategic objectives of the HSDP namely;

i. To contribute to production of a healthy human capital for wealth creation through provision of equitable, safe and sustainable health services.
ii. To address the key determinants of health through strengthening inter sectoral collaboration and partnerships.
iii. To increase financial risk protection of households against impoverishment due to health expenditures.
iv. To enhance the health sector competitiveness in the region and globally.

1.3 The Projected Demographics for FY 2017/18

The population for the period under review has been projected from UBOS's National Population and Housing Census 2014 using a growth rate of 3%. The projected figures are shown in table 1.

TABLE 1: POPULATION PROJECTIONS FOR FY 2017/18

Demographic Variable	Proportion	Population
Total population	100%	37,741,300
Males	48.6%	18,342,272
Females	51.4%	19,399,028
Children under 1 year	4.3%	1,622,876

Children under 5 years	17.7%	6,680,210
Children below 18 years	55.1%	20,795,456
Adolescents and youth (young people) (10 – 24 years)	34.8%	13,133,972
Expected pregnancies	5%	1,887,065
Women of reproductive age (15 - 49 years)	20.2%	7,623,743

UBOS Mid-year population projections 2017

1.4 The process of compiling the report

The process of compiling the AHSPR was highly participatory with all departments and programs of MoH. The initial drafts were compiled by Technical Working Groups (TWGs) composed of MoH, Health Department Partners (HDP), Private Sector, Medical Bureau and Civil Society representatives, and collated by MoH Planning Department secretariat for writing the report.

Information used for compiling the report was both quantitative and qualitative and consisted principally of data generated from the MoH Health Management Information System (HMIS) - District Health Information Software (DHIS) - 2 supplemented by;

i. Ministerial Policy Statement (MPS) 2017/18
ii. Annual Health Sector Performance Reports 2015/16, 2016/17
iii. Monitoring and Evaluation (M&E) Plan for the HSDP 2015/16 to 2019/20
iv. Quarterly progress reports for the FY 2017/18
v. Quarterly financial reports (PBS) FY 2017/18
vi. Program and project reports
vii. Human Resource Audit Report 2017
viii. Uganda National Household Survey Report, 2016/17
ix. National Service Delivery Survey Report, 2015
x. Uganda Population based HIV Impact Assessment, 2016
xi. Malaria Indicator Survey Report, 2015
xii. TB Prevalence Survey Report, 2016

2 Overall Sector Performance and Progress

This chapter highlights an overview of the sector performance of FY 2017/18. It focuses on the performance indicators enshrined in the HSDP 2015/16 – 2019/20, MPS of FY 2017/18 and annual work plans from different departments and institutions in the sector.

2.1 Disease Burden

The MoH routinely monitors the disease burden in the country using the HMIS which captures data from both public and private health facilities in the country.

Malaria was still the leading cause of illness for all ages accounting for 29.5% of all OPD attendances followed by no pneumonia (cough or cold) at 26.9% followed by urinary tract infections at 4.5% and intestinal worms at 4%.

TABLE 2: TOP 20 CAUSES OF OPD ATTENDANCE ILLNESS IN FY 2017/18

No.	Diagnosis	Under 5 Cases	5 and Above cases	Total	%
1.	Malaria	2,739,723	8,322,583	11,062,306	29.5%
2.	No Pneumonia - Cough or Cold	2,773,485	7,292,362	10,065,847	26.9%
3.	Urinary Tract Infections	91,147	1,613,224	1,704,371	4.5%
4.	Intestinal Worms	335,083	1,144,770	1,479,853	4.0%
5.	Gastro-Intestinal Disorders (non-Infective)	131,938	1,336,011	1,467,949	3.9%
6.	Diarrhoea-Acute	803,989	609,403	1,413,392	3.8%
7.	Skin Diseases	423,150	887,618	1,310,768	3.5%
8.	Pneumonia	463,465	514,652	978,117	2.6%
9.	Other Eye Conditions	214,272	638,225	852,497	2.3%
10.	Injuries (Trauma due to other causes)	64,218	523,160	587,378	1.6%
11.	Sexually Transmitted Infections	12,286	518,116	530,402	1.4%
12.	Hypertension	-	513,921	515,373	1.4%
13.	Tooth Extractions	24,894	489,899	514,793	1.4%
14.	Pelvic Inflammatory Disease	-	502,206	505,023	1.3%
15.	ENT conditions	79,026	371,484	450,510	1.2%
16.	Dental Caries	22,449	330,433	352,881	0.9%
17.	Otitis media	90,209	165,657	255,866	0.7%
18.	Epilepsy	16,638	227,741	244,379	0.7%
19.	Malaria in Pregnancy	-	229,110	229,110	0.6%
20.	Diabetes Mellitus	1,028	206,402	207,430	0.6%
21.	Others	516,789	2,219,421	2,731,942	7.3%
	Total	**8,803,789**	**28,656,398**	**37,460,187**	**100%**

In FY 2017/18, malaria was still the leading cause of malaria accounting for 32% of all admissions, followed by pneumonia at 8.5% and respiratory infections at 5.4% of all admissions.

TABLE 3: LEADING CAUSES OF ADMISSIONS IN FY 2017/18

No.	Diagnosis	Total Cases Under 5	Total Cases 5 and above	Total Cases	%
1.	Malaria	247,940	250,899	498,839	32.3%
2.	Pneumonia	94,732	36,052	130,784	8.5%
3.	Respiratory Infections	46,138	37,948	84,086	5.4%
4.	Diarrhoea – Acute	54,837	18,073	72,910	4.7%
5.	Injuries: (Trauma due to other causes)	6,727	47,470	54,197	3.5%
6.	Anaemia	26,221	27,065	53,286	3.4%
7.	Septicemia	31,570	19,613	51,183	3.3%
8.	Urinary Tract Infections	3,861	47,056	50,917	3.3%
9.	Gastro-intestinal disorders (non-infective)	11,271	38,143	49,414	3.2%
10.	Injuries: Road Traffic Accidents	2,242	29,652	31,894	2.1%
11.	Hypertension (Old cases)	-	20,463	20,463	1.3%
12.	Other Neonatal Conditions	19,195	-	19,262	1.2%
13.	Injuries: Motor Cycle (Accidents)	1,246	15,000	16,246	1.1%
14.	Asthma	2,091	11,937	14,028	0.9%
15.	Hernias	2,175	11,760	13,935	0.9%
16.	Sickle cell Anaemia	6,114	7,373	13,487	0.9%
17.	Neonatal Sepsis 0-7 days	13,279	-	13,279	0.9%
18.	Diseases of the skin	4,635	7,094	11,729	0.8%
19.	Premature baby	11,022	-	11,026	0.7%
20.	Diabetes mellitus (re-attendances)	-	10,939	10,939	0.7%
21.	Other diagnoses	90,445	230,888	321,262	20.8%
	Total	**675,741**	**867,425**	**1,543,166**	**100%**

The leading causes of mortality among all ages in FY 2017/18 were malaria (11%), pneumonia (9.1%), anaemia (6.9%) other neonatal conditions (5.3%) and premature baby (5%). When you combine injuries due to road traffic accidents and trauma due to other casues it accounts for 7% of all causes of mortality and therefore is an area that requires better programming in terms of emergency care and hospital care.

TABLE 4: LEADING CAUSES OF MORTALITY AMONG ALL AGES IN HEALTH FACILITIES 2017/18

No.	Diagnosis	Under5	5 and above	All Ages	%
1.	Malaria	2,085	1,455	3,540	11.0%
2.	Pneumonia	1,518	1,409	2,927	9.1%
3.	Anaemia	966	1,264	2,230	6.9%
4.	Other Neonatal Conditions	1,704	-	1,704	5.3%
5.	Premature baby	1,591	-	1,591	5.0%
6.	Injuries: Road Traffic Accidents & Boda boda Accidents	245	915	1,160	3.6%
7.	Injuries: (Trauma due to other causes)	382	702	1,084	3.4%
8.	New TB cases diagnosed: Bacteriologically confirmed & clinically diagnosed	73	1,000	1,073	3.3%
9.	Septicemia	521	524	1,045	3.3%

10.	Hypertension (Old & Newly diagnosed cases)	-	965	965	3.0%
11.	Neonatal Sepsis 0-7days	838	-	838	2.6%
12.	Gastro-intestinal disorders (non-infective)	140	514	654	2.0%
13.	Diabetes mellitus (Newly diagnosed & re-attendances)	14	633	647	2.0%
14.	Other Types Of Meningitis	78	412	490	1.5%
15.	Diarrhoea - Acute	293	191	484	1.5%
16.	Stroke	-	480	480	1.5%
17.	Severe Malnutrition (SAM): Without oedema	390	64	454	1.4%
18.	Respiratory Infections (Other)	190	245	435	1.4%
19.	Severe Malnutrition (SAM): With oedema	357	52	409	1.3%
20.	Urinary Tract Infections	154	251	405	1.3%
21.	Other diagnoses	819	1,307	2,126	6.6%
	Total	**14,354**	**17,780**	**32,134**	**100.0%**

Among the under-fives neonatal conditions and premature baby accounted for 23% of under 5 deaths in 2017/18 FY. This means that focus should be directed towards interventions geared at reducing neonatal mortality.

TABLE 5: TRENDS IN UNDER FIVE CAUSES OF DEATH

2015/16 FY		2016/17 FY		2017/18 FY		
Diagnosis	**No.**	**Diagnosis**	**No.**	**Diagnosis**	**No.**	**%**
Malaria	3,059	Malaria	2,333	Malaria	2,085	14.5%
Pneumonia	1,659	Anaemia	1,181	Other Neonatal Conditions	1,704	11.9%
Perinatal Conditions (in new borne 0 - 7 days)	1,476	Pneumonia	1,142	Premature baby	1,591	11.1%
Anaemia	1,314	Neonatal Sepsis 0 - 7 days	638	Pneumonia	1,518	10.6%
Neonatal Septicaemia	712	Septicemia	351	Anaemia	966	6.7%
Septicemia	457	Diarrhoea - Acute	204	Neonatal Sepsis 0 - 7 days	838	5.8%
Diarrhoea – Acute	404	Respiratory Infections	124	Septicemia	521	3.6%
Injuries - (Trauma due to other causes)	382	Other Types of Meningitis	111	Severe Malnutrition: Without oedema	390	2.7%
Injuries - Road Traffic Accidents	375	Injuries: Road Traffic Accidents	100	Injuries: (Trauma due to other causes)	382	2.7%
Severe Malnutrition (Kwashiorkor)	317	Respiratory distress	98	Severe Malnutrition: With oedema	357	2.5%
Others	3,399	Others	2,464	Others	4,002	27.9%
Total	**13,552**	**Total**	**8,708**	**Total**	**14,354**	**100%**

2.2 Performance against the key Health and Related Services Outcome Targets

The health and related services outcome indicators focus on communicable disease prevention and control, and essential clinical and rehabilitative care. The sector performance is highlighted in table 6 focusing on comparison of performance with the previous FY and the HSDP targets for 2017/18 FY. Although there was improvement in 12 out of the 16 outcome indicators assessed this FY, the sector achieved the 2017/18 targets for only 3 of these indicators. These were ART coverage, HIV+ pregnant women not on HAART receiving ARVs for eMTCT and DPT^{3}HibHeb^3 Coverage.

TABLE 6: PERFORMANCE AGAINST THE HEALTH SERVICE OUTCOME TARGETS

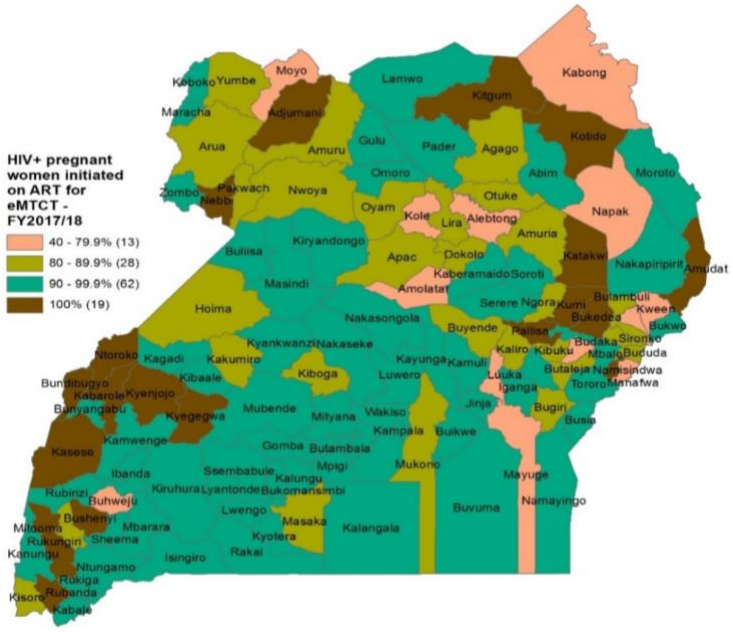
Indicator	Achieved 2015/16		Achieved 2016/17		Achieved 2017/18		HSDP Target	Change
ART Coverage	64.4%	Adult = 915,833 Children = 65,121	73%	Adults = 964,232 Children = 64,677	**85%**	Adults = 1,074,000 Children = 66,110	72%	17.8%
HIV+ pregnant women not on HAART receiving ARVs for eMTCT during pregnancy, labour, delivery and postpartum	68.3%		90%		**95%**		90%	5.5%
TB case detection Rate (all forms)	50.7%		50%		**56%**		78%	12%
IPT^2 doses coverage for pregnant women	55%		54.4%		**63.2%**		79%	16%
IPT3 doses coverage for pregnant women	NA		NA		**9.4%**		79%	
In Patient malaria deaths per 100,000 persons per year	22	M = 20 F = 23	20.2	M = 21.6 F = 18.8	**9.38**	M = 9.34 F = 9.42	5	52%
Malaria cases per 1,000 persons per year	408	M = 365 F = 480	433	M = 516 F = 354	**293**	M = 248 F = 337	285	32.3%
Under five vitamin A second dose coverage	28%	M = 27% F = 28%	25.3%	M = 24.7% F = 25.8%	**35.3%**	M = 34.8% F = 35.8%	62%	39.5%
DPT^{3}HibHeb^3 Coverage	103%	M = 105% F = 99%)	99.2%	99.2% F = 95.5%	**95%**	M = 97.4% F = 93.0%	95%	-4%
Measles coverage under 1 year	96%	M = 96% F = 93%	86.7%	86.7% F = 84.7%	**88%**	M = 90% F = 86 %	95%	1.2%
Bed occupancy rate (Hospitals & HC IVs)	82% 83% 62%	NRH = 82% RRH = 83% GH = 62%	60.1%	NRH = 70.1% RRH = 106% GH = 60%	**72%**	NRH = 89% RRH = 78% GH = 50%	80%	-7%

Indicator	Achieved 2015/16		Achieved 2016/17		Achieved 2017/18		HSDP Target	Change
	52.2%	HC IV	54%	HC IV = 54.2%		HC IV = 47%	65%	-14%
Average length of stay (Hospitals & HC IVs)	4	NRH	5.1	NRH = 7.7	**4.7**	NRH = 4.7	3	7.8%
	4	RRH		RRH = 6.9		RRH = 5.6		
	4	GH		GH = 5.1		GH = 4.9		
	3	HC IV	3	HC IV = 3.2		HC IV = 3.2	3	0%
Contraceptive prevalence Rate among married women for all methods	30% (UDHS 2011)		39% (UDHS 2016)		**39% (UDHS 2016)**			
Couple Years of Protection	2,232,225		2,156,240		**2,540,251**		4.5 million	18%
ANC 4 Coverage	38%		37%		**38%**		42.5%	3.2%
Health facility deliveries	55%		58.1%		**60%**		80%	3.3%
HC IVs offering CEmOC services (C/S and offering blood transfusion)	36%		44.6% (83/186)	HC IVs conducting C/S = 70.4% (131/186)	**48% (87/186)**	HC IVs conducting C/S without blood transfusion services = 78% (142/186)	57%	3%
				HC IVs conducting blood transfusion = 47.3% (88/186)				

- ART coverage among HIV infected adults and children increased to 86% (1,140,110 / 1,340,000) from 73% (1,028,909/1,402,628) in 2016/17 and 61.4% (898,197/1,461,744) in 2015/16. This progressive trend implies that the country is on track to achieve the second of the triple 90-90-90 by 2020 targets in the Fast Track Strategy for ending AIDS by 2030, i.e. 81% of all HIV infected people enrolled on ART.

- HIV+ pregnant women not on HAART receiving ARVs for eMTCT during pregnancy, labour, delivery and postpartum was 95% (95,523/103,670) in 2017/18 compared to 90% (38,243/42,467) in 2016/17 and 68.3% (34,357/50,323) in 2015/16. The number of districts with >80% HIV+ pregnant women initiated on ARVs for eMTCT increased from 32 in 2015/16 to 855 in 2016/17. Only 6 districts including Amuru (57%), Otuke (56%), Bududa (50%), Bukwo (49%), Dokolo (48%) and Kaabong (39%), had <60% of women initiated compared to 43 districts in 2015/16.

FIGURE 1: HIV+ PREGNANT WOMEN INITIATED ON ART BY DISTRICT FY 2017/18



- TB Case Detection Rate increase to 56% in 2017/18 from 50% in 2016/17 and this is still far below the HSDP target of 78%.

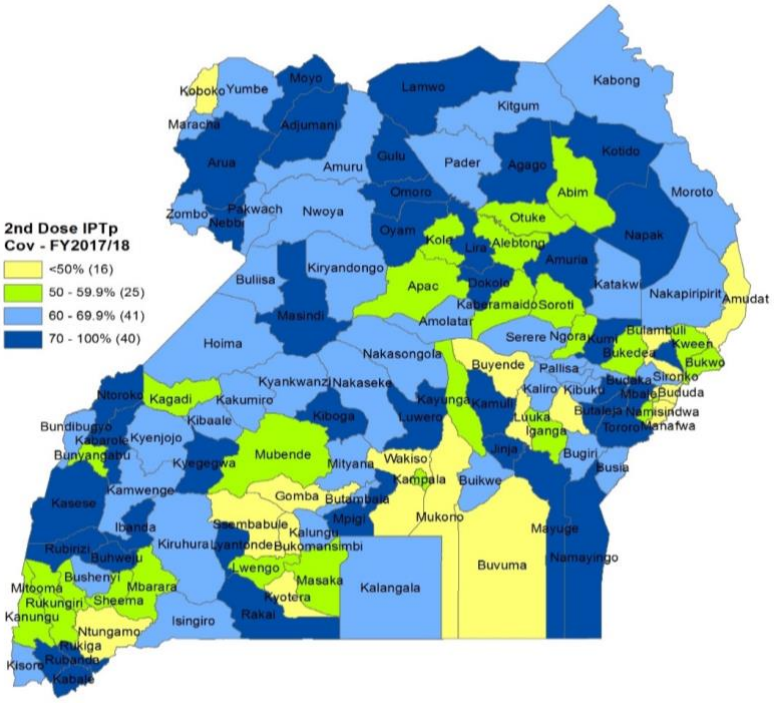
TABLE 7: BREAKDOWN OF TB CASE NOTIFICATION & CASE DETECTION BY REGION.

Region	Case Notification Rate		Case Detection Rate	
	2016/17	2017/18	2016/17	2017/18
Arua	104	124	45%	62%
Fort Portal	101	93	43%	47%
Gulu	156	169	66%	84%
Hoima	109	135	46%	67%
Jinja	90	108	39%	54%
Kampala	78	112	34%	56%
KCCA	446	435	191%	217%
Lira	134	132	57%	65%
Masaka	126	146	54%	73%
Mbale	68	78	29%	39%
Mbarara	95	101	41%	50%
Moroto	175	224	75%	111%
Soroti	67	92	26%	46%
TOTAL	**117**	**129**	**50%**	**64%**

Source: NTLP Quarterly case notification reports

- IPT_3 coverage was only 9.4%. IPT_2 coverage increased to 63.2% in 2017/18 from 54.4% (995.390 / 1,830,295) in 2016/17 but still below the HSDP target of 79%. Districts which achieved the 79% target were; Moy0 (124%), Adjumani (96%), Butaleja (95%), Rubanda (93%), Buhweju (90%), Kabale (89%), Agago (87%), Kiboga (86%), Tororo (85%), Oyam (84%), Mpigi (83%), Gulu (83%), Lamwo (81%) and Kyegegwa (79 %). IPT_2 coverage was lowest in the following districts; Bulambuli (42%), Amudat (42%), Buvuma (37%), Bududa (36%) and Wakiso (34%).

FIGURE 2: IPT^2 COVERAGE BY DISTRICT 2017/18 FY

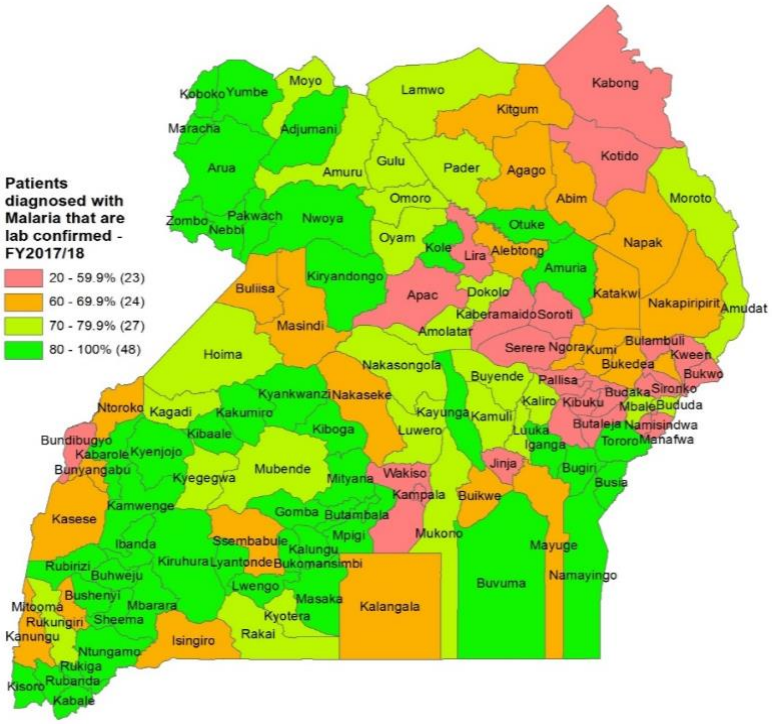


- In Patient malaria deaths recorded in 2017/18 reduced significantly to 9.38 per 100,000 compared to 20/100,000 in 2016/17. There was no significant difference in deaths among males at 934/100,000 compared to 9.42/100,000 among females.

- The number of malaria cases per 1,000 persons significantly reduced from 433 in 2016/17 to 293 cases per 1,000 persons per year close to the HSDP target of 285 in 2017/18. More females were affected at 337 cases compared to 248 cases per 1,000 persons among males.

  Apart from the malaria epidemic and the high incidence of malaria in a number of districts, non-adherence to test results still remains a major challenge. Only 69% (10,922,161/15,857,997) of patients treated for malaria had a laboratory confirmatory test. The following districts had >90% of patients diagnosed with malaria that were laboratory confirmed; Rubirizi (100%), Sheema (100%), Rubanda (100%), Ibanda (98%), Buhweju (98%), Rukiga (98%), Kiruhura (97%), Kabarole (97%), Pakwach (96%), Kiboga (96%), Kisoro (94%), Koboko (94%), Bushenyi (94%), Bukomansimbi (93%), Kole (93%), Kayunga (92%), Otuke (92%), Kabale (91%), Buvuma (91%) and Kamwenge (90%). The following districts had <40% of patients diagnosed with malaria that were laboratory confirmed; Kween (38%), Kaberamido (38%), Butaleja (37%), Pallisa (35%), Serere (35%), Bukwo (34%), Kampala (31%) and Budaka (23%).

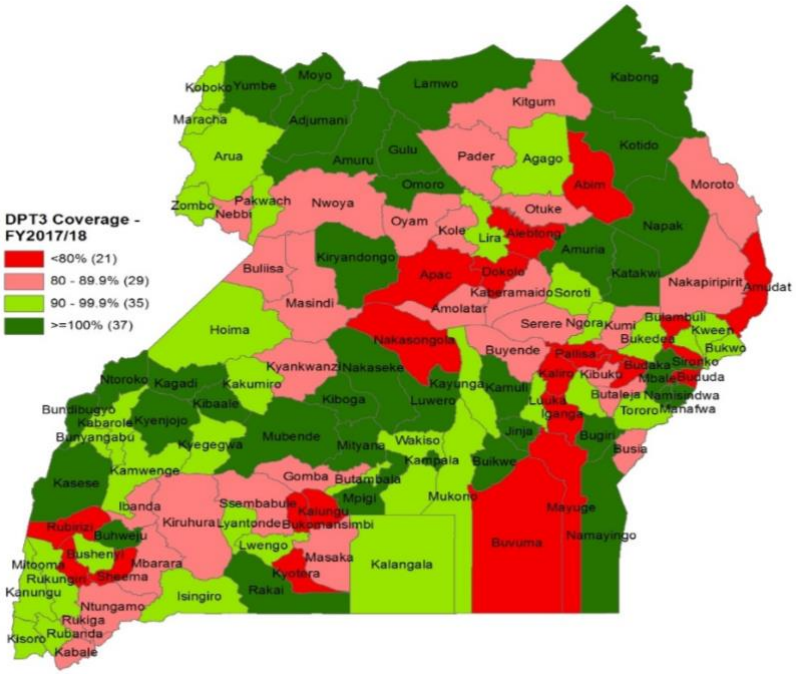
FIGURE 3: MALARIA CASES LABORATORY CONFIRMED BY DISTRICT 2017/18



- The under-five Vitamin A second doses coverage increased to 35.3% from 25.3% in 2016/17, with 34.8% coverage for males and 35.8% for females. Coverage is still far below the HSDP target (62%) for 2017/18. According to UDHS 2016, 61.9% of children 6 – 59 months were given vitamin A supplements in past 6 months. After adjustment, 9% of children age 6-59 months have vitamin A deficiency (<0.825 μmol/L). This is a substantial decline from 33% in 2011.

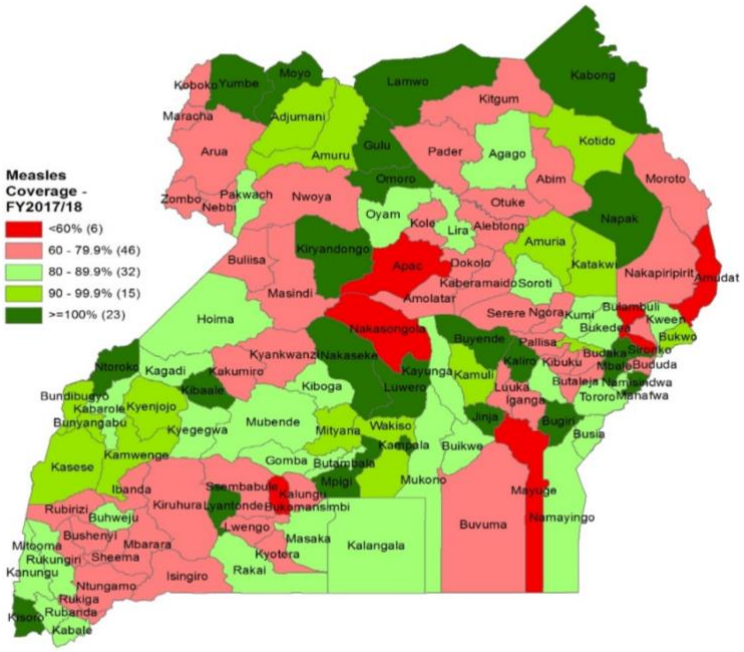
- DPT_3 coverage was 95% in 2017/18 a decline from 99.2% (1,561,539/1,574,054) in 2016/17. The HSDP target of 95% was achieved. Coverage among males was 97.4% compared to 93% among females. DPT^3 coverage was lowest in the following districts; Iganga (79.3%), Alebtong (79.1%), Rubirizi (78.8%), Kaliro (78.4%) and Kalungu 78.3%).

FIGURE 4: DPT3 COVERAGE BY DISTRICT 2017/18



- Measles coverage for under 1 year olds slightly increased to 88% from 86.7% (1,365,082/1,574,054) in 2016/17 FY. Coverage among males was 90% and 86% for females. This was below the HSDP target of 95% for 2017/18. Districts with <60% measles coverage were Nakasongola 59%, Mayuge 58.4%, Apac 58.2%, Bukomansimbi 55.5%, Bulambuli 53.6% and Amudat 53.4%.

FIGURE 5: MEASLES COVERAGE BY DISTRICT 2017/18



- Bed occupancy rate (BOR): The occupancy rate is a measure of utilization of the available bed capacity. It indicates the percentage of beds occupied by patients in a defined period of time, usually a year. It is used to assess the demands for hospital beds and hence to gauge an

appropriate balance between demands for health care and number of beds. BOR was 76% for all hospitals and HC IVs. National Referral Hospitals had a BOR of 89%, RRHs had BOR of 78%, general hospitals at 50%. BOR at the HC IVs declined to 47% from 54% in 2016/17.

- The Average Length of Stay (ALOS) refers to the average number of days that patients spend in hospital and is used as an indicator of efficiency. All other things being equal, a shorter stay will reduce the cost per discharge and shift care from inpatient to less expensive post-acute settings. It is generally measured by dividing the total number of days stayed by all inpatients during a year by the number of admissions or discharges. The ALoS for all hospitals and HC IVs was 4.7 days. The ALoS for the two National referral hospitals was 4.7 days in FY 2017/18. Mulago NRH had ALoS of 2.6 days whereas Butabika had ALoS of 41 days. The nature of the patients attended to at Butabika justifies the longer stay at this institution though there is need to understand why there was a significant increase by 10 days from 31 in FY 2016/17 to 41 in FY 2017/18. ALoS for the RRHs reduced to 5.6 in 2017/18 from 6.9 in 2016/17 and also there was a decline from 5.1 to 4.9 in the general hospitals. There was no change in the ALoS for the HC IVs which remained at 3.2 days.

- There was an 18% increase in the Couple Years of Protection (CYP) to 2,540,251 in 2017/18 from 2,156,240 in 2016/17. There was a notable increase in the use of IUDs and implants but a decrease in the users for all other methods.

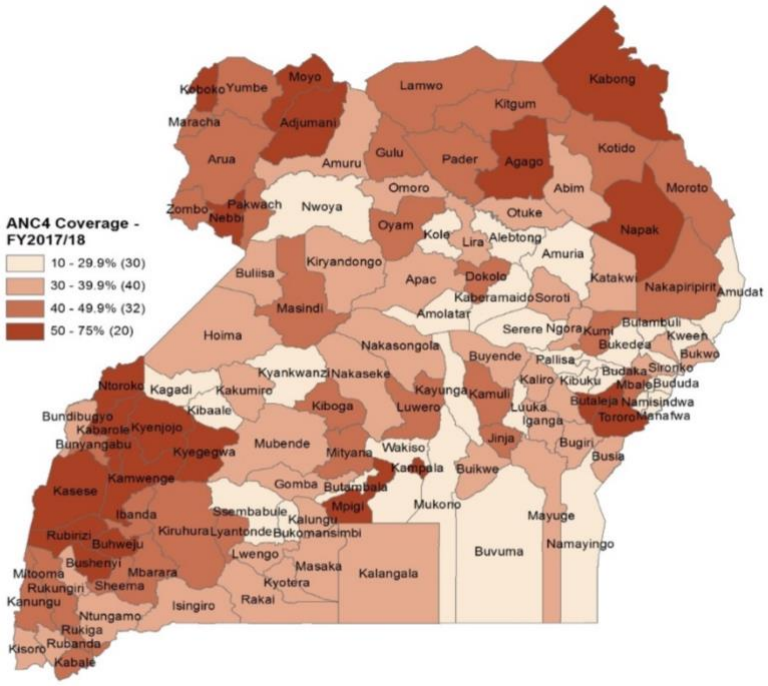
TABLE 8: TRENDS IN CYP BY METHOD

Data	Total CYP 2014/15	Total CYP 2015/16	Total CYP 2016/17	User by method 2017/18	CYP Factor	CYP 2017/18
Emergency contraceptives	1,078	414	827	32,394	0.0143	463
Female condoms	1,196	989	233	58,885	0.002	118
IUD	761,005	727,910	763,260	178,017	5	890,085
Injectable	555,543	572,342	333,722	1,260,957	0.25	315,239
Male condoms	50,113	80,816	3,554	1,535,626	0.002	3,071
Oral microgynon	5,220	4,562	2,040	17,504	0.0143	250
Oral other	435	389	499	13,346	0.0143	191
Oral ovrette or another POP	467	395	229	12,390	0.0143	177
Oral: Lofeminal	560	506	174	151,557	0.0143	2,167
Tubal Ligation	150,025	85,150	91,025	6,255	12.5	78,188
Implant Users	647,010	735,952	944,241	352,811	3.5	1,234,839
Vasectomy	24,063	32,800	16,437.5	1,237	12.5	15,463
Total	**2,196,713**	**2,242,225**	**2,156,240**			**2,540,251**

- Antenatal care (ANC) coverage for the fourth visit increased minimally to 38% in 2017/18 from 37% (677,338/1,830,295) in FY 2016/17 and far below the HSDP target of 42.5% for FY 2017/18. Only 45 out of the 122 districts achieved the target of 42.5% and above. ANC4+ visits were highest in the districts of Moyo (72.7%), Bushenyi (64.1%), Kabarole (62.1%), Adjumani

(61.9%) and Buhweju (57.9%). The lowest ANC4+ visits were in the districts of Manafwa (20.9%), Bududa (18.8%), Wakiso (18.8%), Namisindwa (17.4%) and Buvuma (14.6%).

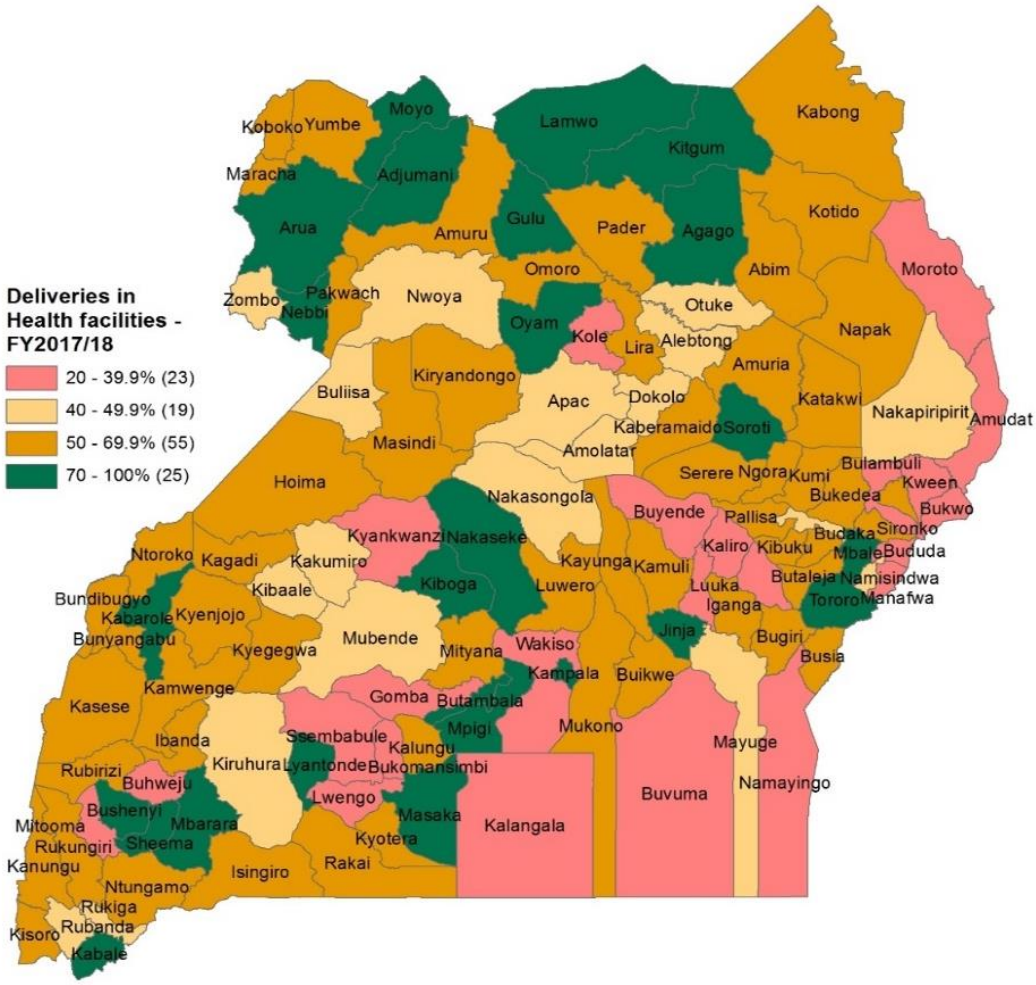
FIGURE 6: ANC4 VISITS BY DISTRICT 2017/18



- Health facility deliveries improved slightly to 60% from 58% (1,032,020/1,775,386) in 2016/17 and is below the HSDP target (80%) for FY 2017/18. Only 13 districts achieved the target of 80% and above health facility deliveries with the top 5 being Kampala (121%), Butambala (119%), Kabarole (103%), Gulu (98%) and Moyo (97.6%). District with less than 30% of health facility deliveries were; Sembabule (29.7%), Kween (29.2%), Kyankwanzi (29%), Luuka (27.1%), and Buvuma (21%).

- The proportion of HC IVs offering CEmOC services (Caesarean Section (C/S) and blood transfusion) increased slightly to 48% (87/186) in 2017/18 from 44.6% (83/186) in 2016/17. The number of HC IVs conducting C/S including those without blood transfusion services also increased to 78% (142/186) from 70.4% (131/186) in the previous FY. This means that a total of 55 out of the 142 HC IVs (39%) are performing C/S without blood transfusion services. A total of 17,729 C/S were conducted at the 142 HC IVs and of these following HC IVs performed the highest number of C/S; Mukono Town Council HC IV (1,533), St. Paul HC IV (1,054), Rukunyu HC IV (803), Mpigi HC IV (585), Rwekubo HC IV (534) and Kyegegwa HC IV (506).

FIGURE 7: % OF HEALTH FACILITY DELIVERIES BY DISTRICT FY 2017/18



2.3 Performance against the key Health Investment and Quality Output Targets

The key health result areas under health investments and quality are health infrastructure, medicines and health supplies, improving quality of care and responsiveness, health information, financing and human resources. The sector performance is highlighted below focusing on comparison of performance with the previous FY and the HSDP targets for 2017/18 FY.

TABLE 9: PERFORMANCE AGAINST THE HEALTH INVESTMENT TARGETS

Indicator	Achieved FY 2015/16		Achieved FY 2016/17		Achieved FY 2017/18		HSDP Target 2017/18	Change
New OPD Utilization rate	1.2	M = 1.0 F = 1.5	1.1	M = 0.9 F = 1.3	1.1	M = 0.9 F = 1.3	1.3	0%
Hospital (Inpatient) admissions per 100 population	3.73 per 100		3.67 per 100		3.25 per 100		9 per 100	11.4%
Population living within 5 km of a health facility	83%		83%		86%		82%	3%
Availability of a basket of commodities in the previous quarter (% of facilities that had over 95%)	87%		83%		85%		100%	2%
Facility based fresh still births (per 1,000 deliveries)	13		10.1		9.4		13	7%
Maternal deaths among 100,000 health facility deliveries	119		148.3		104		106	30%
Maternal death reviews	37%		23.9%		50%		52%	108%
Under Five deaths among 1,000 under 5 admissions	19	M = 15.1 F = 22.3	20.2	M = 17.1 F = 23.6	22.4	M = 19.9 F = 25.2	16.9	-10.9%
ART Retention rate	79%		82%		76%		84%	-7.3%
TB treatment success rate	79%		80%		77%		86%	-3.75%
Client satisfaction index	46% (NSDS 2015)		na		na		75%	
Timeliness of reporting (HMIS 105)	79.4%		88.1%		95%		93%	7.9%
Latrine coverage	75%		77%		83%		78%	7.7%
Villages/ wards with a functional VHT	75% (2014/15)		na		na		85%	

2.3.1 Utilization of health services

- The new OPD utilization rate for FY 2017/18 was 1.1 of which per capita utilization for males was 0.9 and females 1.3 indicating that females utilize the OPD services more than males. The HSDP target of 1.3 not achieved notably due to the low utilization rate by the males.

- Hospital (Inpatient) admissions reduced to 3.25 per 100 population from 3.67 per 100 in 2016/17. The HSDP target was 9 per 100 for 2017/18 which seems to be on the high side and needs to be reviewed. The decline in admissions is largely due to the decline in malaria cases.

- One of the key indicators of accessibility of healthcare is the distance to where the facility is found. Results presented in Table 10 show that in overall, 86% of the population access healthcare within a 5 km radius an increase from 83% in 2012/13 (UNHS 2016). The pattern of access to healthcare is not uniform across the sub-regions. The findings point out that over 34% of the people in Acholi, and 17% in Karamoja, Tooro and Kigezi have to travel more than 5 km to access health care when they need one.

TABLE 10: DISTANCE TO THE FACILITY WHERE FIRST TREATMENT WAS SOUGHT

2012/13			2016/17	
Average distance to facility			Average distance to facility	
Background Characteristics	**Less than 5km**	**5km & above**	**Less than 5km**	**5km & above**
Residence				
Rural	82.0	18.0	84.2	15.8
Urban	87.6	12.4	92.6	7.4
Regions				
Central	85.7	14.3	88.7	11.3
Eastern	87.5	12.5	89.5	10.5
Northern	75.3	24.7	80.7	19.3
Western	80.9	19.1	84.5	15.5
Sub-regions				
Kampala	88.0	12.0	95.1	4.9
Central 1	87.0	13.0	88.6	11.4
Central 2	83.2	16.2	86.6	13.4
Busoga	91.5	8.5	92.0	8.0
Bukedi	89.3	10.7	83.6	16.4
Elgon	88.6	11.4	91.4	8.6
Teso	77.5	22.5	87.0	13.0
Karamoja	70.3	29.7	82.8	17.2
Lango	73.8	26.2	84.9	15.1
Acholi	73.8	26.2	65.9	34.1
West Nile	85.5	14.5	86.7	13.3
Bunyoro	84.7	15.3	87.7	12.3
Tooro	82.2	17.8	82.7	17.3
Ankole	76.5	23.5	84.8	15.2
Kigezi	81.3	18.7	83.1	16.9
PRDP Districts				
Sporadically Affected	74.5	25.5	86.1	13.9
Severely Affected	74.5	25.5	74.1	25.9
Spillovers	87.0	13.0	87.1	12.9
Rest of the country	85.8	14.2	88.0	12.0
Mountainous Areas				
Mountainous	80.7	19.3	86.5	13.5
Non Mountainous	83.5	16.5	86.1	13.9
Total	**83.3**	**16.7**	**86.1**	**13.9**

Source: UNHS (UBOS, 2016/17)

Table 11 shows comparison of source of services in FY 2017/18 which shows that the public facilities contributed 75% of the outputs in the key performance indicators, PNFP facilities contributed 15.1% and PHP 8.2%.

TABLE 11: COMPARISON OF SOURCE OF SERVICES BASED ON THE HMIS DATA FOR 2017/18 FY

Service	Public		PNFP		PHP		Total
	No.	%	No.	%	No.	%	No.
OPD New Attendance	29,268,410	79.7	4,774,798	13.0	2,691,597	7.3	36,734,805
OPD Re-Attendance	1,932,306	49.9	1,096,861	28.3	846,031	21.8	3,875,198
Total OPD	31,200,716	76.8	5,871,659	14.5	3,537,628	8.7	40,610,003
Admissions	1,816,837	69.6	708,409	27.2	83,698	3.2	2,608,944
Deliveries	807,556	74.0	211,285	19.4	72,167	6.6	1,091,008
ANC 4+ Visits	547,912	76.1	123,929	17.2	48,295	6.7	720,136
IPT2	922,529	77.4	201,704	16.9	67,789	5.7	1,192,022
DPT-HepB+Hib$_3$ Immunization	1,185,344	76.2	303,990	19.6	65,336	4.2	1,554,670
Measles immunization	1,161,215	75.6	304,200	19.8	71,339	4.6	1,536,754
Vitamin A second dose	2,123,119	81.7	409,844	15.8	65,252	2.5	2,598,215
HIV+ pregnant women not on HAART receiving ARVs for eMTCT during pregnancy, labour, delivery and postpartum	73,872	77.0	17,813	18.6	4,246	4.4	95,931
Total	**71,039,816**	**76.7**	**14,024,492**	**15.1**	**7,553,378**	**8.2**	**92,617,686**

Source: *HMIS, MoH 2017/18*

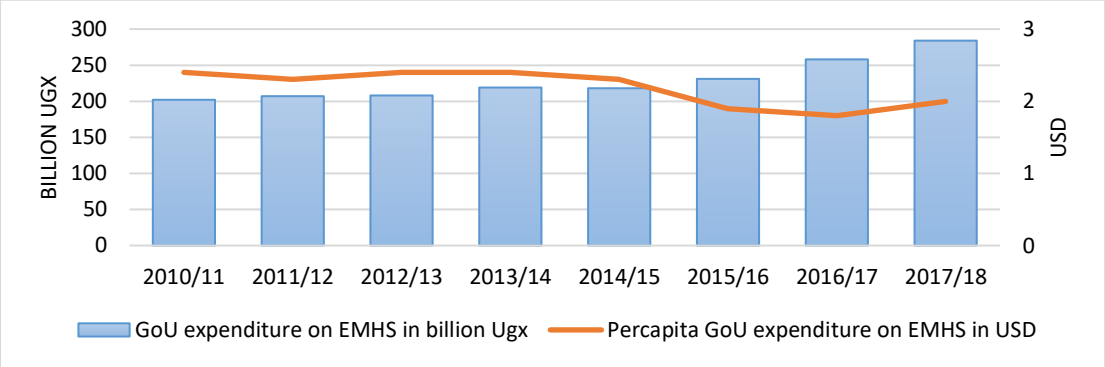
2.3.2 Essential Medicines and Health Supplies (EMHS)

The Pharmaceutical Sector in this FY 2017/18 under Vote 116 received Ug. Shs. 284 billion towards the procurement of EMHS inclusive of the basic immunization supplies.

In addition, vaccines (DPT-HepB-Hib, PCV, HPV, IPV & Rotavirus) worth Ug. Shs. 67,391,968,042/= were procured under the GAVI funds and funding from GFTAM worth Ug. Shs. 392,976,080,130/= was provided between July 2017 and June 2018. Of the GFTAM procurements for medicines ARVs consumed Ug. Shs. 192,973,316,523.96/=, TB Medicines – Ug. Shs. 45,320,481,296/=, Antimalarials Ug. Shs. 143,046,195,706/=, Laboratory commodities – Ug. Shs. 526,944,444/= and condoms Ug. Shs. 11,109,142,160 /=.

The recommended per capita for EMHS according to the Lancet Commission for Essential Medicines is $12 per capita annually. Overtime the GoU EMHS allocation has been increasing from Ug. Shs. 202 billion in FY 2010/11 to Ug. Shs. 284 billion this FY. However, the budget increases for EMHS are not in tandem with the population growth over the years and thus the declining trends in the per capita allocations.

FIGURE 8: TRENDS IN GOU EXPENDITURE FOR EMHS

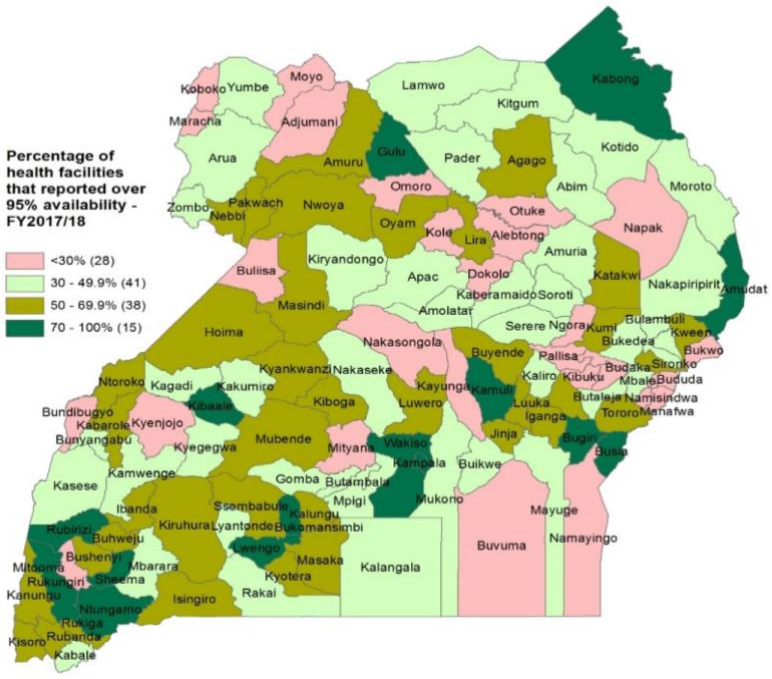


On average, the 41 commodities were available on 77 of the 90 days (85%) in 4,487 (69%) reporting facilities and an average of 57% of health facilities that reported over 95% availability. Key commodities such as ACT's were overstocked (> 5 months of stock). However, nutritional commodities, some RMNCH and TB commodities were either low stocked or stocked out.

TABLE 12: AVAILABILITY FOR THE 41 COMMODITIES FY 2017/18

Indicator	Disaggregation	Baseline data FY 2015/16	FY 2016/17		Quarterly Status Availability 2017/18			
		Value	Target	Actual	Q1	Q2	Q3	Q4
Average % availability of a basket of 41 commodities based on all reporting facilities in the previous quarter	EMHS	86%	89%	84%	84%	88%	84%	81%
	ARVs	89%	89%	86%	86%	88%	85%	84%
	TB	83%	89%	83%	82%	81%	86%	81%
	Lab	87%	89%	85%	86%	89%	81%	85%
	RMNCH	89%	89%	88%	89%	92%	87%	84%
Overall Average		**87%**	**89%**	**85%**	**87%**	**89%**	**85%**	**83%**
% of facilities with over 95% availability	EMHS	49%	70%	54%	54%	63%	53%	46%
	ARVs	50%	70%	61%	62%	66%	57%	58%
	TB	60%	70%	62%	66%	63%	54%	63%
	Lab	54%	70%	57%	53%	62%	65%	49%
	RMNCH	47%	70%	50%	51%	61%	48%	39%
95% availability of commodities		**52%**	**70%**	**57%**	**57%**	**63%**	**55%**	**51%**

FIGURE 9: % OF FACILITIES THAT REPORTED >95% AVAILABILITY OF 41 COMMODITIES IN 2017/18 FY

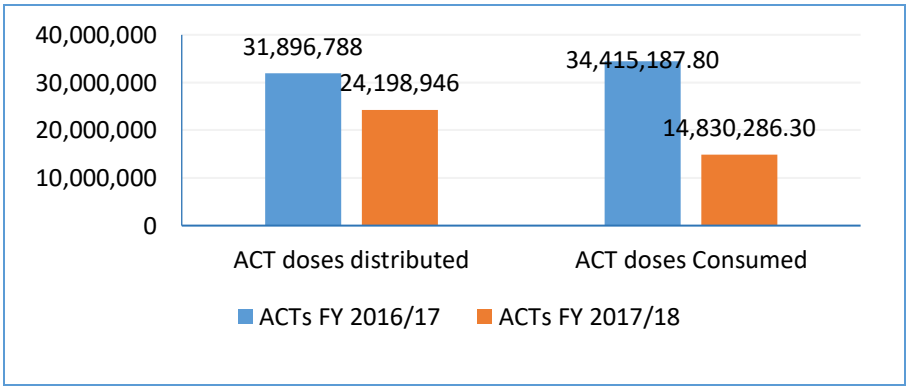


The overstock of ACTs at facility level was as a result of a number of reasons and interventions in place;

- High reduction in incidence of malaria cases was realized in the first half of 2018 as well the seasonal peaks of malaria were not noted
- Adherence of test and treat
- Distribution of Nets
- Inpatient pharmacy and
- Functionalization of the Medicines and Therapeutic Committees

The reduction in cases led to a reduction in ACTs consumed by almost 9.5 million doses in this FY compared to last year resulting in overstock of malaria commodities in many facilities.

FIGURE 10: ACT DOSES DISTRIBUTED AND CONSUMED



At the central warehouse, less issues have been noted, the AMC of the central warehouses reduced hence the stock pile. Interventions in place to address this issue are; supply plans have been reviewed, shipment delays or cancellations requested from the suppliers and monitoring of the stock status and redistribution of overstock commodities is on-going.

In respect to stock out of TB commodities, the global shortages of the active pharmaceutical ingredients (rifampicin) resulting into longer lead times depleting the buffer stock and leading to stock out of TB commodities.

Accumulation of Depo Provera at facility level initially led to overstock and expiries, this led to NMS suspending the procurement of Depo Provera leading to the current stock out.

TABLE 13: NMS RELEASE & EXPENDITURE FOR FY 2017/18

CODE	Vote Output	RELEASE	EXPENDITURE
085906	Supply of EMHS to HC II (Basic Kit)	22,326,473,942	22,326,473,942
085907	Supply of EMHS to HC III (Basic Kit)	36,720,000,000	36,720,000,000
085908	Supply of EMHS to HC IV	15,984,000,000	15,984,000,000
085909	Supply of EMHS to General Hospitals	14,456,000,000	14,456,000,000
085910	Supply of EMHS to Regional Referral Hospitals	13,024,000,000	13,024,000,000
085911	Supply of EMHS to National Referral Hospitals	12,365,600,000	12,365,600,000
085913	Supply of EMHS to Specialized units.	23,103,629,836	23,103,629,836
085914	Supply of Emergency and Donated Medicines	2,500,000,000	2,500,000,000
085915	Supply of Reproductive Health Items	11,484,763,000	11,484,763,000
085916	Immunization Supplies	17,000,000,000	17,000,000,000
085917	Supply of Laboratory Items to accredited Facilities	5,000,000,000	5,000,000,000
085918	Supply of ARVs to Accredited Facilities	94,891,375,000	94,891,375,000
085919	Supply of ACTs to Accredited Facilities	8,108,625,000	8,108,625,000
085920	Supply of Anti TB drugs to Accredited Facilities	6,999,999,558	6,999,999,664
TOTAL		**283,964,466,336**	**283,964,466,442**

2.3.2.1 EMHS credit line for PNFP's at Joint Medical Stores (JMS)

The implementation of the PNFP EMHS credit line started this FY as a means of achieving more efficient use of resources to ensure medicines availability in the PNFP sub-sector. This reform is expected to increase transparency in the use of the funds and the benefits of pooled procurement are expected to translate into improved affordability and availability for the patients that access services from these facilities.

UGX 7.4 billion which is 50% of the entire PHC non-wage grant to PNFPs was released to JMS to procure and distribute EMHS for accredited PNFP facilities. By the end of the FY, 100% of the EMHS

amounting to the UGX 7.4 billion had been purchased and distributed to the accredited 550 PNFP facilities and the facility order fill rate was 99.4%.

TABLE 14: SUMMARY OF JMS ORDER SOLICITATION, DELIVERIES AND FUNDS RELEASED IN FY 2017/18

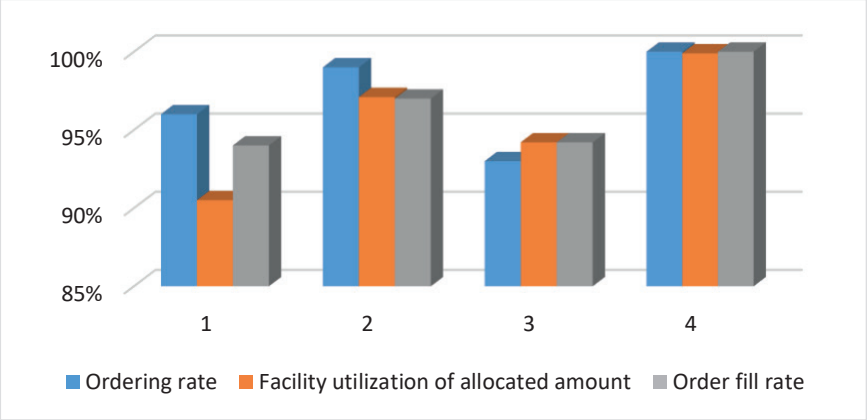
Quarter	Order solicitation	Delivery of items	Funds released
1.	15th July – 30th Aug 2017	29th Aug -30th Sept 2017	1,850,000,000.00/= was released for 532 facilities.
2.	20th Oct -10 Dec 2017	17th Nov-22 Dec 2017	1,850,000,000.00/= was released for 532 facilities.
3.	5th Feb- 29th March 2018	22nd Feb -16th April 2018	1,850,000,000.00/= was released for 532 facilities.
4.	1st April -30th June 2018	18th May-14th July 2018	1,850,000,000.00/= was released for 532 facilities.

TABLE 15: PNFP EMHS CREDIT LINE PERFORMANCE FY 2017/18

Indicator	Achievement		Comments
Ordering rate	100%		All facilities placed in their orders before closing the FY.
Facility utilization of allocated amount	99.9%		Ug. Shs. 7,400,000,000/= was received and only 194,869.31/= wasn't utilized to be returned to MoFPED. This arose from small balances that wouldn't be utilized by the health facilities.
Order fill rate	100%		JMS supplied all order requirements
VEN classification of items	Classification	% age	Training should be done to ensure that facilities order more of the Vital items.
	Vital	64	
	Essential	23	
	Necessary	14	
Average delivery time	3.8 days		Some roads were impassable making delivery too hard especially in the rainy season.

The performance in ordering and facility utilization rate of the allocated resources improved each quarter to 100% ordering and order fill rate by Q4.

FIGURE 11: TRENDS IN PNFP EMHS CREDIT LINE KEY PERFORMANCE INDICATORS



Some of the challenges and strategies used to improve the PNFP EMHS Credit Line utilization are shown in Table 16.

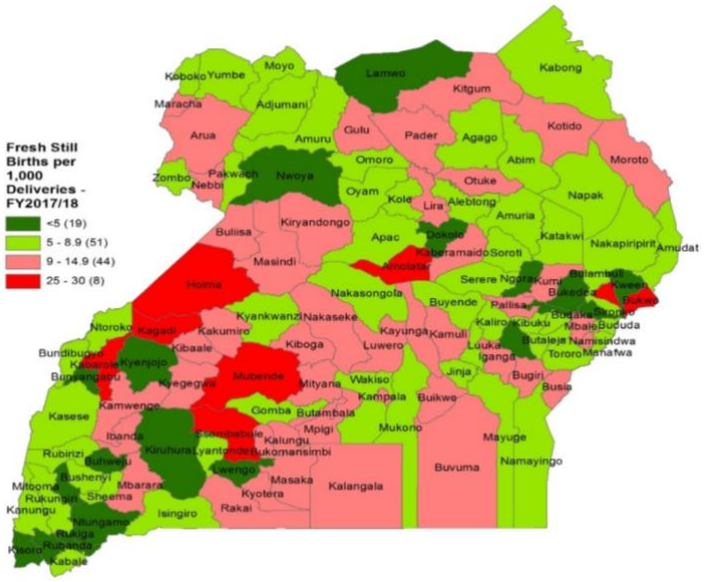
TABLE 16: CHALLENGES AND STRATEGIES TO IMPROVE UTILIZATION

Challenges	Strategies to improve
Facilities delay to order affecting the delivery schedule	1. Communicate delivery schedule on time to so that facilities adhere to it. 2. Work with the Bureaus to Medical Bureaus to enforce timely ordering
Impassable roads during the rainy season.	Airlifting in such circumstances
Un clear orders	Person receiving the order should follow up immediately
Some facilities order partially leading to delay thus incomplete utilization	Facilities to be encouraged to fully utilize allocation amount.
Delayed release of PHC funds by ministry	Ministry should release funds on time which will enable JMS perform better.

2.3.3 Improving Quality of Care

- Facility based fresh still births (per 1,000 deliveries) reduced to 9.4 per 1,000 deliveries from 10.1 per 1,000 deliveries in 2016/17. This performance is above the HSDP target of 13/1,000 for 2017/18. Among the RRHs, Hoima RRH registered the highest number of fresh still births with an increase from 256 in 2016/17 to 333 in 2017/18; Mubende RRH had 214, Fort Portal RRH 201. Nsambya and Moroto RRH registered the lowest FSBs of 14 each and Mengo 15. Among the general hospitals, the highest number of fresh still births were reported in; Iganga (128), Kagadi (111), St. Mary's Lacor (102), Kamuli Mission (93), Mityana (79) and Entebbe GH (71).

FIGURE 12: FRESH STILLBIRTHS PER 1,000 DELIVERIES BY DISTRICT 2017/18



- The number of maternal deaths among 100,000 health facility deliveries reduced to 104 per 100,000 health facility deliveries from 148.3 per 100,000 health facility deliveries in 2016/17. This is a 30% reduction which is a positive trend and the sector achieved the target for FY 2017/18. Among the RRHs the highest number of maternal deaths were still registered in Fort Portal RRH (53), Hoima RRH (52) and Mubende RRH (33). Among the general hospitals, the highest number of maternal deaths were reported in the following; St. Mary's Lacor (26 down from 30 in 2016/17), Kagadi (15), Lubaga (14 down from 18), and Kamuli Mission (14).

- In 2017/18 FY a total of 1,111 maternal deaths were reported through the MoH HMIS compared to 1,118 in 2016/17. Of these 555 (50%) were notified and reviewed (audited) compared to 267 (24%) reviewed (audited) in 2016/17. This is a 108% increase in the number of maternal deaths reviewed and this is largely because of the training conducted and dissemination of the MPDSR guidelines.

TABLE 17: MATERNAL DEATH NOTIFICATION AND REPORTING

Item	2013/14	2014/15	2015/2016	2016/17	2017/18
Number of maternal deaths reported through HMIS	1,147	1,019	1,136	1,118	1,111
Total number of deaths notified	371	238	246	na	555
% of maternal deaths notified compared to reported in HMIS	32.3%	23.4%	21.7%	-%	50%
Number of maternal deaths reviewed	-	-	419	267	555
% of maternal deaths reviewed	-	-	37%	24%	50%

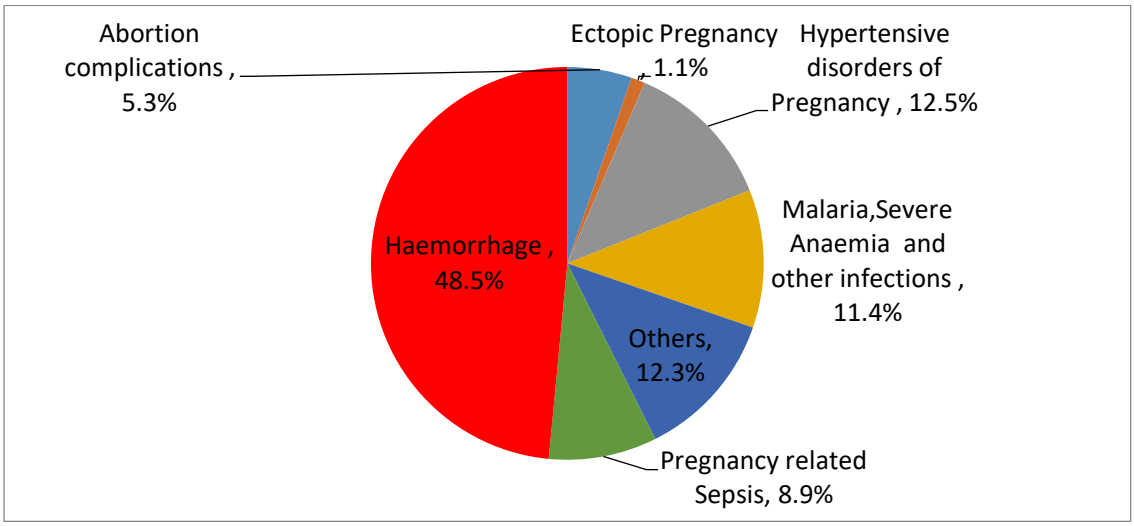
General Hospitals had the highest percentage of maternal deaths reviewed.

TABLE 18: NUMBER OF MATERNAL DEATHS REVIEWED BY LEVEL

HF Level	No. Reviews done	% of total
NRH	68	13%
RRH	158	29%
GH	224	42%
HC IV	49	9%
HC III	36	7%
HC II	3	1%
Total	**538**	

Heamorrhage still accounts for the highest percentage of maternal deaths at 48.5%, followed by hypertensive disorders of preganancy (12.5%) and pregnancy related sepsis (8.9%).

FIGURE 13: CAUSES OF MATERNAL DEATHS IN FY 2017/18

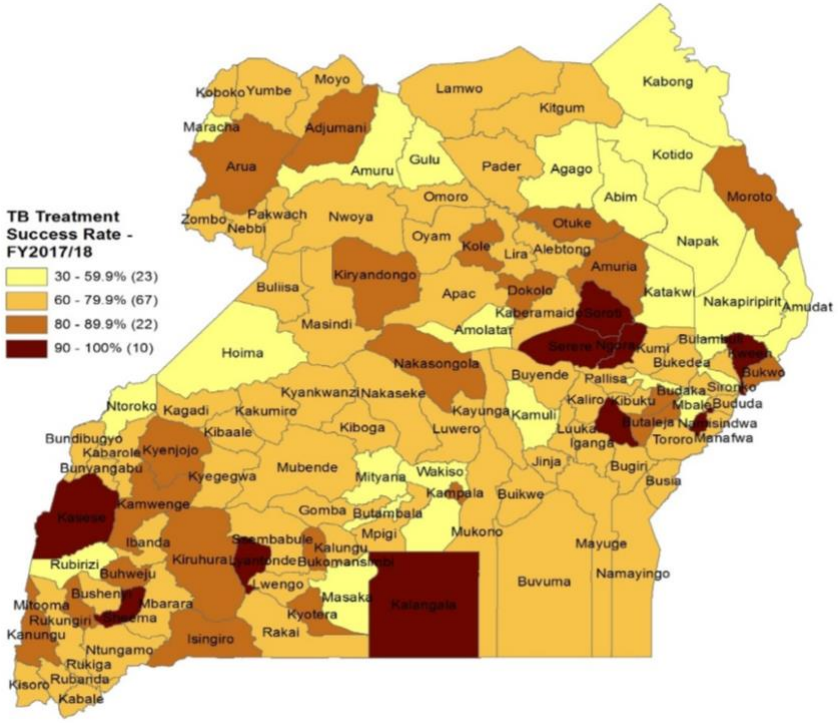


- The rate of under five deaths among 1,000 under 5 admissions increased to 22.4 per 1,000 admissions compared to 20.2 per 1,000. The HSDP target was 16.9 per 1,000.

- ART retention declined to 76% in 2017/18 from 82% in 2016/17 which is short of the HSDP target of 84%.

- TB treatment success rate declined to 77% in 2017/18 from 80% in 2016/17 which is still far below the HSDP target of 86% for the year.

FIGURE 14: TB TREATMENT SUCCESS RATE BY DISTRICT 2017/18 FY

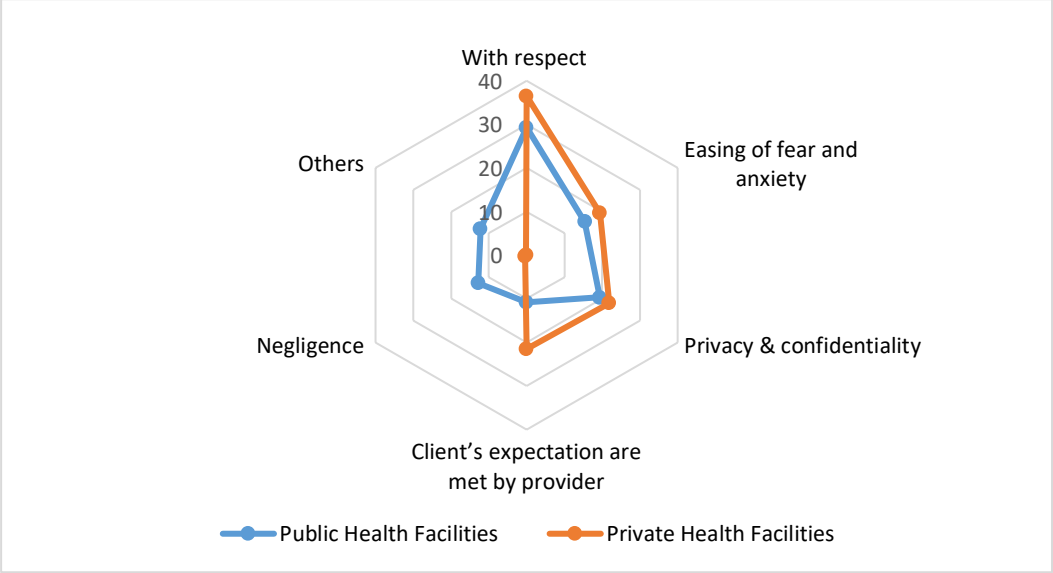


- The Client Satisfaction Index was not assessed this year however, there was an assessment of the community perspectives on an array of healthcare related services undertaken in the Uganda National Household Survey 2016/17 by UBOS. Proper handling of patients contributes significantly to the patient's appreciation of the overall quality of care which in turn attracts patients to seek healthcare at such facilities once they are in need. The UNHS 2016/17 findings show that communities value handling clients with respect as the top quality issue for both public and private facilities. Privacy and confidentiality and meeting client's expectations also rank highly both in public and private facilities indicators of good quality of healthcare. The findings mean that other than the challenges of drug stock outs, long distances to access care, issues like treating patients with respect, privacy and confidentiality, being negligence free improve the overall quality of health service delivery both in public and private health facilities.

TABLE 19: HOW PATIENTS ARE HANDLED/TREATED BY STAFF IN PUBLIC AND PRIVATE HEALTH FACILITIES (%)

Health Facilities	With respect	Easing of fear and anxiety	Privacy & confidentiality	Client's expectation are met by provider	Negligence	Others
Public	29.3	15.4	19.4	10.8	12.8	12.2
Private	36.5	19.4	21.9	21.5	0.4	0.1

FIGURE 15: HOW PATIENTS ARE HANDLED/TREATED BY STAFF IN PUBLIC AND PRIVATE HEALTH FACILITIES (%)



According to the UNHS 2016/17, the major concerns of the communities in accessing health services at the public health facilities were; unavailability of medicines/supplies (23%), long waiting time (13%), long distance (12%), limited range of services (14%) and understaffing (10%). Whereas, in private facilities, it was found that the services being expensive (39%) ranked top followed by limited range of services (23%) and long distance (9%).

- Timeliness of monthly HMIS reporting improved to 95% from 88.1% in 2016/17. The districts of Kaabong, Napak, Luuka, Kyegegwa, Bunyangabu and Kampala had the lowest reporting below 79.9% of the monthly reports (HMIS 105) sent timely.48% (59/122) of the districts achieved 100% completeness of the monthly reports submitted and only 3 districts (Kampala, Luuka and Kyegegwa) has <79.9% completeness of the monthly reports. This implies that the data provided is getting more comprehensive with most of the data points in the reports filled.

FIGURE 16: TIMELINES OF MONTHLY REPORTING (HMIS FORM 105) IN 2017/18 FY

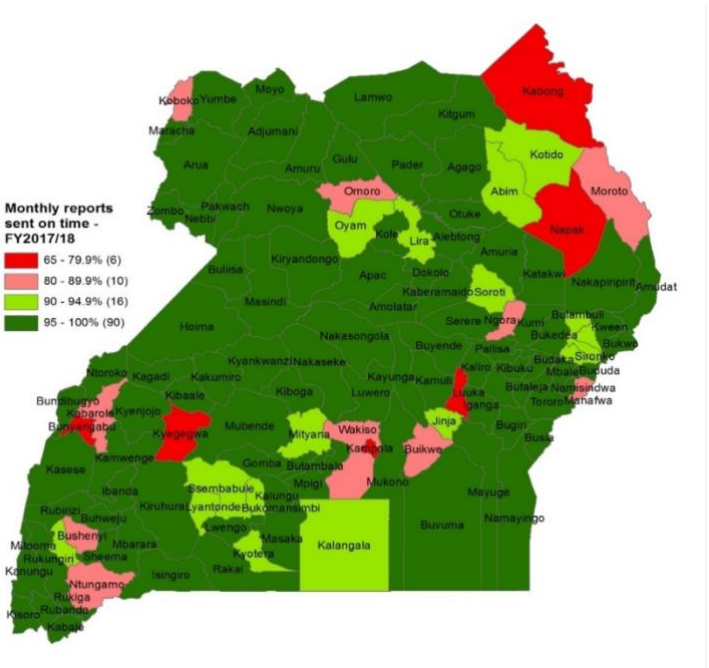
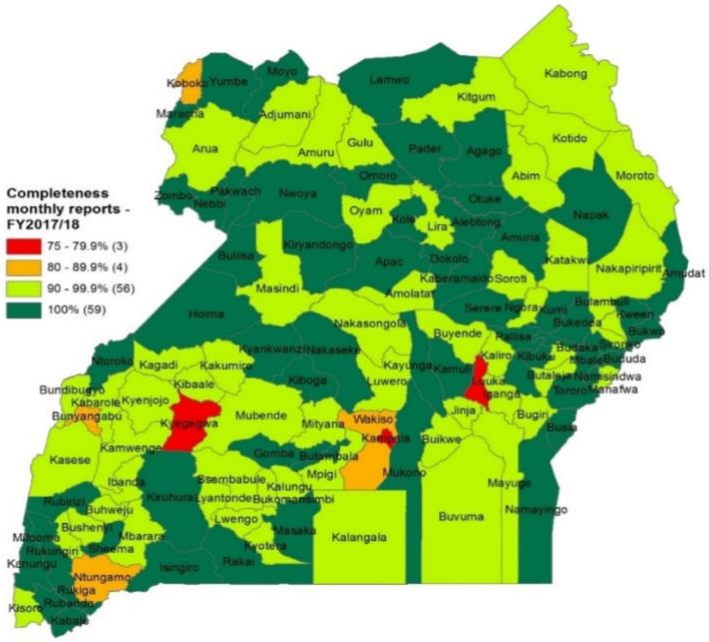


FIGURE 17: COMPLETENESS OF MONTHLY HMIS REPORTS 2017/18 FY



- The National Household Survey report of 2016/17 findings show that 83% of households used pit latrines. Only 3% used flush toilets. 84% of households did not have hand washing facilities and of the households that had, 8% had facilities with water only and only 6% had facilities with both soap and water.

TABLE 20: TYPE OF TOILET FACILITIES USED (%)

Year	Pit Latrine	VIP Latrine	Bush / No Toilet	Flush	Total
2012/13	83.0	5.8	9.8	1.5	100
2016/17	82.6	7.6	7.3	2.6	100

Source: UNHS Report 2016/17

- There was no significant investment in building the capacity of Village Health Teams (VHTs). Much effort was towards finalizing the Community Health Extension Workers (CHEWs) policy, strategy. GoU allocated UGX 3.2 billion for CHEW allowances in FY 2018/19. Selection of the CHEW trainees in the 13 pilot districts (Apac, Oyam, Kole, Lira, Dokolo, Amolatar, Alebtong, Otuke, Amuru, Gulu, Nwoya, Omoro and Mayuge) was conducted and training of the CHEWS shall commence in FY 2018/19. A CHW registry to monitor performance of CHW was developed being piloted in the 13 districts. Some HDPs e.g. USAID, UNICEF & WHO have committed to supporting the funding of the training, supplies and tools in the first year.

2.3.4 Health Financing

The health system, including service delivery continues to be financed by a multiplicity of stakeholders namely; Government, Private firms, Households and Health Development Partners (HDPs). Service delivery and developments in public facilities were mainly financed through Government grants, concessional loans and grants from HDPs. Government continued to support service delivery in the PNFP facilities by way of grants and seconding personnel.

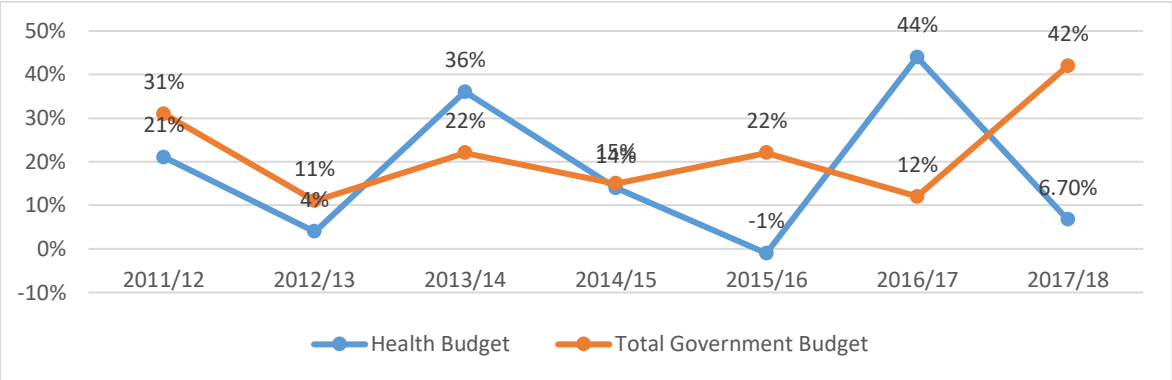
In the Financial Year 2017/18, the allocation to the Health Sector was 6.4% of the total National Budget of Shs. 29 trillion. This represents a reduction from 7% in FY 2016/17. Over the last 7 years the funding to the sector as a proportion of the total national budget has ranged between 5 - 8% as shown in Table 21 and Figure 18.

The budget for the Health Sector increased from Shs. 1.87 trillion in FY 2016/17 to Shs. 1.95 trillion in the FY 2017/18 (initial approved budget was Shs. 1.85 trillion). This increase is mainly attributable to additional allocations to Uganda Cancer Institute(37bn), National Medical Stores (40bn), and Mulago Hospital Complex (12bn). During the year under review the Health sector benefitted supplementary budgets in favour of NMS to the tune of Shs. 46 billion for EMHS and Blood Reagents; MoH amounting to Shs. 35 billion for capital development projects and balance was for Pensions and Gratuity for several votes across the sector.

TABLE 21: TRENDS IN GROWTH & ALLOCATION OF THE HEALTH SECTOR BUDGET AGAINST THE TOTAL GOVERNMENT BUDGET

Year	Health Budget	*Growth*	*Total Government Budget*	*Growth*	Health as % of total budget
2010/11	660		7,377		8.9%
2011/12	799	*21%*	9,630	*31%*	8.3%
2012/13	829	*4%*	10,711	*11%*	7.7%
2013/14	1,128	*36%*	13,065	*22%*	8.6%
2014/15	1,281	*14%*	14,986	*15%*	8.5%
2015/16	1,271	*-1%*	18,311	*22%*	6.9%
2016/17	1,827	*44%*	20,431	*12%*	8.9%
2017/18	1,950	*6.7%*	29,000	*42%*	6.7%

FIGURE 18: GROWTH IN THE HEALTH BUDGET AGAINST THE TOTAL GOVERNMENT BUDGET



Out of the total of Shs. 1.95 trillion allocated to the Health Sector, Shs. 1.28 trillion which represents 66% was released. All votes received about 100% of the budget except Ministry of Health with only 36% and Uganda Cancer Institute with 48% because of the African Development Bank (ADB) project which was behind schedule. The low absorption is largely attributable to low disbursements by some donor funded projects namely Global Fund and GAVI.

Of the total Shs. 1.279 trillion released to the sector, Shs. 1.191 trillion representing 93% was actually spent. Whereas the GoU funds were absorbed to the tune of over 90%, the utilization of external funds was quite low. With the exception of MoH, and some RRHs, the rest of the votes absorbed over 90% of the budget released. The low absorption by RRHs was due to delays in the procurement processes for their civil works. The low absorption by Uganda Cancer Institute was attributable to the readjustments on the technical aspects of the project which led to delays in execution since approvals had to be sought from ADB. The low absorption by MoH is due to unpaid pensions arising from the lengthy exercise for verification of pensioners.

TABLE 22: HEALTH SECTOR BUDGET PERFORMANCE FOR FY 2017/18 IN BILLION UG. SHS.

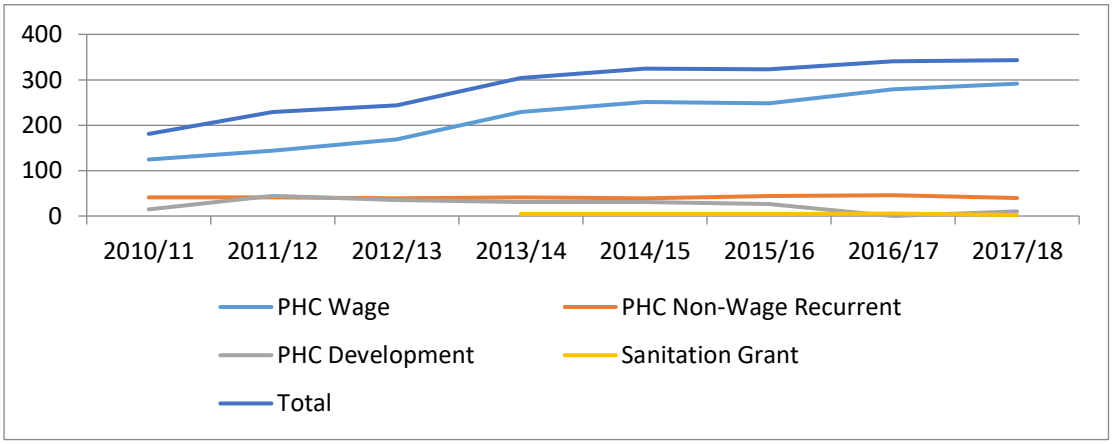
Vote No:	Institution	16/17 revised budget	Approved Budget FY 2017/18	Revised Budget FY 2017/18	%age of budget released	% of release spent	%age budget absorption
014	Ministry of Health HQ	1,010.32	973.05	1,008.68	36%	82%	30%
107	Uganda AIDS Commission	7.69	7.24	7.24	100%	98%	98%
114	Uganda Cancer Institute	14.86	52.25	52.25	48%	94%	46%
115	Uganda Heart Institute	12.02	18.10	18.10	98%	95%	93%
116	National Medical Stores	264.96	258.08	304.75	100%	100%	100%
134	Health Service Commission	5.26	5.42	5.42	100%	95%	95%
151	Uganda Blood Transfusion Services	9.12	9.44	13.35	100%	96%	96%
161	Mulago Hospital Complex	63.30	75.47	75.47	97%	95%	92%
162	Butabika Hospital	11.33	12.76	13.16	99%	94%	93%
304	Uganda Virus Research Institute	1.66	1.86	7.34	100%	94%	94%
163-176	Regional Referral Hospitals	94.27	99.07	103.15	100%	87%	87%
500-850	LG Health	375.84	343.25	343.25	100%	100%	100%
122	KCCA Health Grant						
	TOTAL	**1,870.62**	**1,856.00**	**1,952.16**	**66%**	**93%**	**61%**
	National Budget	**26,360.45**	**29,008.54**	**29,008.5**			
	% allocation to health sector	**7.1%**	**6.4%**	**6.7%**			

SOURCE: THE VOTES' ANNUAL PERFORMANCE REPORTS

TABLE 23: OVERALL HEALTH FINANCING TRENDS FY 2011/12 – 2017/18

FY	GOU Financing	External Financing	Total (Ug. Shs. Billion)
FY 2011/12	593	206	799
FY 2012/13	631	221	852
FY 2013/14	711	417	1,127
FY 2014/15	749	533	1,281
FY 2015/16	819	452	1,271
FY 2016/17	993	877	1,870
FY 2017/18	1,008	944.36	1,952

FIGURE 19: TRENDS IN THE HEALTH SECTOR GRANTS



Analysis of the PHC Non-Wage allocation by Service Delivery Strata reveals that average allocations per level of service are far below what is required to carry out the core functions of management and ensure quality service delivery. At the individual facility level, the challenge of inadequate PHC non-wage recurrent funding is escalated by the huge disparities across the districts.

TABLE 24: PHC NON-WAGE ALLOCATION BY SERVICE DELIVERY STRATA WITHIN THE PHC SYSTEM FOR FY 201/18

Level of Care	Ownership	Number of units	Annual NWR Allocation	Average allocation per unit	Minimum	Maximum
DHO/ MHO office	Districts	121	4,599,947,365	38,016,094	105,297,619	4,999,532
	Municipals	41	454,078,055	11,075,075	45,081,465	2,717,334
General Hospital	GoU	45	8,776,361,326	195,030,252	450,744,531	28,871,723
	PNFP	49	5,293,193,436	108,024,356	293,200,372	18,391,667
HC IV	GoU	172	5,274,528,985	30,665,866	62,572,824	9,400,408
	PNFP	14	110,900,172	7,921,441	29,163,625	2,902,474
HC III	GoU	918	8,169,015,501	8,898,710	36,498,020	3,606,741
	PNFP	230	1,175,570,837	5,111,178	42,453,141	696,485
HC II	GoU	1574	4,404,641,983	2,798,375	43,624,687	740,887
	PNFP	313	1,081,444,203	3,455,093	24,419,934	817,769

2.3.5 Health Financing Initiatives

The MoH is implementing the Health Financing Strategy and during FY 2017/18 a number of partners supported initiatives under Community Health Insurance Schemes and Results Based Financing (RBF).

2.3.5.1 Community Health Insurance Initiatives

Community Health Insurance Schemes (CHIS) were first introduced in Uganda in 1996 and have since spread to 16 Districts. Community Health Insurance as a supplementary financing mechanism has over the years received promotion financial support from: Families, MoH, DFID, BftW, CORDAID, and USAID.

The existing CHIS in Uganda are categorized as: (1) community-managed; (2) service provider-managed; and (3) third- party managed. The categorization is based on how much effort the communities/ families put in the day-to-day operations of the scheme. The CHIS are making it easy for families to access health care services of quality that they would otherwise not afford or finance using life sustaining assets and investments hence pushing many deeper or into poverty. The schemes have also improved patient-provider relations, improved cost recovery on the part of service providers, and mobilized resources from families to a tune of about 3.8 billion shillings. On average, each individual paid Ug. Shs. 25,000/= as premium in 2017/2018.

There are 8 organizations promoting CHIS in Uganda today. They are: (1) Save for Health Uganda operating in 10 districts; (2) Kabale Diocese; (3) Kisizi Hospital; (4) Bwindi Hospital; (5) Health Partners Uganda; (6) ICOBI; (7) Happy Health Insurance Scheme; and (8) Ishaka Health Plan. Together in 2017/2018, these organizations supported 12 CHIS spread in 20 districts of Western and Central Uganda covering a total of 152,260 people representing 0.4% of the population in Uganda.

The number of health care facilities providing services to CHIS members is now 42. Of these, 15 are hospitals, 4 are HC IVs, 19 are HC IIIs, and 4 are HC IIs. Two (2) of the facilities (hospitals) are Government owned, 8 are Private for Profit (PFP), and 32 are PNFP.

Generally, the schemes cover all services provided at the specific partner health care facilities. Referrals to non-partner health care facilities, self-inflicted injuries, and elective surgeries are excluded. Depending on the scheme/ product, members pay a co-payment at the point of service ranging from Ug. Shs. 1,000/= to 30,000/= per episode. All schemes have a ceiling on the amount the scheme pays per episode. In most cases, ceilings are set according to the type of service with out-patient services and in-patient services having different ceilings. Generally, ceilings range between Ug. Shs. 80,000/= to 500,000/=.

Among the many challenges CHI promoters, schemes and beneficiaries face include:

1) Low public trust due to absence of a CHI law. Fake NGO defrauded communities in the past and these experiences are still present and fresh in the communities;
2) Low capacity of families to pay the actual premiums. For those who join, a lot of adverse selection as a coping strategy is done. Because of this situation, most schemes charge low premiums only enough to cover medical bills excluding administration and marketing expenses;
3) Limited and reducing funding for the promoters to scale up operations to new areas.
4) Lack of the National Health Insurance Scheme (NHIS) law to which most CHI donors look as proof that the Uganda Government is interested in health insurance as a viable health financing source.

2.3.5.2 Results Based Financing

1. USAID/Uganda Voucher Plus Activity

The USAID/Uganda Voucher Plus Activity is a five-year (2016 - 2021) USAID-funded RBF mechanism implemented by Abt Associates, in partnership with Communication for Development Foundation Uganda (CDFU), Price Waterhouse Coopers (PwC) and BDO-East Africa. The Activity is designed to increase access to quality obstetric, newborn, and postpartum family planning services to poor women through the private sector in 33 districts in Northern and Eastern Uganda so as to contribute to the reduction of maternal and newborn mortality and morbidity.

The Activity identifies and accredits private providers to deliver a package of safe motherhood and newborn services and reimburses them for services provided to voucher clients. The Activity works

with VHTs to sell subsidized vouchers to eligible poor women for Ug. Shs. 4,000/=. The VHTs use a poverty grading tool to determine eligibility. The voucher entitles the women to the package of services at contracted private facilities at no extra cost. The package includes four ANC visits, HIV counseling and testing (plus eMTCT) for those who are HIV positive), management of pregnancy related illnesses and complications, facility-based delivery under skilled hands, emergency transportation for complications, postnatal care, management of neonatal illnesses and postpartum family planning services.

Simultaneously the VHTs conduct community mobilization events to provide safe motherhood information to target populations (pregnant women, youth and male partners), and they follow up with clients to make sure they take advantage of services.

The Activity gives providers technical support through training, on-site mentoring, supportive supervision, and annual clinical audits to improve their service quality. Besides the clinical support, the Activity helps providers report to the districts through the HMIS, addresses system gaps in their facilities, and helps them manage timely submission of claims for reimbursement.

Achievements during the review period include:

- Contracted 156 health facilities (includes 4 private wings of public hospitals).
- Paid out over Ug. Shs. 10.93 billion to participating facilities for services offered.
- Distributed 196,107 vouchers to eligible women.
- Achieved 71,389 skilled births within contracted facilities.
- 80,957 first ANC visit attendance.
- 25,946 ANC 4 attendances.
- 38% eMTCT enrollment at voucher facilities and 62% tracked referral to ART accredited public sector facilities for eMTCT from non-ART accredited private facilities.
- Reached 182,845 individuals through community mobilization events.
- Recruited over 546 VHTs to conduct demand generation activities.
- Achieved 50% PNC service utilization.
- Achieved 18% postpartum FP service utilization.
- Trained 392 health workers in EmONC, 382 in eMTCT and 132 in comprehensive FP.
- Trained 154 private facility providers on MoH revised HMIS and records management to improve data capture, use and reporting.
- Supported 134 private providers to report into DHIS2.
- Many facilities have re-invested funds received from voucher Activity into quality improvements like infrastructure improvements, qualified staff recruitments, drugs and medical supplies, etc.
- Private providers now understand how to participate in an output based or RBF mechanism, readying them for the future Health Insurance and the RBF initiatives from the MoH.

2. PNFP Project

The PNFP project supported by Enabel is implemented in the 15 districts of West Nile (8) and Rwenzori (7) in 49 health facilities of which 8 are hospitals, 4 HC IVs and 37 HC IIIs. The total RBF budget amount for these facilities was Ug. Shs. 8,734,509,000/= and a total of Ug. Shs. 7,737,921,000/= was paid out giving an execution rate of 89%. (See Annex 4 for the budget and payments per facility in FY 2017/18).

FIGURE 20: RATIO DECLARED VS HMIS (LEVEL OF QUALITY) FOR PNFP FACILITIES 2017/18

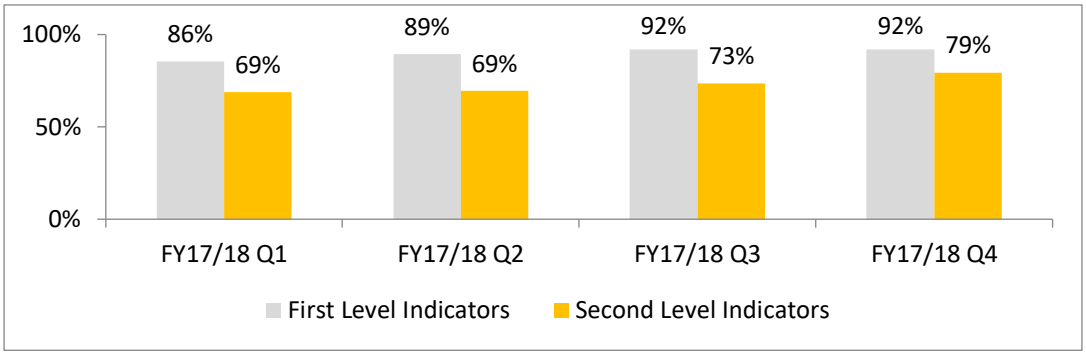
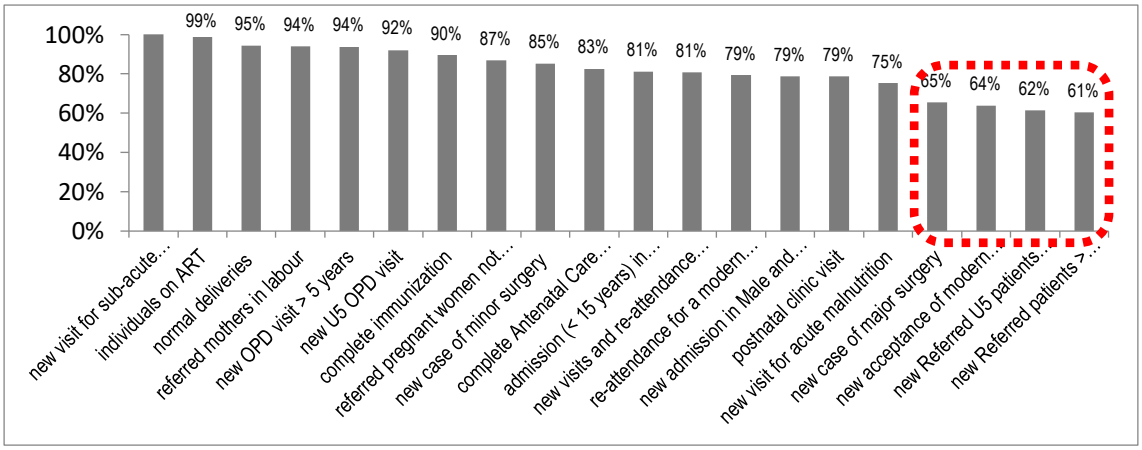


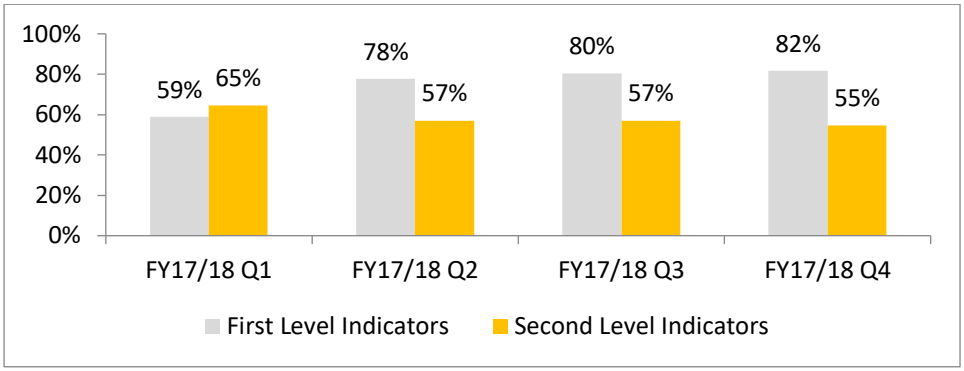
FIGURE 21: RATIO DECLARED / HMIS BY INDICATOR FOR PNFP FACILITIES Q4 2017/18



3. Institutional Capacity Building (ICB) II Project

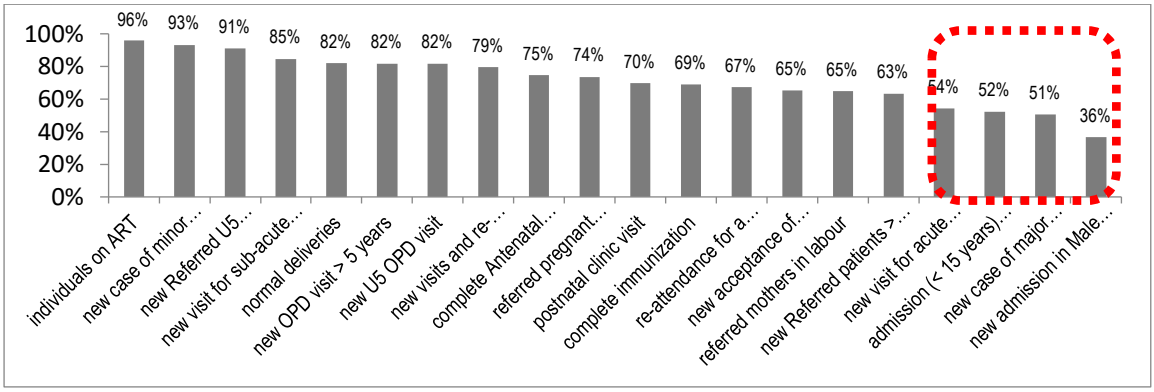
In FY 2017/18, the ICB II project supported by Enabel made the first RBF payments in a total of 33 health facilities in West Nile and Rwenzori of which 5 are hospitals, 4 HC IVs and 24 HC IIIs. On average, all health facilities perform better in terms of outputs and quality and received more RBF-payments every quarter. The total RBF budget amount for these facilities was Ug. Shs. 5,500,476,500/= and a total of Ug. Shs. 3,552,031,700/= was paid out giving an execution rate of 65%. The health facilities receive more RBF-money on average in Rwenzori than in West Nile which gives an indication about their regional performances. (See Annex 5 for the budget and payments per facility in FY 2017/18).

FIGURE 22: RATIO DECLARED VS HMIS (LEVEL OF QUALITY) FOR ICB II FACILITIES 2017/18 FY



There is variation in the ratio indicators declared and the HMIS indicating that there is need to address the quality gaps for the indicators with the lowest quality of care and the trend of quality (Figure 23).

FIGURE 23: RATIO DECLARED / HMIS BY INDICATOR FOR ICB II FACILITIES Q4 2017/18

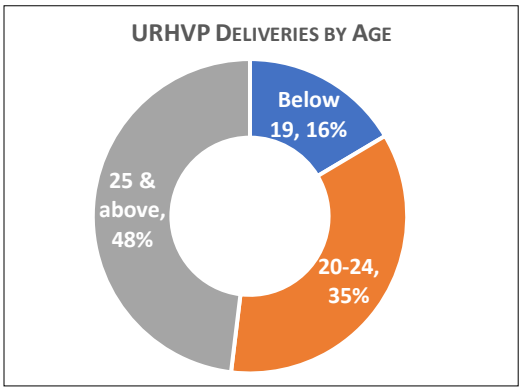


4. Uganda Reproductive Health Voucher Project (URHVP)

The URHVP is in the third year of implementation and is implemented in the South-Western districts of Uganda in Mbarara, Kabale, Kanungu, Ntungamo Kiruhura, Sheema, Buhweju, Mitooma, Ibanda, Isingiro, Bushenyi, Rubirizi, and Eastern Uganda districts of Jinja, Bugiri Kamuli, Buyende, Kaliro, Luuka, Mayuge, Iganga, Namutumba, Kibuku, Tororo, Namayingo and Busia. The Project is implemented through Marie Stopes Uganda and supports poor women in the rural areas access maternity services from health facilities through use of a voucher as a financing mechanism (the voucher helps to remove the financial barrier to the poor women to access maternity services).

- 90,299 vouchers were distributed and this resulted in 57,832 deliveries; representing a 64% redemption rate. Out of these, 48,038 (83%) were normal, 983 (17%) Caesarian Sections and 40 (less than 1%) were assisted deliveries.

- The increase in facility-based deliveries is attributed to (1) increased awareness of voucher services and choice through community-based distributors (2) improved quality of care at VSP sites and increased client follow ups by the Community Based Distributors (CBDs). To date, the proportion of deliveries by Caesarean Section is 15%. In addition, 17% (9,831) of deliveries were from mothers under age 19 years, 35% (20,241) between 20-24 years and 48% (27,759) above the age of 25 years.



- 75,563 (84%) women received ANC 1 services and 22,420 (39%) women received PNC. Out of the women who delivered in FY 2017/18, 14,975 (26%) received Post-partum FP (PPFP) translating into 47,520 CYPs.
- Four hundred thirty-eight (438) service providers from 212 contracted facilities were mentored on the management of Post-partum hemorrhage (PPH), the provision of PPFP, with a focus on Long Acting Reversible Contraception methods and the management of side effects.

TABLE 25: URHVP CUMULATIVE OUTPUTS BY JUNE 2018

	Key Indicators (Numbers)	Project Year 1, 2 & 3 up to end of FY 17/18	Project Life Target (Revised)
1.	# and % of deliveries assisted under the project	**115,377 (73.7%)**	**156,400**
2.	# and % of women attending at least one ANC visit	**147,948 (73.9)**	**200,000**
INTERMEDIATE RESULTS (Component One): Package of safe delivery services to poor pregnant women			
3.	Vouchers distributed and redeemed for postnatal care	**42,875 (55%)**	**78,000**
4.	# of pregnant women tested for HIV	**122,948 (61.4%)**	**200,000**
5.	# of Mothers referred	**7,870 (39.5%)**	**19,900**

- To increase the uptake of voucher services especially ANC service, the URHVP worked with Community Based Distributors (CBD) to conduct community dialogues through which health education messages were provided to expectant mothers and their influencers. This involved working with pregnant women, their spouses, family members and local leaders that have direct influence on the behaviours and practices of expectant women. By the end of FY 2017/18, 186 community sessions (102 in Eastern and 84 in South western) were conducted at 186 VSP sites reaching 2,684 men and 26,225 women of reproductive age with information on the importance of accessing health facility based maternity services including PPFP.

Good Practices & Lessons Learned

- Transport vouchers (vouchers in general) for pregnant women who stay more than 5km from the facility, and when referred. This has been implemented by UNICEF/CUAMM in Karamoja, and findings showed that transport voucher greatly increase hospital deliveries, are effective for emergency transportation and facility workers comfortably work as the voucher distributors to achieve efficiencies in scheme management.
- There has been an increase in maternal death reporting and reviews in areas where MPDSR trainings were conducted.

- New contraceptive methods introduced including; Sayana Press especially at the community level, Levoplant, FAM has improved the contraceptive method mix (FAM has increased uptake of FP by a new category of new users) especially among the faith based facilities.
- HC IIIs have capacity to provide long acting FP methods, and should be allowed to provide them either by including these commodities as part of the EMHS supplies kit for HC IIIs, or through redistribution from higher facilities. This is an opportunity missed in increasing CYP and CPR.

Challenges

- Inadequate funding and emergency of new districts (North region to be covered in 2018/19).
- High attrition rate and transfer of staff between districts but also Movement of Human labor to South Sudan.
- HC IIs conducting delivery services were difficult to grade and were not receiving supplies.

5. URMCHIP RBF Component for Primary Health Care Services

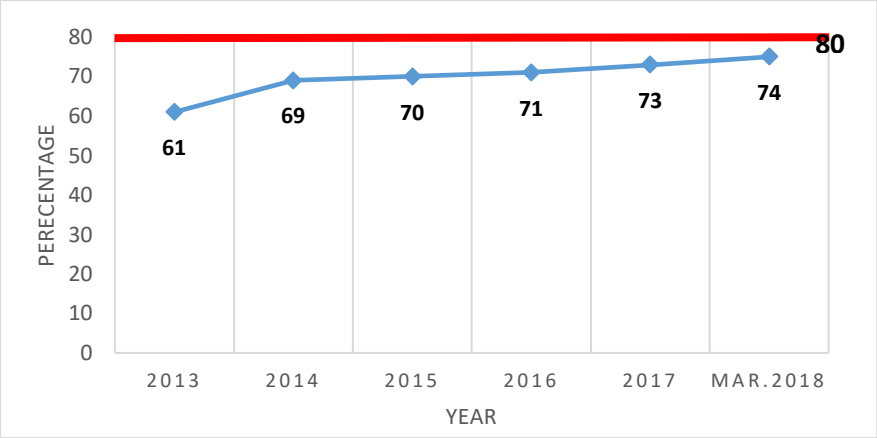
The MoH is scaling up the RBF program under Component 1 of the URMCHIP Project. During the FY 2017/18, the National RBF Unit was established under Planning Department to support RBD scale up and institutionalization. Four RBF Officers were recruited to support the department. The Department undertook most of the preparatory activities for the scale up and these included; finalization of the RBF assessment tools, training manual, Performance Improvement Plan and RBF Performance Agreements for LGs and health facilities; National RBF stakeholder orientation meeting including the Phase 1 districts, training of trainers for 46 RBF trainers; and held district orientation meetings on RBF in the 28 Phase 1 districts.

2.4 Human Resources for Health

According to HSDP 2015/16-2019/20, MoH projected to raise staffing levels in public sector facilities from 69% (2014) to 80% (2018). By March 2018 staffing levels was 74%. The ultimate goal is to have sufficient, competent, equitably distributed, motivated and facilitated health workers at all levels of the system in order to achieve a good standard of health by all people in Uganda.

In FY 2017/18 however, 6 new districts (Butebo, Bunyangabu, Namisindwa, Kyotera, Packwach and Rukiga) were created making the total number of districts in country 122. This phenomenon correspondingly changed the denominator (total Staffing Norm) and the average staffing levels. During the last 12 months many MoH central institutions and districts conducted recruitment of new staff. Preliminary findings indicated that by June 30th 2018 over 1,200 health workers had been recruited across the board. By the time of writing this report the attained average staffing had not been established because the HRH audit exercise was going on. Reliable figures could be received after the exercise. In general term the staffing levels were following an upward trend.

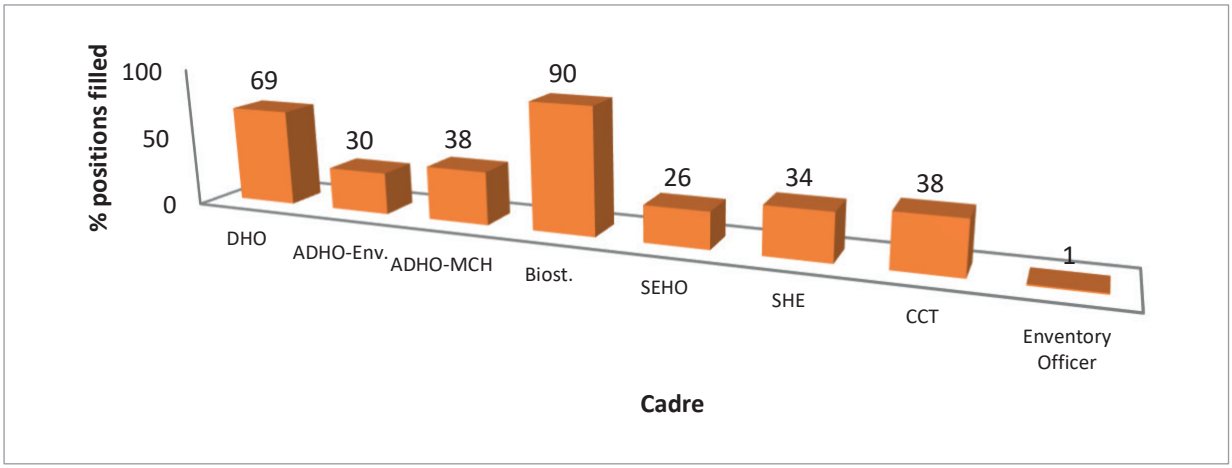
FIGURE 24: STAFFING LEVEL TRENDS OVER AS AT 30TH MARCH 2018



Source: SHRH M&E, April 2018

Good Governance and leadership is very crucial in achieving the organization's set goals. In many central MoH central institutions over 98% of approved leadership positions were substantively filled. However, at the district levels only 45% of the approved District Health Teams (DHTs) were substantively filled with 55% being occupied by officers in acting capacities or completely vacant. This poses a threat on leadership and governance at these levels that could be responsible for suboptimal performance observed.

FIGURE 25: SUMMARY OF OVERALL PROPORTION OF DHT CADRES FILLED BY JUNE 2018



Source: *SHRH quarterly M&E June 2018 Report*

The WHO estimates that at least 2.5 medical staff (physicians, nurses and midwives) per 1,000 people are needed to provide adequate coverage with primary care interventions (WHO, World Health Report 2006). Based on the HRH Audit report for 2017, the health worker (physicians, nurses and midwives) population ratio was 0.4 per 1,000 which is far below the recommended.

TABLE 26: APPROVED POSTS FILLED FOR SOME CRITICAL CADRES IN 2017/18 FY

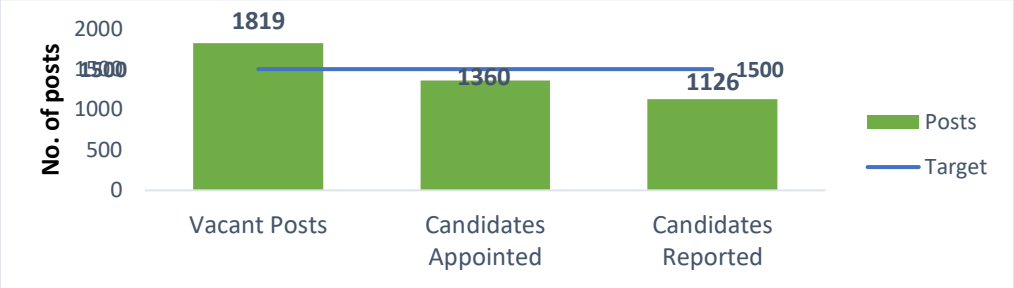
Job Title	Approved	Filled	% filled
Principal Anaesthetic Officer	15	6	40%
Anaesthetic Officer	338	136	40%
Anaesthetic Assistant	342	29	8%
Anaesthetic Attendant	123	32	26%
Hospital Director	14	13	93%
Senior Consultant	101	48	48%
Consultant	247	104	42%
Medical Officer Special Grade	559	149	27%
Principal Medical Officer	140	39	28%
Senior Medical Officer	279	141	51%
Medical Officer	765	742	97%
Senior Principal Nursing Officer	28	12	43%
Principal Nursing Officer	84	46	55%
Senior Nursing Officer	972	511	53%
Nursing Officer	2,759	2,923	106%
Senior Enrolled Midwife	130	17	13%
Senior Enrolled Nurse	89	24	27%
Enrolled Midwife	5,669	4,680	83%
Enrolled Nurse	5,733	5,472	95%

2.4.1.1 Staff Recruitment

The GoU together with HDPs supported the Central health institutions and LGs to conduct wage analysis develop costed three-year and annual recruitment plans for wage allocation. In the previous FY 2016/17, 122 districts and 18 Central institutions were supported. Following this mechanism over 2,500 positions were advertised. By June 2018 over 1,200 health workers had been recruited and the exercise

is still continuing. Figure 26 summarizes vacant positions advertised, candidates appointed and numbers that reported on duty in LGs.

FIGURE 26: SUMMARY OF NUMBER VACANT POSTS AND HEALTH WORKERS APPOINTED IN LGS FY 2017/18

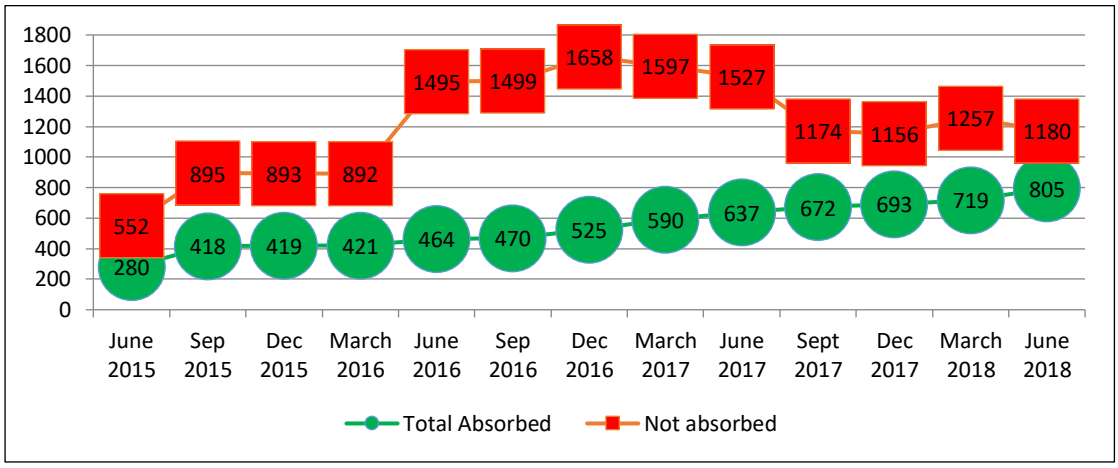


Source: SHRH M&E Report June 2018

2.4.1.2 USG funded contract staff absorption

In order to achieve the global UNAIDS targets of 90-90-90 towards HIV epidemic control, USG through PEPFAR complemented GoU efforts to accelerate availability of health workers for HIV/AIDS services by recruiting PEPFAR contracted health workers and deployed them in both high volume Public and PNFP facilities. These contracted health workers are supposed to be gradually prioritized for absorption in into public pay role as wage becomes available. By June 30th 2018, a total of 805 PEPFAR contracted health workers had been absorbed. 1,180 were yet to be absorbed and majority of this group were in PNFP facilities. The absorption of staff by PNFP facilities were restricted by limited wage despite the number for the skilled man power.

FIGURE 27: PROGRESS OF ABSORPTION OF USG-CONTRACTED HEALTH WORKERS BY JUNE 2018

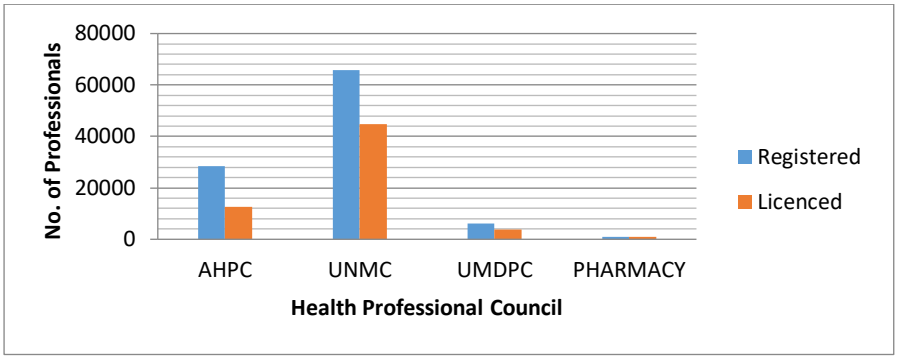


Source: SHRH M&E Reports

2.4.1.3 Health Workforce Stock and Density

Overall, the stock of qualified health profession available for employment in the health sector increased from 90,412 (2017) to 101,350 (June 2018). This is attributed to increase in production from pre-service training of some cadres e.g. Nurse, Midwives, Laboratory staff and Clinical Officers. The strengthened regulatory capacity for Health Professional Councils (HPCs) to monitor registration and licensure using a Human Resource Information System (HRIS) and District Health Supervisory Authorities could also have led to the improved registration. Despite the above it was observed licensure of health professionals was lower compared to registration. This could imply that the numbers of health professionals in the country legally qualified to practice but not actually practicing or practicing legally is high which a threat to quality of service delivery.

FIGURE 28: HEALTH PROFESSIONAL REGISTRATION VS LICENSURE-2018



Source: *HPC HRIS-Qualify*

2.4.1.4 Community Health Workforce

Harnessing community capacity, especially use of Community Health Workers (CHW) to expand access to integrated promotive, preventive and curative health services is crucial in improving health services delivery in the country. During the FY 2017/2018, the focus was on strengthening the community health workforce through establishment of a motivated cadre of CHWs namely the CHEWs and the development of systems for the management of the community health workforce in general. Establishing the CHEWs involved developing their training program, curriculum and other training materials. Selection of the CHEW trainees in the pilot districts was conducted and training will commence in next FY. Development of the CHW management systems commenced with the drafting of the CHW scope of work and management guidelines. In addition, a CHW registry to monitor performance of CHW was developed being piloted 13 districts of Apac, Oyam, Kole, Lira, Dokolo, Amolatar, Alebtong, Otuke, Amuru, Gulu, Nwoya, Omoro and Mayuge.

2.4.1.5 HRH Development 2017/18

The MoH paid scholarship debt of Ug. Shs. 160.5 million and 75 million is yet to be paid for scholarships that were awarded under the GoU funding in the previous FYs. Training Needs guidelines and tools were developed and awaiting approval by Top Management. The MoH In-Service Training / Continuous Professional Development curriculum has been developed and will be finalized in FY 2018/19. The following cadres are being sponsored by under the URMCHIP in various institutions.

TABLE 27: URMCHIP SCHOLARSHIPS AWARDED IN FY 2017/18

S/N	Name of courses	Vacancies Advertised	Numbers Applied	Numbers Selected	Numbers in Training
1.	Diploma in Anaesthesia	75	69	45	33
2.	Diploma in Clinical Nutrition	10	13	9	0
3.	Diploma in Paedriatrics - Nursing	15	12	8	4
4.	Certificate in Theatre Techniques	80	110	80	78
5.	Bachelors of Anaesthesia	40	30	30	24
6.	Bachelors of Biomedical Engineering	7	26	11	11
7.	Bachelors of Child Adolescent mental health	10	5	4	0
8.	Masters of Public Health-Nutrition	3	13	2	2

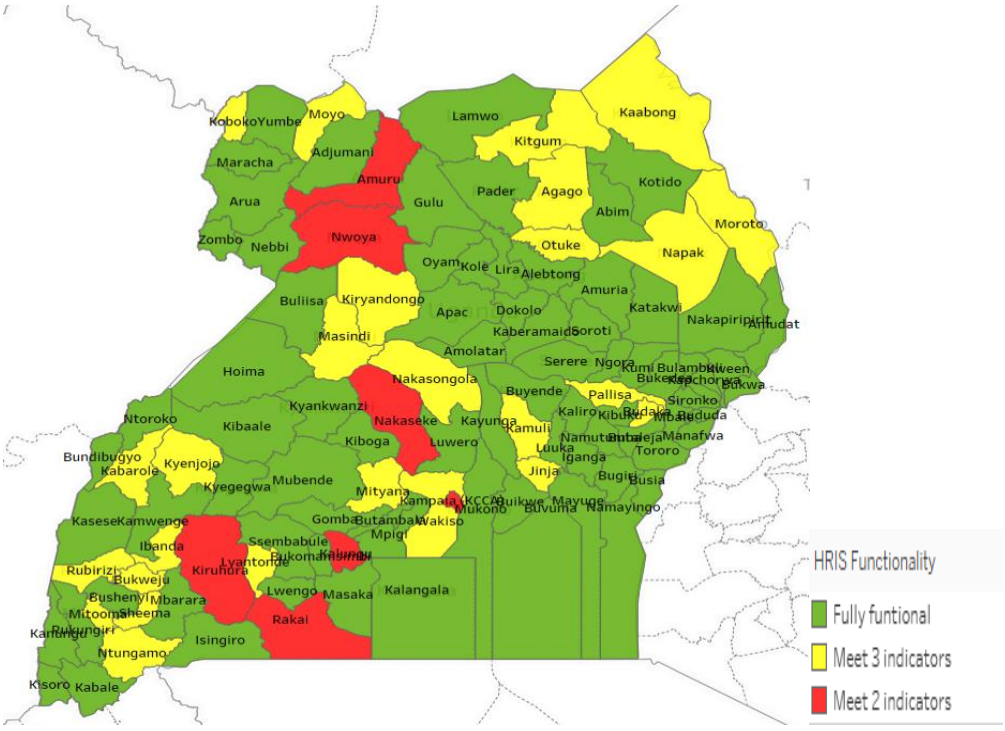
9.	Masters of medicine in Obstetrics & Gynecology	5	31	10	12
10.	Masters of Medicine - General Surgery	5	26	6	6
11.	Fellowship in Neonatology	5	0	0	0
12.	Master of Medicine in Anaesthesia	15	13	13	13
	Total	**270**	**318**	**188**	**184**

2.4.1.6 Human Resource Information System (HRIS)

The Integrated Human Resource Information System (iHRIS) is a human resources management tool that enables an organization to design and manage a comprehensive human resources strategy. A fully functional iHRIS enables leaders to quickly answer the key HRH policy and management questions affecting service delivery. MoH has established the iHRIS in all districts and 33 central institutions including 14 referral hospitals, two National referrals and KCCA. However, functionality was still low and varied among institutions. Figure 29 shows iHRIS functionality in districts across the country.

Having supported the system implementation since 2007, IntraHealth through USAID Strengthening Human Resources for Health Project (HRSP) transitioned the support to the LGs in 2017. The transitioning criteria was mainly based on the following two; iHRIS technical support provided by the institution, MoH or any other entity other than IntraHealth, ability to finance iHRIS costs by the host institution. To ensure sustainability of HRIS, a call center was set up at the MoH to help iHRIS users fix simple problems instantly and a core team is in place to provide technical support as and when it is needed. Some of the challenges affecting functionality so far is inability of institutions to update data in the system regularly and low use iHRIS data for decision making particularly at district level.

FIGURE 29: DISTRICT MAPPING OF IHRIS FUNCTIONALITY AS AT JUNE 2018



Source: HRIS June 2018

2.4.1.7 Managing absenteeism in the Health sector

Absenteeism impacts demand and utilization of health services by preventing communities from accessing care, increasing costs, loss in wages with multiple attempts to access care, worsening conditions leading to additional costs and worsening health condition and trust in the system.

It also impacts the quality of services by increasing the volume of work for those present, Low morale, present workers adopt negative practices and Some are forced to perform tasks for which they are unqualified.

2.4.1.7.1 The Prime Minister's Delivery Unit (PMDU)

The PMDU for Health established an Inter-Ministerial Committee composed of MoPS, MoLG, MoH and Partners - Intrahealth & Health Monitoring Unit (HMU) to work together to achieve 100% attendance in 20 districts (Tororo, Serere, Soroti, Mbale, Bulambuli, Sironko, Kapchorwa, Kween, Bukwo, Pallisa, Buyende, Bugiri, Kayunga, Namutumba, Luuka, Mayuge, Buvuma, Bududa, Manafwa and Bulambuli) in Eastern Uganda.

Hon. Prime Minister, Dr. Ruhakana Rugunda in the lead "Driving Action and Accountability towards Elimination of Health Worker and Teacher Absenteeism" – Jinja Civil Service College, May 2018

Head PMDU Prof. Ezra Suruma receiving the robust fingerprint mobile phone readers from a representative of DFID

Strategies agreed:

- Daily attendance recording, routine tracking and periodic reporting by the PMDU.
- Enforcing sanctions and rewards with appropriate actions taken by district LGs.
- Strengthening leadership and management at district and health facility levels.

With funding support from DFID, Office of the Prime Minister (OPM) the sector acquired 52 biometric fingerprint readers and 188 Robust phones to facilitate real time reporting and improve the quality of data. IntraHealth (HRSP) which is part of the task force was contracted by DFID to carry out installation and roll out of the biometric system in 8 general hospitals, 29 HC IVs and 183 HC IIIs and 1 HC II.

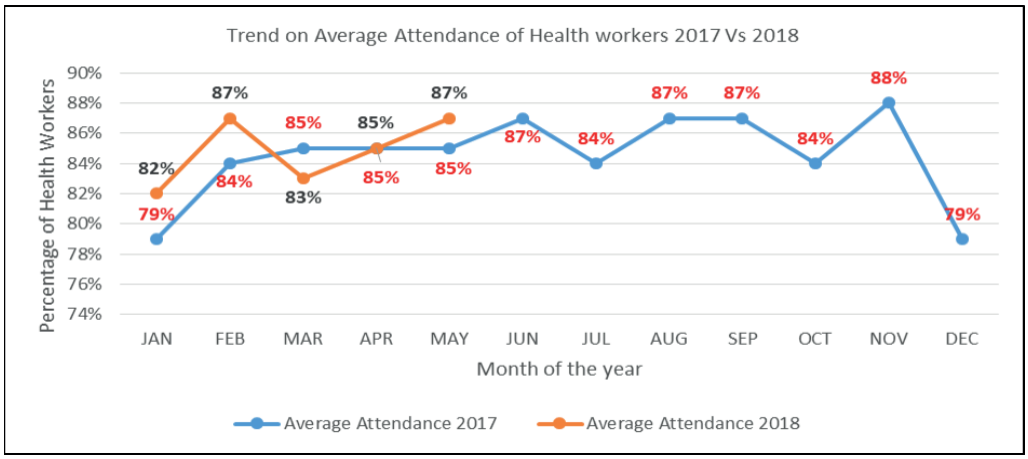
TABLE 28: NUMBER OF HEALTH FACILITIES WITH BIOMETRIC ATTENDANCE SYSTEM INSTALLATIONS

District	Health Facility Level				Grand Total
	HC II	HC III	HC IV	Hospital	
Bududa		7		1	8
Bugiri		9	1	1	11
Bukwo		3		1	4
Bulambuli		11	1		12
Buvuma		3	1		4
Buyende		4	1		5
Kaliro		4	1		5
Kapchorwa		7		1	8
Kayunga		8	2	1	11
Kween		9	1		10
Luuka		6	1		7
Manafwa		10	3		13
Mayuge		8	3		11
Mbale		23	3		26
Namutumba		8	1		9
Pallisa		17	1	1	19
Serere		6	2		8
Sironko	1	12	2		15
Soroti		10	2		12
Tororo		18	3	2	23
Grand Total	**1**	**183**	**29**	**8**	**221**

Buvuma HC IV staff being undergoing finger print registration (left) while Staffing lists (right) are being uploaded onto the HIRS system under the watchful eye of the ADHO Sr. Mutesi.

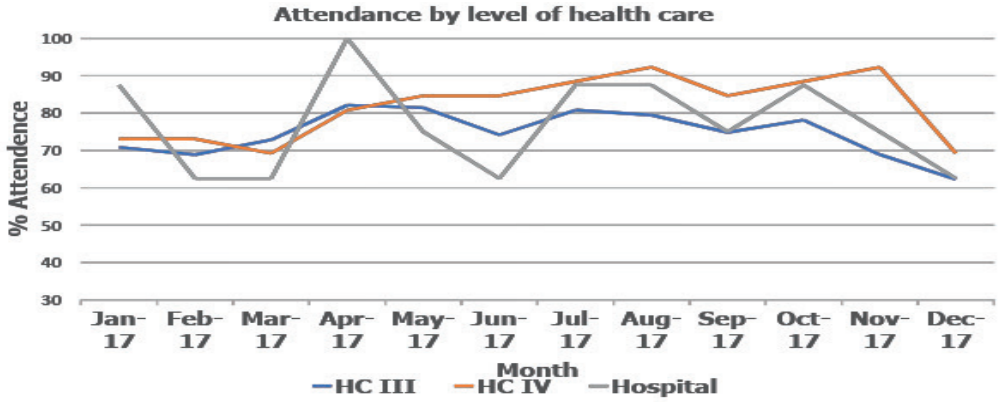
Moderate improvement seen over time. Attendance rose from 79% in January 2017 to 87% in May 2018.

FIGURE 30: TRENDS IN HEALTH WORKER ATTENDANCE



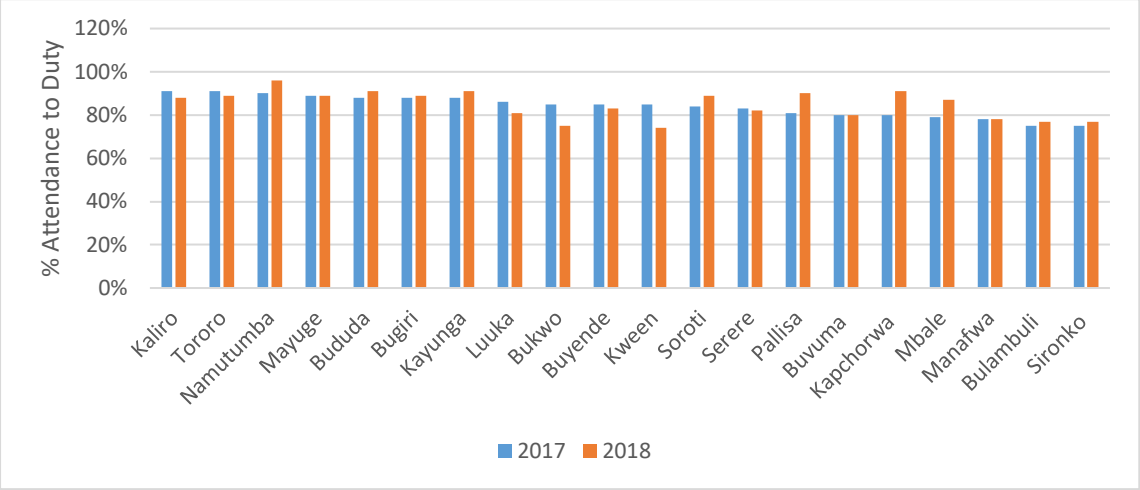
Attendance more volatile in general hospitals than the lower levels.

FIGURE 31: ATTENDANCE BY LEVEL OF CARE



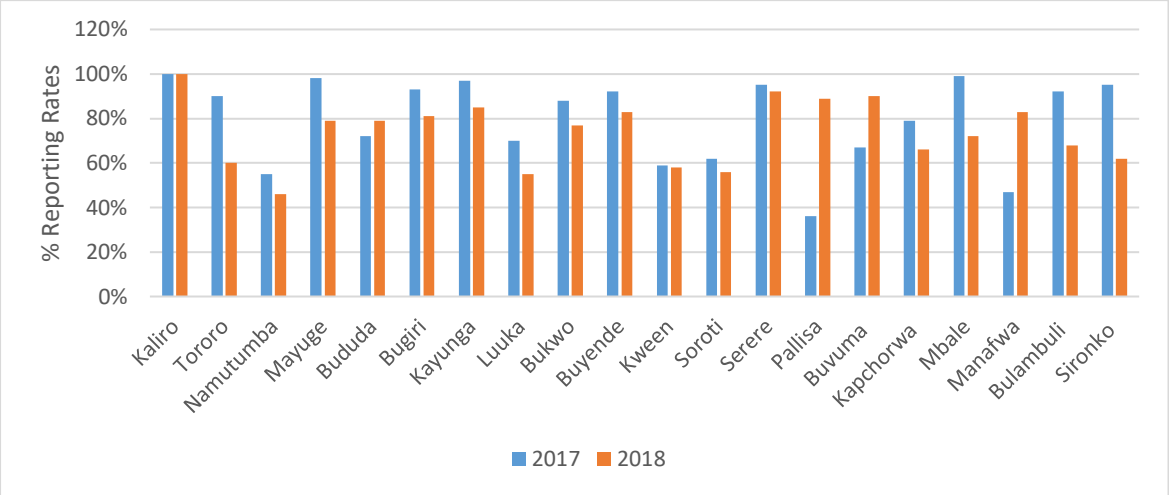
Comparison of attendance across districts in 2017 and 2018 shows that Kaliro & Tororo have declined in attendance in 2018, Namutumba has maintained fairly good attendance rates and Sironko and Bulambuli still among the worst although with a slight improvement of 2%.

FIGURE 32: ATTENDANCE ACROSS DISTRICTS 2017 TO 2018



Reporting rates varied considerably across districts. Majority of districts are still below the 85% target.

FIGURE 33: AVERAGE REPORTING RATES PER DISTRICT



Some districts like Kaliro, Buvuma, Bududa, Bulambuli, Kayunga and Mayuge have administered sanctions or rewards based on attendance.

Sanctions

- 147 warning letters
- 95 forwarded to CAO
- 34 deleted from payroll
- 1 interdiction
- 17 dismissals by the respective District Service Commissions (DSC)

Rewards

- 17 certificates and handshake recognitions
- 14 assorted gifts
- 5 promotions in service recommended by DSC.

Good practices:

- Designation of focal point persons for iHRIS reporting and follow up.
- Regular monitoring by all levels, empowering local authorities to check on attendance & dialogue with staff.
- Sensitisation, regular communication and training of in-charges and wards managers.
- Regular data analysis and use to S&R performance; CAO backing and taking actions.
- Investment in equipment to facilitate reporting (mobile phones & airtime, modems, laptops).
- Use of technology and existing reporting platforms (mTRAC, WhatsApp, for information sharing.
- Feedback on performance and quality of submission by PMDU.

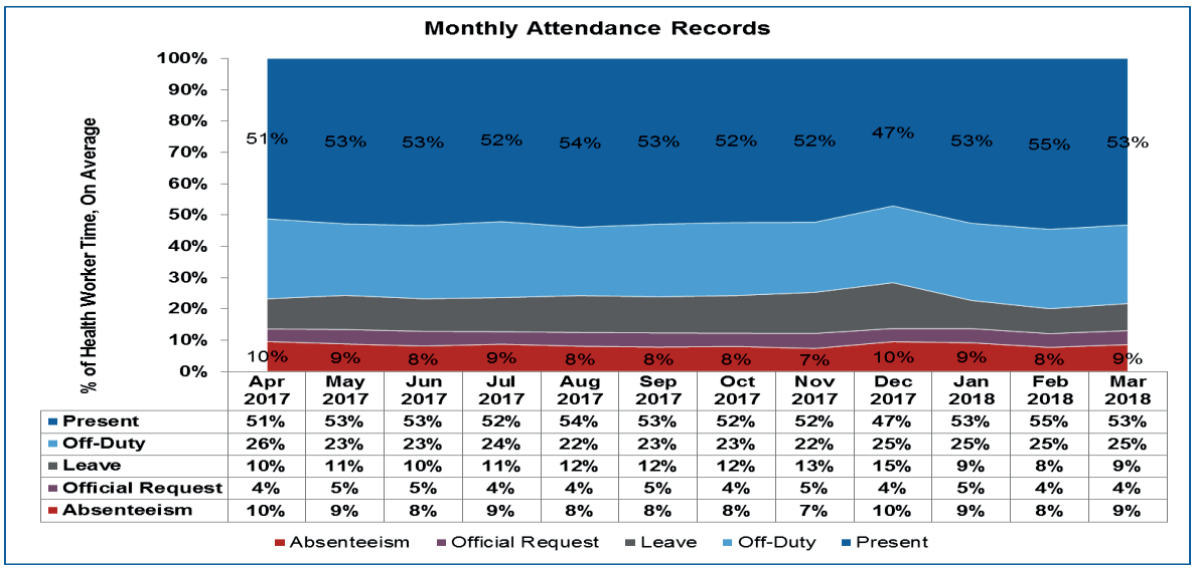
Key challenges:

- Insubordination and Absenteeism among In-charges
- Poor communication by facilities - poor internet/network
- Travel challenges (transport & lack of housing facilities on site)
- Competing activities, poor coordination by external players (event invites not coordinated with supervisor)
- Tampering (rosters, staff signing for others, etc.)
- Slow action by District Service Commissions
- Irregular salary payment
- Inadequate facilities and essential supplies

2.4.1.7.2 Automated Attendance Analysis Initiative

As part of managing performance of health workers, MoH with support from SHRHP rolled out the mechanism for attendance tracking and absenteeism management using the Automated Attendance Analysis (AAA) in 2016 starting with a few districts as a pilot and later rolled out to all district by February 2018. Most districts were tracking attendance to duty monthly and generated duty attendance report. The analysis was being used by some districts to take administrative HRH decision including salary payment based on number of days worked. Figure 34 shows that by March 2018 the absenteeism without authority had reduced from an average **10**% same time in April 2017 to **9%**. In addition, absenteeism (with or without approval) reduced from 42% in 2017 to 22% in 2018.

FIGURE 34: NATIONAL MONTHLY ATTENDANCE ANALYSIS – MARCH 2018



	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018
Present	51%	53%	53%	52%	54%	53%	52%	52%	47%	53%	55%	53%
Off-Duty	26%	23%	23%	24%	22%	23%	23%	22%	25%	25%	25%	25%
Leave	10%	11%	10%	11%	12%	12%	12%	13%	15%	9%	8%	9%
Official Request	4%	5%	5%	4%	4%	5%	4%	5%	4%	5%	4%	4%
Absenteeism	10%	9%	8%	9%	8%	8%	8%	7%	10%	9%	8%	9%

Source: SHRH M&E Report, May 2018

2.4.1.8 Strengthening Support supervision systems

MoH working with Partners investing in HRH is committed to improve performance of health workers. In particular, MoH has worked with IntraHealth led USAID-funded Strengthening HRH project to improve performance management through strengthening support supervision systems. Support was provided to MoH Headquarters, Mulago RRH, UVRI, Uganda Blood Transfusion Services (UBTS), 3 RRHs, and 45 districts. During the orientation participants were taken through the Guidelines for Support Supervision.

2.4.1.9 Gender Mainstreaming & Occupational Safety and Health (OSH)

In an effort to main stream gender equality and promote a conducive work environment, MoH working with IntraHealth led SHRHP trained health managers in 45 districts and 3 RRHs on Occupational Safety and Health best practices and the law. Using the findings of the study conducted in 2015 that assessed sexual harassment in the Health sector, MoH and partners to have been developing a sexual harassment prevention and response system. The necessary tools to implement the intervention were finalized and pilot implementation is expected in FY 2018/19. A trainees' manual on mainstreaming human rights and gender in the health sector and Guidelines on prevention and response to sexual harassment in the health sector were developed.

2.4.1.10 Good practices in HRH

- Districts and other health institutions conducting wage analysis to inform recruitment of new health workers.
- Several districts like Buhweju and Kotido have developed and implemented retention packages like; facilitating staff for further training, giving rewards to good performers etc.
- Districts like Iganga like are using monthly duty attendance reports to compensate health workers basing on days worked where applicable.
- Keeping Call Centre 24 hours operational to address health related issues including HRH issues.

2.4.1.11 HRH Challenges and outstanding issue

- ❑ Poor/Inadequate infrastructure (including staff accommodation)
- ❑ Competitive employment opportunities leading to high staff turnover in some districts
- ❑ Low capacity for HRH planning in some institutions (especially new districts)
- ❑ Inadequate supervision at all levels
- ❑ Low Job Satisfaction and among health workers
- ❑ Low supply of some critical cadres
- ❑ Weak systems for absorbing bonded students
- ❑ High cost of medical education and few opportunities for sponsorship
- ❑ High number of trainees in practicum site
- ❑ Low salaries and incentives which do not attract graduates in remote services areas
- ❑ Lack of career progression for some programs – theatre assistants
- ❑ Weak implementation of the laws and policies on gender.

2.5 Health Partnerships

2.5.1 Progress in implementation of the HSDP Compact

This section assesses performance of the Health Policy Advisory Committee (HPAC), Senior Management Committee (SMC) and Technical Working Groups (TWGs) and progress in implementation of the partnership commitments made in the HSDP Compact.

2.5.1.1 Performance of HPAC

HPAC is a stakeholder coordination mechanism which supports the functions of the MoH Top Management in policy related issues and meets monthly.

Twelve monthly meetings were held and 10 of these were on the scheduled dates (first Wednesday of the month). A total of 35 items (17 policy issues and 18 non policy issues) were presented and discussed in these meetings i.e. approximately 3 policies/strategic issues discussed per month. The signed minutes of the meetings are available.

List of the policies or strategic issues presented to HPAC for the period July, 2017 to June, 2018.

1. Presentation of the compact for HSDP and IHP+.
2. NCDs Implementation Strategy.
3. Draft Adolescent Health policy
4. Draft National Policy guidelines and service standards for SRHR
5. Draft Sexual Reproductive & Health Rights Policy
6. CHEWs Policy & Strategy
7. Draft Revision of the Public Health Act 2000.
8. Scope of practice for nurses and mid wives in Uganda.
9. Service Scheme for the laboratory service.
10. Policy implementation guidelines on the sexual harassment prevention and response in the health sector.
11. Draft Proposed Private Public Partnership pipeline for the health sector.
12. Draft Emergency Medical Services policy.
13. Update on the Ministerial Policy Statement for FY 2018/19.
14. Draft Public Private Partnership Bill for Pharmacy professional.
15. Discussion of MoH strategic direction and HPAC functions and operation modalities.
16. Regulatory Impact Assessment Report for National Health Insurance Scheme.
17. Medical Credit Fund Proposal

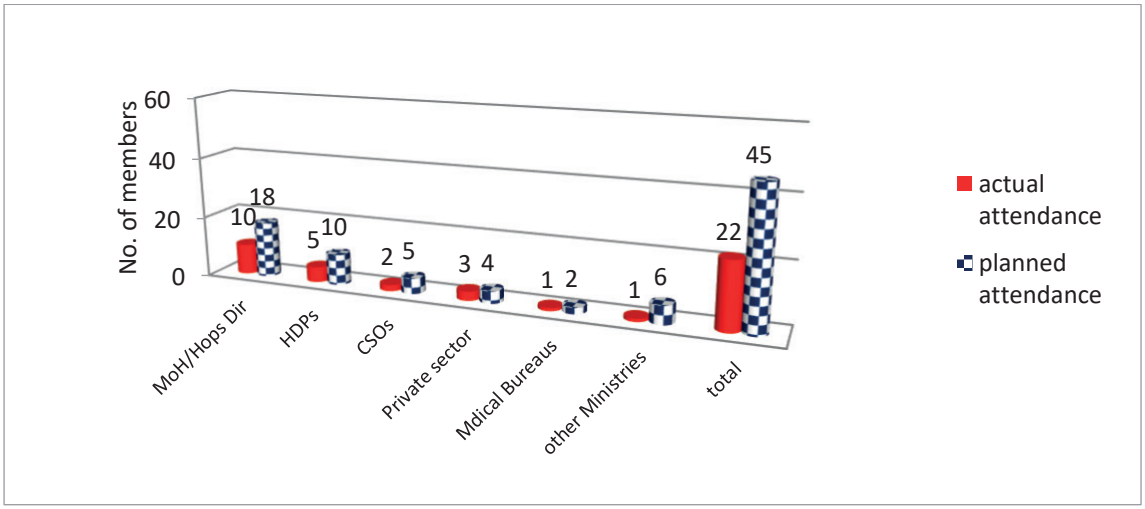
Non policy issues presented to HPAC for the period July, 2017 to June, 2018.

1. Presentation of the Measles –Rubella application to GAVI.
2. The concept note for 23rd Joint Review Mission and 10th National Health Assembly.
3. The Uganda Rural Sanitation and Hygiene Investment Plan 2018-2023.
4. Setting up of National Immunization Coordination Committee.
5. Update on the progress on implementation of the 21st JRM aide memoire recommendations.
6. The medicines stock status report.
7. The Partnership Fund Proposal
8. Presentation of the annual work plan and budget 2017/18 and monitoring tool for HPAC.
9. Presentation of the 1st budget call circular for FY 2018/19.
10. Update on the Basket Funding Proposal developed with support from BTC.
11. Update on the status report on de-wormers and Vitamin A for child days.
12. Update on the development of resource mapping tools.
13. Presentation on the concept for the mid –term review of the HSDP 2015/16-2019/20.
14. Updates from Senior Management Committee and TWGs committees.
15. Presentation on the request for technical assistance for preliminary work on the management service (PPP).
16. Presentation on the role of the MoH in the refugees' crisis in northern Uganda.

17. Presentation on the proposed Private Public Partnership pipeline for health sector.
18. Presentation of the Technical Assistance work plan.

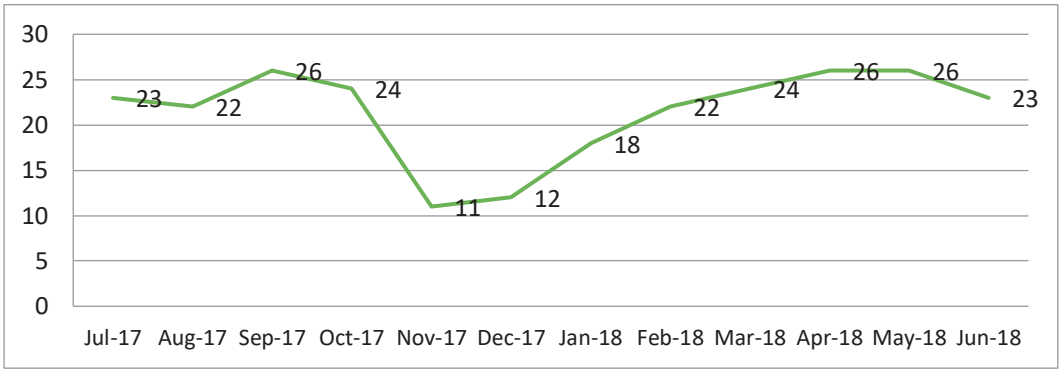
Overall average attendance of HPAC members was 49%. Representatives of HDPs, Private sector and Medical bureaus attended above average of 50%. Representatives from MoH, CSOs, and other ministries need to improve attendance.

FIGURE 35: AVERAGE ATTENDANCE IN FY 2017/18 BY MEMBERSHIP



November and December, 2017 recorded the lowest attendance with 24.4% and 26.6% of the member attending followed respectively. The month September, April and May recorded the highest attendance.

FIGURE 36: HPAC ATTENDANCE PER MONTH IN FY 2017/2018



Three areas were planned for monitoring implementation of the Compact for the HSDP 2015/16 – 2019/20, and these have been assessed for this reporting, including:

- Planning and budgeting,
- Monitoring program implementation and performance, and
- Policy guidance and monitoring.

Performance against the implementation of the Compact is shown in Table 29.

TABLE 29: PROGRESS IN IMPLEMENTATION OF THE COUNTRY COMPACT DURING FY 2017/18

/#	Compact Indicator	Targets/Means of Verification	Achievement	Comments
1.0.	**Planning and Budgeting**			
1.1.	MoH Annual Work plan reflecting stakeholder contribution (all resources on-plan)	Partners' support is captured in the plan	Not all resources in one MoH Annual Work plan	Some donors still prefer off-budget support
1.2.	All new sector investments are appraised by SBWG	Submission of new projects to SBWG	All new projects and proposals were submitted to SBWG	SBWG met monthly
1.3.	All planned procurements reflected in the Comprehensive procurement plan	Adherence to procurement plan	Annual integrated comprehensive procurement plan was made but not fully implemented	Delays in initiating procurements
1.4.	Response to Auditor General's report	Timely response to AG's report	Response to all audit reports was made.	Advise of the AG's advice is being used in improving accountability systems
1.5.	Implementation of harmonized Technical Assistance (TA) Plan	HPAC approval of ToRs & procurement of short & long term TA	Harmonized TA plan developed and presented to HPAC	TA needs assessment conducted by Departments
2.0.	**Monitoring Program Implementation and Performance**			
2.1.	Area Team Visits - Quarterly Reports	Presentation of reports to HPAC within 30 days after completion of Area Team visits	Two Area team reports compiled and submitted to HPAC.	Reports submitted
2.2.	MoH Quarterly Performance Assessment	Dissemination of reports to HPAC within 30 days after completion of MoH quarterly review.	Three quarterly performance review meetings held	Reports circulated on the MoH website
2.3.	Technical Review Meeting	Present of report from TRM to HPAC by 30 April	TRM not done	
2.4.	Technical Working Group meeting	Target 80% of TWG meetings held	50% of TWGS held regular meetings and briefs informing policy presented to senior management and HPAC.	This was an improvement from 40% in FY 2016/17
2.5.	Annual Health Sector Performance Report	Submission of Final Report by 30 Sept	Report written, discussed at the 23rd JRM (26th to 28th September 2017) and disseminated	Achieved fully
2.6.	Submission of Annual Report to OPM	Submission to OPM by 30 August	Health component of the GAPR submitted to OPM on time.	
2.7.	Joint Review Mission - review of sector performance	Aide Memoire presented to HPAC by 30 Nov	The JRM was held on schedule and AIDE Memoire was presented to HPAC signed in January 2017	
2.9.	End of HSDP Evaluation	Completion of end of HSDP review by June 2018	Not due	Mid-Term review undertaken
3.0.	**Policy Guidance and monitoring**			
3.1.	Senior Management Committee	12 SMC meetings	11/12 SMC meetings were held	Technical issues from TWGs discussed.
3.2.	Health Policy Advisory Committee	12 meetings	All 12 meetings were held	Discussed issues with policy implications.
3.3.	Country Coordination Mechanism	4 meetings	CCM met quarterly and organized other meetings to support the Global Fund Grant Application	New members appointed

2.5.1.2 Performance of MoH Senior Management Committee

11 out of the planned 12 (92%) Senior Management Committee (SMC) meetings were held during 2017/18 FY. The following are selected items were adopted and forwarded to HPAC for further consideration:

1. Second Quarter Area Team Support Supervision report.
2. Key highlights in the revised 2018 HMIS tool kit.
3. End of Project report: USAID/Uganda Private Health Support Program (UPHP).
4. MoH Quality of Care (QoC) web based reporting tool.
5. Draft UNEPI Standards.
6. Concept Note of Midterm Review of the HSDP 2015/16 – 2019/20.
7. Uganda National Integrated Health Response Plan for Refugees.
8. Concept Note Public Expenditure Review (efficiency study).
9. Workload Indicators of Staffing Need (WISN) methodology in Uganda.
10. Social Enterprise Income Generation Models and Incentives for Volunteer Community Health Workers.
11. National Family Planning Social BCC Communication strategy (2016-2020).
12. Reproductive, Maternal and New-born Health Project in 5 districts (CHAI).
13. Accident and Emergency Services framework.
14. Revised Integrated Management of Acute Malnutrition guidelines.
15. Review and update Malaria Policy 2011.
16. Terrewode Specialised Women Community hospital.
17. Proposed Private Public Partnership Pipeline for the Health Sector.
18. Conducting Institutional Triggering, by Environmental Health.
19. Policy Guidelines on Sexual Harassment Prevention and Response in the Health Sector.
20. Manual for Human Rights and Gender for Health Professionals.
21. National Sanitation Guidelines.
22. National multi-Sectoral framework on adolescent girl.
23. Guidelines for pre-registration of Allied Health Professionals Council.
24. The Sickle cell management guidelines.
25. Innovative method of Training health workers on Maternal Newborn care and Adolescent Health services.
26. Assessment of health progress and performance of the HSDP 2015/16 – 2019/20 to inform the Mid-Term Review,
27. Midwifery Services Framework.
28. Improving access and quality for all through affordable financing – Medical Credit Fund

1. Technical Working Groups (TWGs):

Seven out of the fourteen (50%) TWGs were able to hold regular monthly meeting and these are: Health Sector Budget; Supervision Monitoring Evaluation and Research; Maternal and Child Health; Medicines Procurement and Management, Private Public Partnership for Health (PPPH) and e-Health TWGs. Modest improvement from last FY (46%). Three TWGs (21%), Non-Communicable Disease Control, Health Infrastructure, Hospitals and Lower Level, and Nutrition TWGs met at least once in each quarter. The rest of the TWGs (29%) held fewer and irregular meetings recorded.

Policy and strategic issues discussed were synthesized and forwarded to SMC for further review and appropriate action.

2.6 Key Sector Challenges and Recommendations

Despite the achievements, the sector still faces several challenges in ensuring a healthy and productive population as summarized in table 30.

TABLE 30: KEY SECTOR CHALLENGES AND RECOMMENDATIONS

No.	Challenges	Recommendations
1.	Huge disease burden owing to mainly malaria, newborn conditions and growing number of NCDs.	Investment in health promotion and disease prevention interventions for example the CHEWs, since 75% of the diseases are preventable.
2.	Inadequate staffing at all levels a significant number of posts are not filled and current staffing norms not commensurate with the services provided and workload.	The staffing norms for the health facility staff should be revised to take into consideration the growing population and range of services provided.
3.	Inadequacy in the maintenance of medical equipment nationwide.	Increased funding for maintenance of medical equipment including training and recruitment of Biomedical Engineers.
4.	Management of various disease outbreaks and public health emergencies is not equitably funded for example current influx of refugees into the country and internally displaced persons puts pressure on existing resources and is a risk of importation of vaccine preventable diseases.	Advocacy and mobilization of resources of contingency funds at district and National level for epidemic response. Financing of the Refugee Health and Nutrition Plan.
5.	Inadequate transport and funding for district level coordination and support supervision.	Develop a costed National Supervision Strategy Review the HSD Concept to strengthen the District & HSD Management Functions.
6.	Stocks outs of key commodities at facility level owing to inadequate budget allocation for EMHS. The budget increases for EMHS are not in tandem with the population growth over the years and thus the declining trends in the per capita allocations.	Advocate for increase in budget allocation for EMHS.
7.	There is inadequate funding for sector activities especially PHC Services at lower level leading to influx of patients at the referral facilities. No commensurate funding for recurrent costs for utilities and/or maintenance arising from the raise in costs as well as construction of new buildings and equipment especially for hospitals.	Increase investment in health towards meeting recommended per capita health expenditure of minimum $84 per capita for low income countries, if the country is to increase access to health care and improve quality of services.
8.	Inadequate funding for preventive interventions at community level.	
9.	Poor / inadequate infrastructure (including staff accommodation).	
10.	Low data use at all levels	There is need to emphasize data use at subnational level and point of collection through training and mentorship and in with collaboration with the Division of Health Information.
11.	Challenge of the alignment of off-budget funding to sector priorities.	The MoH needs to improve coordination of donors and ensuring alignment to country strategies to the Paris Declaration principles for more aid effectiveness.

2.7 East African Community (EAC) Regional Integration

Article 118 of the treaty for the establishment of the EAC stipulates the activity areas to be undertaken for cooperation by the Partner States. The EAC Secretariat in collaboration with the Partner States are implementing activities in line with the treaty in order to widen and deepen regional integration in the health sector. In this regard the summary of the key achievements during the year under review among others include:

1. Approval of the ten (10) year EAC Health Sector Investment Priorities by the EAC Heads of State Summit which was held in February 2018 at Speke Resort, Munyonyo in Kampala. The priorities will guide all investments in the health sector for the Region over the next ten years. Each of the priorities have sub priorities. Broadly the priorities are;

   Priority 1: Expansion of Access to Specialized healthcare and cross border health services.

   Priority 2: Strengthen the network of medical reference laboratories and the Regional Rapid Response Mechanism to protect the region from health security threats including pandemics, bio-terrorism and common agents.

   Priority 3: Expansion of capacity to produce skilled and professional workforce for health in the region based on a harmonized regional training and practice standards and guidelines.

   Priority 4: Increase access to safe, efficacious and affordable medicines, vaccines and other health technologies focusing on prevalent diseases such as malaria, TB, HIV/AIDS, Non-communicable diseases (NCDs)and other high burden conditions.

   Priority 5: Upgrading of health infrastructure and equipment in priority national and sub national health facilities/hospitals.

   Priority 6: Establishment of strong primary and community health services as a basis for health promotion and disease prevention and control.

   Priority 7: Expansion of health insurance coverage and social health protection.

   Priority 8: Improvement of Quality of healthcare, health sector efficiency and health statistics.

   Priority 9: Strengthening of Health Research and Development.

Each of the above priorities have sub priority actions under them. The implementation framework for the priorities is under development after which resource mobilization will start spearheaded by the EAC Secretariat.

2. Under health systems strengthening, the EAC Partner States are operationalizing Regional Centers of excellence for higher medical training, research and service delivery in key areas in order to build enough human capital and infrastructure to reduce on referral of patients outside the region. These Regional Centers of Excellence are;
   - EAC Regional Centre of Excellence for Oncology hosted by the Uganda Cancer Institute.
   - EAC Regional Centre of Excellence for Urology and Nephrology hosted by Kenyatta National Hospital in Kenya.
   - EAC Regional Centre of Excellence for Cardiovascular Sciences hosted at Muhimbili University of Health and Allied Sciences in Tanzania.
   - EAC Regional Centre of Excellence for Vaccines, Immunization and Health Supply Chain Management hosted by the University of Rwanda in Kigali.
   - EAC Regional Centre of Excellence for E-Health and Biomedical Engineering hosted by the University of Rwanda.

- EAC Regional Centre of Excellence for Nutritional Sciences and dietetics hosted by the University of Burundi.

The centers of excellence are funded by the AfDB except the one of Vaccines, Immunization and Health Supply Chain Management which is funded by the Germany Government. All the centers are already operational except the one of nutritional sciences which is being finalized. The aim is to have a network of these Regional Centers of Excellence to strengthen the capacities, training, research and service delivery in the specialized areas to minimize referrals outside the region.

3. The EAC Sectoral Council of Ministers of Health approved the establishment of the East African Network of Reference Laboratories for Communicable Diseases supported by the Federal Republic of Germany (KFw). The financing agreement for this project worth 10 million Euros was signed between Kfw and the EAC Secretariat on 23rd November 2017. The main interventions under this project are;
   - Provision of nine (9) Mobile Laboratory Units and Equipment of bio-safety level 3-4 to handle bacteriology and virology.
   - ICT equipment and installation of Webex systems and Video Teleconference facilities.

   Training in use of the mobile labs, field exercises among others. Two (2) experts from each EAC Partner State will start later this year for training at the Bernd Nocht Institute in Hamburg Germany. These TOTs on return will be supported to train other ten (10) experts in country. The focal point for this project in Uganda is the CPHL in collaboration with UVRI.

4. Under the area of regulation of health professionals training and practice in the EAC Region, the EAC Health Professional Boards and Councils have close working framework the EAC TWG for Regulation of Health professional training and practice. The Medical/Dental Boards and Councils have developed harmonized training curricula, standards and guidelines for Joint Inspection of the Medical Training Schools and University Teaching Hospitals. Regular inspections of the medical schools are carried out to ensure minimum standards of training are adhered to in the region. The Medical and Dental Councils have finalized the "Mutual Recognition Agreement" which will ensure the free movement of Medical and Dental Practitioners within the EAC Partner States in line with the EAC Common Market Protocol for free movement of goods, services and people.

5. There has been strengthened cooperation in the area of Medicine Regulation in the region. The Medicines Regulatory Agencies (MRAs) are implementing the EAC Medicine Registration Harmonization (EAMRH) project to ensure more efficient registration of new medicines for the region. This involves Joint Dossier Assessment, Joint Inspection of Good Manufacturing Practice and Joint Pharmacovigilance activities in order to reduce the time it takes to approve and register new medicines, ensure safety and lower the costs of medicines. The EAC MRAs have concluded a cooperation agreement that will provide guidance for technical cooperation among the EAC Partner States MRAs to improve efficiency and effectiveness in the regulation of medicines and health technologies through information and work sharing and convergence. In addition, the Sectoral Council of Ministers of Health approved the Regional Policy and Strategic Plan to guide the EAC Partner States ensure adequate, rational use and reliable supply of safe and efficacious medicines and health technology to all people of EAC.

6. The EAC is implementing an integrated Health Program with SIDA support to harmonize and integrate SRHR/EMNCAH and HIV/AIDS services, strengthen Innovation and Knowledge Management, Leadership and Accountability. As a result, a Regional Knowledge Management Fair Share was held in Entebbe in June 2018, during which lessons were share and learnt for better integration of RMNCAH and HIV/AIDS interventions/programming.

7. The EAC TWG on Communicable and NCDs has developed and are implementing an Epidemic Disease Surveillance and Response Contingency Plan. As a result, Standard Operational procedures

have been developed for One Health Approach, Disease out-break response and Simulation Exercises among others.

8. The East African Health Research Commission (EAHRC), an institution of the EAC Partner States to advice upon all matters of health and health related research is now operational. EAHRC Headquarters is in Bujumbura, Burundi. The Commission hosted the first Regional Digital Health Conference at Lake Victoria Serena Hotel in September last year. Following the conference, the EAHRC is in advanced stages of finalizing the first "Digital Regional EAC Health Initiative'' which is a comprehensive program that seeks to support the digitalization and harmonization of key health information.

9. Under the East, Central and Southern Africa Health Community (ECSA-HC), the country is benefiting from the implementation of the "East African Public Health Laboratories Network Project'' which has supported the strengthening of laboratory services in the country through trainings, provision of equipment, reagents and other supplies. It has supported the TB Supra reference laboratory perform its mandate and also support other countries improve on TB lab services.

2.8 Local Government Performance

The District League Table (DLT) is composed of input, process, output and outcome indicators – e.g. staffing levels TB case detection rate, deliveries in health facilities, PCV3 coverage, and latrine coverage, among others; in line with the HSDP. The composite index employed is computed by weighting the agreed upon indicators, ranking districts from best to worst performer.

2.8.1 District League Table (DLT) Performance

During FY 2017/18, the number of districts + KCCA increased from 116 to 122. The new districts are Butebo from Pallisa, Bunyangabo from Kabarole, Namisindwa from Manafwa, Rukiga from Kabale, Kyotera from Rakai and Pakwach from Nebbi. The districts are used as the units of analysis with key objectives of comparing performance between districts; provide information to facilitate the analysis for good and poor performance at districts and thus enable corrective measures which may range from increasing the amount of resources (financial resources, human resources, infrastructure) to the LG or more frequent and regular support supervision.

The DLT is not meant to embarrass LG leaders of poorly performing districts, but rather to make them question why their district is performing poorly, and consider ways in which that performance can improve.

The objectives of the DLT are;
1) To compare performance between districts and therefore determine good and poor performers.
2) To provide information to facilitate the analysis for good and poor performance at districts thus enable corrective measures.
3) Appropriate corrective measures which may range from increasing the amount of resources (funds, human resource, infrastructure) to the LG or more frequent and regular support supervision.
4) To increase LG ownership for achievements – the DLT to be included in the AHSPR to be discussed at the JRM with political, technical and administrative leaders of districts.
5) To encourage good practices – good management, innovations and timely reporting.

Routine HMIS data was the primary data source for majority of the indicators and other indicator data were provided by MoH programs such as HIV/AIDS, TB, Environmental Health Division and MoFPED for the quarterly PBS reporting.

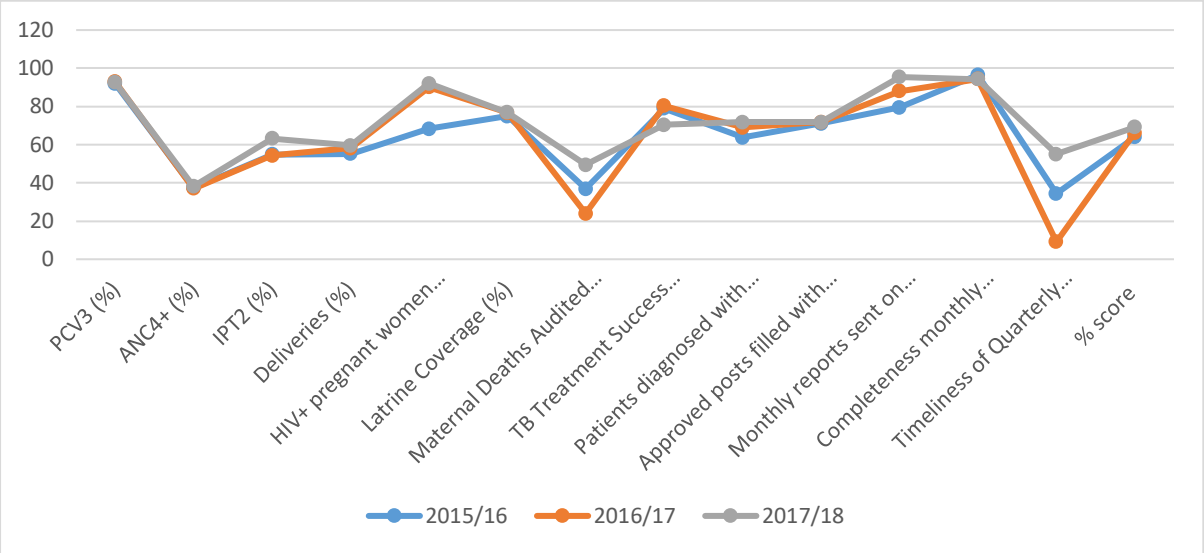
There was an improvement in the overall DLT score to 69.2% in 2017/18 from 66.2% in 2016/17 FY. Remarkable improvement was registered in the maternal deaths audited to 50% from 23.9% in 2016/17. The great improvement in the quarterly financial reporting was due to the change in the indicator definition from considering the all quarterly reports being submitted per district to analyzing performance based on the individual quarters.

TABLE 31: AVERAGE PERFORMANCE IN THE DLT INDICATORS

Financial Year	PCV3 (%)	ANC4+ (%)	IPT2 (%)	Deliveries (%)	HIV+ pregnant women initiated on ART (%)	Latrine Coverage (%)	Fresh Still Births per 1,000 Deliveries	Maternal Deaths Audited (%)	TB Treatment Success Rate (%)	Patients diagnosed with Malaria that are lab confirmed (%)	Approved posts filled with qualified personnel (%)	Monthly reports sent on time (%)	Completeness monthly reports (%)	Timeliness of Quarterly Financial (PBS) reporting (%)	*% score*

2015/16	91.9	37.3	54.9	55.2	68.3	74.9	12.7	36.9	78.9	63.7	71.1	79.4	96.5	34.4	***63.9***
2016/17	92.9	37	54.4	58.2	90.1	76.7	10.2	23.9	80.4	68.9	71.7	88	94.3	9.1	***66.2***
2017/18	92.6	38.2	63.2	59.6	92.1	76.8	9.4	50	70.3	71.8	71.8	95.4	94.3	55	***69.2***
% change 2016/17 & 2017/18	-0.3	3.2	16.2	2.4	2.2	0.1	7.8	107	-12.6	4.2	0.1	8.4	0.0	50.4	4.5

FIGURE 37: TRENDS IN NATIONAL AVERAGE PERFORMANCE IN THE DLT INDICATORS



The top ten best performing districts in FY 2017/18 as ranked by the percentage (%) score computed by (total score)/90*100 are; Adjumani, Moyo, Bushenyi, Gulu, Kabarole, Oyam, Kabale, Kamwenge, Sheema and Jinja. The lowest performance levels were noted in Buliisa, Nakapiripirit, Namisindwa, Amudat, Abim, Budaka, Kaberamaido, Mayuge, Amolatar and Luuka.

Table 32 shows the district performance their total scores and ranks. 73% of the districts scored above the national average of 69.2%. The detailed DLT can be seen in the Annex 7.

TABLE 32:SUMMARY OF THE DISTRICT PERFORMANCE AGAINST THE DLT 2017/18 FY

District	% Score	Rank		District	% Score	Rank
ADJUMANI	86.3	1		IGANGA	72.1	61
MOYO	85.6	2		KANUNGU	72.0	63
BUSHENYI	83.4	3		RAKAI	71.7	64
GULU	82.1	4		MASINDI	71.2	65
KABAROLE	81.7	5		BUYENDE	71.0	66
OYAM	80.8	6		BUNDIBUGYO	70.9	67
KABALE	80.6	7		KAMULI	70.9	67
KAMWENGE	80.1	8		KUMI	70.7	69
SHEEMA	80.0	9		NTOROKO	70.7	69
JINJA	79.5	10		KAPCHORWA	70.6	71
KYENJOJO	78.6	11		KIBUKU	70.6	71
LUWERO	78.3	12		KWEEN	70.6	71
TORORO	78.2	13		KALANGALA	70.6	71
RUBANDA	78.0	14		KYEGEGWA	70.6	71
LAMWO	77.7	15		BUKEDEA	70.3	76
KIRUHURA	77.4	16		BUIKWE	70.1	77
NEBBI	77.3	17		SIRONKO	70.0	78
KOBOKO	77.0	18		BUNYANGABU	70.0	78
BUHWEJU	76.8	19		ISINGIRO	69.7	80
DOKOLO	76.7	20		NWOYA	69.6	81
MASAKA	76.6	21		BUSIA	69.5	82
LYANTONDE	76.4	22		ALEBTONG	69.5	82
OMORO	76.3	23		KAGADI	69.2	84
KASESE	76.3	23		BUTALEJA	69.2	84
KIBAALE	76.2	25		KATAKWI	69.1	86
NTUNGAMO	76.1	26		NAKASONGOLA	69.0	87
MPIGI	76.1	26		MANAFWA	69.0	87
LIRA	75.9	28		KALUNGU	68.9	88
ZOMBO	75.9	28		WAKISO	67.9	90
SOROTI	75.8	30		BULAMBULI	67.8	90
OTUKE	75.4	31		BUKOMANSIMBI	67.7	92
MARACHA	75.2	32		GOMBA	67.3	93
NGORA	75.1	33		BUKWO	67.2	94
MBALE	75.0	34		HOIMA	66.7	94
RUKUNGIRI	74.8	35		BUTEBO	66.5	96
RUBIRIZI	74.6	36		KAABONG	66.4	96
KIBOGA	74.6	36		APAC	66.3	96
YUMBE	74.5	38		NAMAYINGO	66.2	99
NAKASEKE	74.4	39		SERERE	66.0	100
KAYUNGA	74.4	39		KABERAMAIDO	65.8	101
BUTAMBALA	74.2	41		KALIRO	65.8	101
ARUA	74.0	42		PADER	65.2	103

District	% Score	Rank		District	% Score	Rank
IBANDA	73.7	43		PALLISA	65.1	104
AGAGO	73.7	43		KAKUMIRO	64.5	105
NAMUTUMBA	73.7	43		SEMBABULE	64.4	105
KISORO	73.7	43		KYAKWANZI	64.3	107
RUKIGA	73.7	43		NAPAK	64.3	107
MUKONO	73.6	48		BUDUDA	64.1	109
KAMPALA	73.4	49		MUBENDE	64.1	110
KITGUM	73.3	50		BUVUMA	64.0	111
KIRYANDONGO	73.2	51		MAYUGE	63.5	112
AMURU	73.2	51		KOTIDO	63.5	112
MITOOMA	73.1	53		NAMISINDWA	62.8	114
PAKWACH	73.1	53		MOROTO	62.4	115
BUGIRI	73.0	55		BUDAKA	62.3	116
MITYANA	72.9	56		AMOLATAR	61.3	117
LWENGO	72.9	56		BULIISA	60.1	118
KYOTERA	72.7	58		ABIM	59.6	119
MBARARA	72.5	59		NAKAPIRIPIRIT	59.0	120
AMURIA	72.3	60		AMUDAT	58.0	121
KOLE	72.3	60		LUUKA	56.3	122
National Average					**69.2**	

Table 33 shows the trend of individual district performance in the league table for the top 10 and the bottom 10 positions for the three years from 2015/16 to 2017/18. The districts hosting refugees like Adjumani and Kamwenge have been among the top ten districts for the last 2 years. Kabarole district has remained among the top 10 districts for the last 3 FYs. Further analysis needs to be undertaken to explain the varied performance of most districts in the top ten.

Districts in Karamoja region have persistently been among the bottom ten districts. It is worth noting that none of the newly created districts on FY 2017/18 were among the bottom ten districts as there is perception that newly created districts perform poorly.

TABLE 33: TOP 10 AND BOTTOM 10 DISTRICTS FROM 2015/16 TO 2017/18

DLT Position	2015/16	2016/17	2017/18
Top 10	Lyantonde, Rukungiri, Mpigi, Gulu, Amuria, Lamwo, Katakwi, Serere, Kabarole and Buyende	Adjumani, Gulu, Mbale, Kamwenge, Kiboga, Kampala, Kabale, Oyam, Kabarole and Koboko	Adjumani, Moyo, Bushenyi, Gulu, Kabarole, Oyam, Kabale, Kamwenge, Sheema and Jinja.
Bottom 10	Wakiso, Sembabule, Bulambuli, Kotido, Koboko, Moroto, Napak, Sironko, Amudat and Buvuma	Bududa, Budaka, Nakapiripirit, Napak, Kakumiro, Buliisa, Moroto, Bulambuli, Kaabong, Buvuma and Amudat.	Buliisa, Nakapiripirit, Namisindwa, Amudat, Abim, Budaka, Kaberamaido, Mayuge, Amolatar and Luuka.

2.8.1.1 Most Improved Districts

The most improved district between 2016/17 and 2017/18 FY was Amudat with 25% positive change in score followed by Bulambuli and Kaabong both with 22% and Buvuma with 21% change in score. (See Annex 8 for the change in all districts).

TABLE 34: THE 10 MOST IMPROVED DISTRICTS IN THE DLT SCORE IN FY 2017/18

District	DLT Score		% Change
	2016/17	2017/18	
AMUDAT	46.8	58.3	25%
BULAMBULI	55.7	68.1	22%
KAABONG	54.6	66.6	22%
BUVUMA	53.0	64.3	21%
LAMWO	65.4	77.9	19%
KIRUHURA	65.3	77.6	19%
NTUNGAMO	65.0	76.3	17%
SHEEMA	68.9	80.3	17%
MOYO	73.7	85.8	16%
OMORO	65.9	76.5	16%
NEBBI	67.2	77.7	16%

There was a decline in performance in 15 districts with the biggest decline in performance registered in Luuka district which declined by 13% from a score of 65% in 2016/17 to 56.6% in 2017/18.

TABLE 35: 15 DISTRICTS WITH DECLINE IN PERFORMANCE IN FY 2017/18

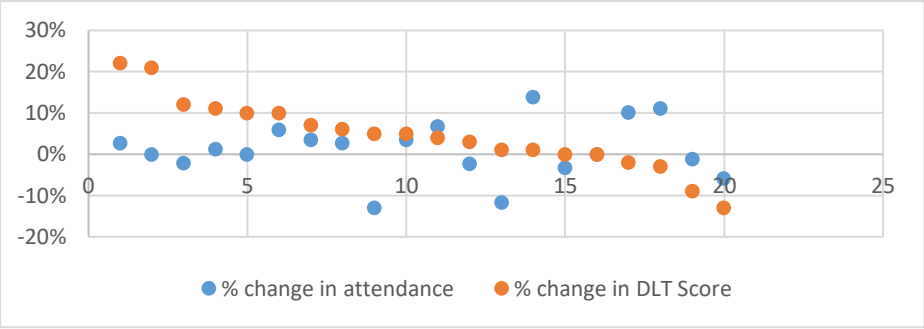
DISTRICT	DLT SCORE		% Change
	2016/17	2017/18	
KYEGEGWA	71.7	71.1	-1%
AMOLATAR	63.0	62.4	-1%
KAMULI	72.4	71.5	-1%
MBALE	76.6	75.5	-1%
SEMBABULE	66.0	65.1	-1%
KIBOGA	76.5	75.2	-2%
KAMPALA	75.1	73.8	-2%
KOTIDO	65.2	64.0	-2%
NAKAPIRIPIRIT	60.6	59.4	-2%
PALLISA	67.2	65.4	-3%
KATAKWI	71.5	69.3	-3%
KABERAMAIDO	71.3	66.3	-7%
SERERE	72.5	66.4	-9%
ABIM	67.6	59.9	-11%
LUUKA	65.0	56.6	-13%

Attendance of duty has been identified as one of the factors affecting performance of districts an analysis of the districts under the PMDU where attendance monitoring is implemented shows that there is is no correlation between improvement in duty attendance and improvement in the DLT score.

TABLE 36: CHANGE IN DLT SCORE FOR THE 20 DISTRICTS IN EASTERN UGANDA SUPPORTED BY PMDU

District	Attendance			DLT Score		
	2016/17	2017/18	% change	2016/17	2017/18	% change
BULAMBULI	75%	77%	3%	55.7%	67.8%	22%
BUVUMA	80%	80%	0%	53.0%	64%	21%
TORORO	91%	89%	-2%	69.5%	78.2%	12%
BUGIRI	88%	89%	1%	65.6%	73%	11%
MANAFWA	78%	78%	0%	62.6%	69%	10%
SOROTI	84%	89%	6%	68.8%	75.8%	10%
KAYUNGA	88%	91%	3%	69.6%	74.4%	7%
SIRONKO	75%	77%	3%	66.3%	70%	6%
KWEEN	85%	74%	-13%	67.2%	70.6%	5%
BUDUDA	88%	91%	3%	61.0%	64.1%	5%
NAMUTUMBA	90%	96%	7%	70.8%	73.7%	4%
BUYENDE	85%	83%	-2%	68.6%	71%	3%
BUKWO	85%	75%	-12%	66.6%	67.2%	1%
KAPCHORWA	80%	91%	14%	70.0%	70.6%	1%
KALIRO	91%	88%	-3%	65.6%	65.8%	0%
MAYUGE	89%	89%	0%	63.8%	63.5%	0%
MBALE	79%	87%	10%	76.6%	75%	-2%
PALLISA	81%	90%	11%	67.2%	65.1%	-3%
SERERE	83%	82%	-1%	72.5%	66%	-9%
LUUKA	86%	81%	-6%	65.0%	56.3%	-13%

FIGURE 38: CORRELATION BETWEEN THE CHANGE IN DLT SCORE AND CHANGE IN DUTY ATTENDANCE IN THE 20 DISTRICTS SUPPORTED BY PMDU



2.8.2 Conclusion on District Performance

In conclusion, overall there was some improvement in the DLT performance by 4% from an average national score of 66.2 in 2016/17 to 69.2% in 2017/18. Remarkable improvement was registered in the maternal deaths audited to 50% from 23.9% in 2016/17. There was a decline in the TB treatment success rate and almost no change and approved posts filled with qualified health workers.

Factors like influx of refugees can have a positive or negative effect on service delivery but also on the performance indicators which are based on utilization rates. This is shown by marked improvement in the DLT performance in the refugee host district and therefore there is need to establish clear monitoring mechanism and adjustment of the district population figures for performance assessment.

2.9 Health Facility Performance

The health facility performance was measured in terms of Standard Unit of Output (SUO)[2], and quality. The SUO is a composite measure of outputs that allows for a fair comparison of volumes of output of hospitals that have varying capacities in providing the different types of patient care services. The SUO attempts to attribute the final outputs of a hospital a relative weight based on previous cost analyses taking the outpatient contact as the standard of reference. The SUO converts all outputs to outpatient equivalents by weighting the services taking the outpatient contact as the standard reference. The basis of this parameter rests on the evidence that the cost of managing one inpatient is 15 times the cost managing one outpatient, one immunization 0.2 times more, one delivery 5 times more and one (ANC+MCH+FP) client 0.5 times the cost of managing one outpatient.

Beginning this FY 2017/18 the SUO for the referral hospitals has been revised to take into account the core services of a referral hospital in comparison to a general hospital or HC IV which serve as primary referral facilities. Thus, the following outputs ANC, FP, Immunization & postnatal attendances have been replaced with major surgery for computation of the SUO.

Assumption is that the cost of managing one inpatient for a major surgery operation including Caesarean Sections is 20 times the cost of managing an outpatient.

2.9.1 Performance of the National Referral Hospitals

The country has two national referral hospitals; Mulago National Referral Hospital and Butabika National Mental Referral Hospital. Butabika is a specialized hospital for mental health services. Using the new variables as described above, the total SUO for the two national referral hospitals increased significantly from 1,768,991 in 2016/17 to 3,055,763 in FY 2017/18.

TABLE 37: SUO FOR NATIONAL REFERRAL HOSPITALS FROM 2015/16 TO 2017/18

Services	National RHs			Mulago NRH			Butabika NMRH		
	2015/2016	2016/2017	2017/18	2015/2016	2016/2017	2017/18	2015/2016	2016/2017	2017/18
Admissions	88,427	94,379	139,747	85,941	87,473	131,999	2,486	6,906	7,748
Patient Days	330,645	496,725	657,531	254,544	255,747	343,631	76,101	240,978	313,900
Beds	2,115	1,943	2,014	1,343	1,343	1,422	550	550	592
OPD Total	219,574	266,426	432,433	164,722	194,529	357,531	54,852	71,897	74,902
Deliveries	23,674	11,884	26,301	11,455	11,884	26,301	-	-	
Total ANC visits	41,113	26,739	na	41,113	26,739	na	-	-	na
PNC Attendances	1,928	11,186	na	1,928	11,186	na	-	-	na
Family Planning	6,588	4,842	na	6,409	4,723	na	179	na	na
Immunization	40,931	30,380	na	40,292	29,560	na	639	na	na
Major Surgery	na	na	19,781	na	na	19,781	na	-	-
SUO	**1,697,350**	**1,768,991**	**3,055,763**	**1,543,649**	**1,594,126**	**2,864,641**	**92,551**	**175,957**	**191,122**

Source: MoH DHIS2

2.9.1.1 Efficiency of the national Referral Hospitals

The first efficiency indicator is utilization of beds, a more efficient hospital should have a high BOR, and similarly the ALoS should be shorter for better efficiency. BOR: The occupancy rate is a measure of utilization of the available bed capacity. It is used to assess the demands for hospital beds and hence to gauge an appropriate balance between demands for health care and number of beds.

WHO defines optimum bed efficiency as 85% BOR. Table 38 shows variation across the hospitals. The average BOR increased to 89% in 2017/18 from 70% in the previous year. Butabika hospital had BOR of 145% compared to Mulago whose BOR was 66%. Mulago per se realized an increase in BOR from 52% in 2016/17 to 66%.

[2] SUO stands for standard unit of output an output measure converting all outputs in to outpatient equivalents.
SUO total for Referral Hospitals = Σ(IP*15 + OP*1 + Del.*5 + Major Surgery*20)
SUO total for General Hospitals & HC IVs = Σ(IP*15 + OP*1 + Del.*5 + Imm.*0.2 + ANC/MCH/FP*0.5)

The ALoS for the two National referral hospitals was 4.7 days in FY 2017/18. Mulago NRH had ALoS of 2.6 days whereas Butabika had ALoS of 41 days. The nature of the patients attended to at Butabika justifies the longer stay at this institution though there is need to understand why there was a significant increase by 10 days from 31 in FY 2016/17 to 41 in FY 2017/18.

TABLE 38: EFFICIENCY PARAMETERS FOR NATIONAL REFERRAL HOSPITALS

Services	National RHs			Mulago NRH			Butabika NMRH		
	2015/16	2016/17	2017/18	2015/16	2016/17	2017/18	2015/16	2016/17	2017/18
Admissions	88,427	94,379	139,747	85,941	87,473	131,999	2,486	6,906	7748
Patient Days	330,645	496,725	657,531	254,544	255,747	343,631	76,101	240,978	313,900
Beds	2,115	1,943	2,014	1,343	1,343	1,422	550	550	592
Deliveries	23,674	11,884	26,301	11,455	11,884	26,301	-	-	
Caesarian Sections	519	5,265	6,759	519	5,265	6,759	0	0	
Major Operation	1,027	11,634	19,781	1,027	11,657	19,781	0	0	
IPD Deaths	4,452	3,077	5,649	4,393	2,984	5,521	59	93	128
Fresh Still births	89	56	555	892	567	555	0	0	
Macerated still births	561	550	618	561	550	618	0	0	
Newborn deaths	547	841	539	547	841	539	0	0	
Maternal Deaths	92	78	117	92	78	117	0	0	
BOR/100	82%	70%	89%	52%	52%	66%	38%	120%	145%
ALoS (days)	33	5	4.7	5	3	2.6	3	31	40.5
Maternal Deaths Risk/100,000	803	656	445	803	656	445	-	-	-
FSB Risk/1,000	78	48	21	78	48	21	-	-	-

Source: MoH DHIS2

Overall there was an increase in the utilization of the services of Mulago NRH and this could be attributed to the two satellite facilities opened at the newly constructed 100 bed capacity Kawempe and Kiruddu hospitals as Mulago undergoes renovation. There was a remarkable increase in the number of admissions from 87,473 to 131,999 and an increase in deliveries from 11,884 in FY 2016/17 to 26,301 in FY 2017/18. The C/S rate declined from 44% of the deliveries to 26% in FY 2017/18.

The number of newborn deaths declined significantly to 539 in FY 2017/18 from 841 newborn deaths in FY 2016/17. Maternal deaths reported in Mulago NRH increased from 78 in FY 2016/17 to 117 in FY 2017/18 however, the maternal death risk in Mulago declined to 445/100,000 deliveries compared to 656/100,000 in FY 2016/17. There was a slight decline in the number of Fresh Still Births (FSBs) to 555 compared to 567 in the previous FY. It is worth noting that there was over 50% reduction in the FSB Risk from 48/1,000 deliveries in FY 2016/17 to 21/1,000 deliveries in FY 2017/18.

2.9.2 Regional Referral & Large PNFP Hospital Performance

The budget performance of the RRHs was 86% compared to 98% in 2016/17 as shown in table 39. This excludes the value of medicines supplied to these hospitals by the NMS.

TABLE 39: BUDGET PERFORMANCE FOR THE RRHS

Hospital	Total Annual Budget 2017/18	Wage (Ug. Shs. '000,000)		Non-Wage (Ug. Shs. '000,000)		Development (Ug. Shs. '000,000)		Total (Ug. Shs. '000,000)		Budget performance		
		Released	Spent	Released	Spent	Released	Spent	Released	Spent	2017/18	2016/17	2015/16
Arua	6,812	3,095	2,698	2,638	2,564	1,060	1,060	6,793	6,322	93%	100%	112%
Fort Portal	7,422	3,552	2,928	2,685	2,296	1,060	1,057	7,297	6,281	85%	98%	96%
Gulu	7,635	3,283	2,579	2,757	2,643	1,488	1,487	7,528	6,709	88%	100%	94%
Hoima	7,192	4,132	2,842	1,995	1,830	1,060	1,060	7,187	5,732	80%	100%	90%
Jinja	9,732	4,578	3,517	3,469	3,080	1,488	1,371	9,535	7,968	82%	100%	97%
Kabale	6,759	2,719	2,246	1,950	1,774	1,488	1,488	6,157	5,508	81%	99%	106%
Lira	6,829	2,825	2,700	1,873	1,846	2,058	2,058	6,756	6,604	97%	98%	98%
Masaka	11,041	3,946	3,729	3,858	3,825	3,058	3,057	10,862	10,611	96%	100%	90%
Mbale	6,548	2,791	2,697	2,235	2,114	1,488	627	6,514	5,438	83%	99%	93%
Mbarara	6,646	3,227	2,811	1,912	1,907	1,488	1,488	6,627	6,206	93%	97%	110%
Moroto	8,163	3,399	2,983	1,829	1,852	1,978	1,872	7,206	6,707	82%	100%	109%
Mubende	5,673	3,439	2,482	1167	1,076	1,060	1,058	5,666	4,616	81%	100%	91%
Soroti	5,996	2,988	2,048	1,515	1,011	1,488	1,488	5,991	4,547	76%	100%	106%
Naguru	6,703	4,246	3,229	1,022	1,211	1,056	1,056	6,324	5,496	82%	100%	92%
Total	**103,151**	**48,220**	**39,489**	**30,905**	**29,029**	**21,318**	**20,227**	**100,443**	**88,745**	**86%**	**98%**	**99%**

The total SUO for the 14 RRHs and 4 Large PNFP Hospitals was 9,834,485 in FY 2017/18 compared to 9,837,521 in 2016/17. There was almost no increase in the number of deliveries at the RRHs. A total of 60,277 major operations were conducted in FY 2017/18. There was a decline in the number of admission and OPD attendances in the RRHs FY 2017/18 and this could be attributed to the overall reduction in the malaria cases as a result of the LLINs distribution.

TABLE 40: SUO FOR THE RRHS AND LARGE PNFP HOSPITALS

Services	2015/16	2016/17	2017/18
Admissions	432,064	437,833	383,932
OPD Total	2,731,170	2,510,783	2,354,235
Deliveries	85,814	103,131	103,146
Total ANC visits	195,659	210,111	na
Postnatal Attendances	119,217	139,332	na
FP	35,487	35,362	na
Immunization	221,742	228,437	na
Major Surgery	na	na	60,277
SUO	**9,860,730**	**9,837,521**	**9,834,485**

Source: MoH DHIS2

The change is the variable for the SUO has not resulted in significant change in the total SUO for the hospitals however, there are observed positive (increase in SUO) and negative (decrease in SUO) changes in the SUO for some of the hospitals ranging from +23% for Mengo to -24% for Mubende RRH.

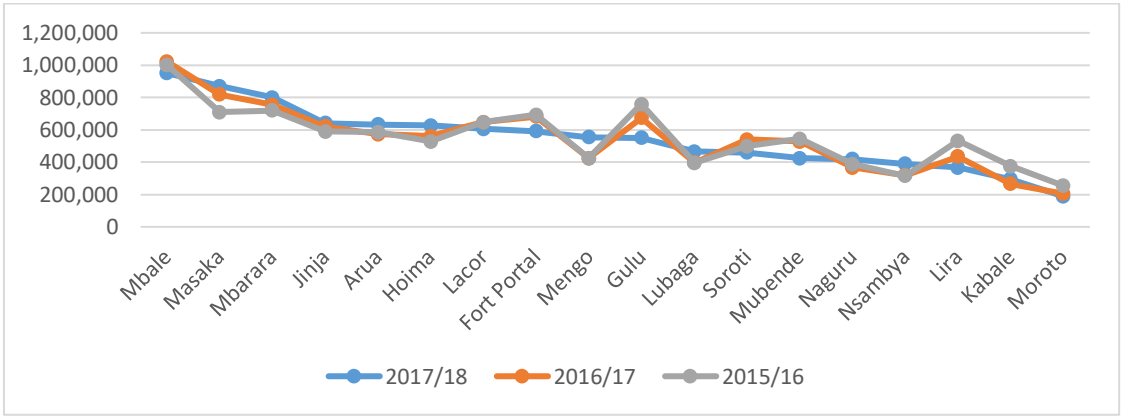
TABLE 41: SUO PER RRH AND LARGE PNFP HOSPITAL

RRH	Admissions	Total OPD	Deliveries	Major Operations	SUO			% SUO change
					2017/18	2016/17	2015/16	
Mbale	49,306	76,179	7,904	4,781	***950,909***	*1,022,283*	*1,000,426*	***-8%***
Masaka	32,047	257,091	9,594	4,214	***870,046***	*819,087*	*709,114*	***6%***
Mbarara	31,588	170,988	7,721	5,868	***800,773***	*755,751*	*718,777*	***6%***
Jinja	25,343	158,951	5,986	3,642	***641,866***	*621,023*	*590,719*	***3%***
Arua	23,823	162,010	6,999	3,945	***633,250***	*573,502*	*584,993*	***9%***
Hoima	23,276	150,990	8,222	4,301	***627,260***	*561,389*	*527,436*	***11%***
Lacor	25,879	104,604	5,976	4,168	***606,029***	*647,148*	*646,574*	***-7%***
Fort Portal	25,427	92,862	6,877	4,118	***591,012***	*682,422*	*692,127*	***-15%***
Mengo	12,977	263,703	5,045	3,567	***554,923***	*425,345*	*424,556*	***23%***
Gulu	24,183	134,176	3,452	1,788	***549,941***	*674,146*	*759,313*	***-23%***
Lubaga	13,680	176,883	4,833	3,023	***466,708***	*397,628*	*396,050*	***15%***
Soroti	18,174	105,286	3,781	3,147	***459,741***	*539,784*	*498,721*	***-17%***
Mubende	16,646	100,812	4,909	2,517	***425,387***	*526,983*	*544,106*	***-24%***
Naguru	14,096	98,457	8,312	3,310	***417,657***	*366,728*	*387,102*	***12%***
Nsambya	13,048	98,170	4,504	3,616	***388,730***	*319,063*	*315,406*	***18%***
Lira	14,408	79,928	4,478	2,456	***367,558***	*435,056*	*531,113*	***-18%***
Kabale	12,223	64,983	3,781	1,329	***293,813***	*265,027*	*375,236*	***10%***
Moroto	7,808	58,162	772	487	***188,882***	*205,156*	*254,298*	***-9%***
Total	**383,932**	**2,354,235**	**103,146**	**60,277**	**9,834,485**	**9,837,521**	***9,956,067***	***0.0%***

Source: MoH DHIS2

Mbale RRH continues to produce significantly higher SUOs than other RRHs mainly owing to the much higher number of admissions (49,306) compared to other RRHs. OPD attendance at Mbale RRH is rather lower than most of the RRHs which may imply that the lower level facilities Mbale region are functional and providing adequate PHC services to decongest the RRH. Mengo Hospital and Masaka have the highest total OPD attendances; Masaka (9,594), Naguru (8,312) and Hoima (8,222) have the highest deliveries; and Mbarara (5,868), Mbale (4,781) and Hoima (4,301) conducted the highest number of major operations.

FIGURE 39: TRENDS IN SUO FOR THE RRHS AND LARGE PNFP HOSPITALS



2.9.2.1 Efficiency of the RRHs

The efficiency parameters were assessed using BOR, ALOS, recurrent costs per bed and recurrent costs per SUO. The average BOR reduced to 84% from 105% in 2016/17. The reduction is most likely attributed to improvement in the data quality whereby Lira RRH had registered a BOR of 338% in 2016/17 and in 2017/18 has registered BOR of 145%. In 2017/18 Lira RRH still registered the highest BOR of 145% and the lowest is 65.7% at Kabale. Hospitals with BOR between 80% and 90% are considered optimally operating while those below that or above that need to make corrective actions to attain optimum state.

The ALoS is was at an average of 5 days in 2017/18. Lira RRH registered a significant decline from 29.7 days in 2016/17 to 14.7 days in 2017/18 which is still on the high side and needs to be investigated further to determine the cause of long hospital stays. The lowest ALoS is at Mbale with 2.6 days and Naguru Referral Hospital at 2.8 days.

The average recurrent cost per SUO increased from Ug. Shs 2,932 in 2016/17 to Ug Shs. 4,139 otherwise explained as – 1 outpatient equivalent takes Ug Shs. 4,139 to produce. The average recurrent cost per bed per year increased from Ug. Shs. 5.3 million to Ug Shs. 6.9 million in 2017/18. The minimum was Ug Shs. 3.8 million shown by Soroti RRH and the maximum is Ug. Shs. 12.1 million at CUFH Naguru hospital.

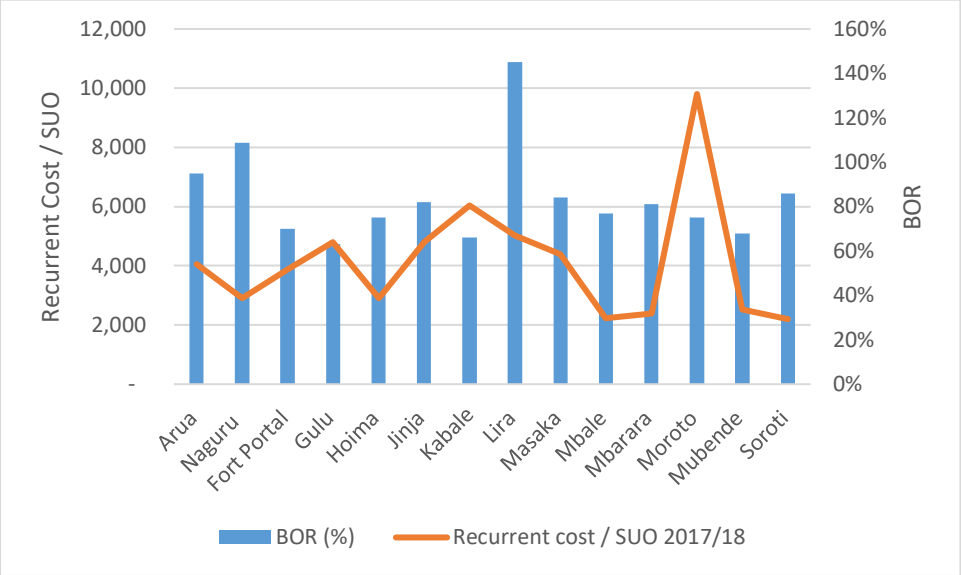
TABLE 42: EFFICIENCY PARAMETERS FOR RRHS AND LARGE PNFP HOSPITALS IN 2017/18

RRH	Beds	Inpatient Days	SUO	BOR (%)	ALOS (Days)	Recurrent Cost Spent (PHC Non-Wage) 2017/18 (Ug. Shs. '000,000)	Recurrent cost / SUO 2016/17 (Ug. Shs.)	Recurrent cost / Bed 2017/18 (Ug. Shs. '000,000)	Recurrent cost / SUO 2017/18 (Ug. Shs.)
Arua	278	96,142	633,250	94.7	4	2,564	4,045	9.2	4,049
Naguru	100	39,689	417,657	108.7	3	1,211	2,809	12.1	2,900
Fort Portal	384	98,426	591,012	70.2	4	2,296	2,052	6.0	3,885
Gulu	350	80,033	549,941	62.6	3	2,643	2,566	7.6	4,806
Hoima	308	84,011	627,260	74.7	4	1,830	3,420	5.9	2,917
Jinja	474	141,952	641,866	82.0	6	3,080	3,204	6.5	4,799
Kabale	310	74,393	293,813	65.7	6	1,774	6,414	5.7	6,038
Lira	400	211,965	367,558	145.2	15	1,846	3,126	4.6	5,022
Masaka	330	101,178	870,046	84.0	3	3,825	3,785	11.6	4,396
Mbale	455	127,238	950,909	76.6	3	2,114	1,458	4.6	2,223
Mbarara	461	136,901	800,773	81.4	4	1,907	2,898	4.1	2,381
Moroto	180	49,509	188,882	75.4	6	1,852	5,947	10.3	9,805
Mubende	214	53,068	425,387	67.9	3	1,076	2,125	5.0	2,529
Soroti	267	83,332	459,741	85.5	5	1,011	1,908	3.8	2,199
Total	*4,511*	*1,377,837*	*9,834,485*			*29,029*			
Average	**601**	**183,712**	**1,176,839**	**84**	**5**		**2,932**	**6.9**	**4,139**

Source: MoH HMIS and Hospital Financial Reports

The minimum recurrent cost per SUO was shown by Soroti RRH (Ug Shs. 2,199) and the maximum Ug Shs. 9,805 shown by Moroto RRH.

FIGURE 40: RECURRENT COST / SUO AND BED OCCUPANCY RATE IN RRHS



2.9.2.2 Quality Parameters at the RRHs and Large PNFP Hospitals

A number of parameters were analyzed to determine the quality of care in the RRHs as shown in Table 43.

TABLE 43: QUALITY OF CARE PARAMETERS FOR RRHS AND LARGE PNFP HOSPITALS 2017/18

Hospital	Beds	Caesarian Sections	Major Operations	IPD Deaths	Fresh Still Births	Macerated Still Births	Newborn Deaths (0-7days)	Maternal Deaths	C/S Rate	Maternal Death Risk / 100,000 deliveries	FSB Risk / 1,000 deliveries
Arua	278	2,310	3,945	1,231	188	120	7	21	33%	300	27
Fort Portal	384	2,224	4,118	1,160	201	128	110	53	32%	771	29
Gulu	350	426	1,788	421	24	52	19	3	12%	87	3
Hoima	308	2,660	4,301	865	333	172	39	52	32%	632	48
Jinja	474	1,897	3,642	1,013	97	95	9	16	32%	267	14
Kabale	310	992	1,329	307	51	38	33	5	26%	132	7
Lacor	482	1,583	4,168	1,283	102	93	107	26	27%	435	15
Lira	400	993	2,456	619	78	68	18	5	22%	112	11
Lubaga	236	2,009	3,023	351	62	53	98	14	42%	290	9
Masaka	330	2,929	4,214	1,174	106	113	209	27	31%	281	15
Mbale	455	2,316	4,781	1,416	168	157	69	24	29%	304	24
Mbarara	461	3,078	5,868	1,531	144	135	20	41	40%	531	21
Mengo	249	1,624	3,567	326	15	52	29	11	32%	218	2
Moroto	180	160	487	193	14	3	5	1	21%	130	2
Mubende	214	1,451	2,517	558	214	140	200	32	30%	652	31
Naguru	100	2,118	3,310	288	95	83	94	11	26%	132	14
Nsambya	276	2,266	3,616	625	14	64	71	8	50%	178	2
Soroti	267	1,394	3,147	699	53	49	39	15	37%	397	8
Total	***5,754.5***	***32,430***	***60,277***	***14,060***	***1,959***	***1,615***	***1,176***	***365***			
Average	**319.69**	**1,802**	**3,349**	**781.1**	**109**	**89.7**	**65.33**	**20**	**31%**	**354**	**19**
MIN	**100**	**160**	**487**	**193**	**14**	**3**	**5**	**1**	**12%**	**112**	**2**
MAX	**482**	**3,078**	**5,868**	**1,531**	**333**	**172**	**209**	**53**	**50%**	**771**	**48**

Source: MoH DHIS2

The total number of Caesarean Sections (C/S) increased to 1,802 in 2017/18 from 1,603 in 2016/17. Mbarara (3,078) and Masaka (2,929) performed the highest number of C/S. Gulu (426) and Moroto (160) had the lowest C/S performed. There was a significant increase in the number of C/S performed by Masaka RRH from 657 in 2016/17 to 2,929 in FY 2017/18.

FIGURE 41: NUMBER OF CAESAREAN SECTIONS CONDUCTED BY RRHS & LARGE PNFP HOSPITALS 2016/17 – 2017/18

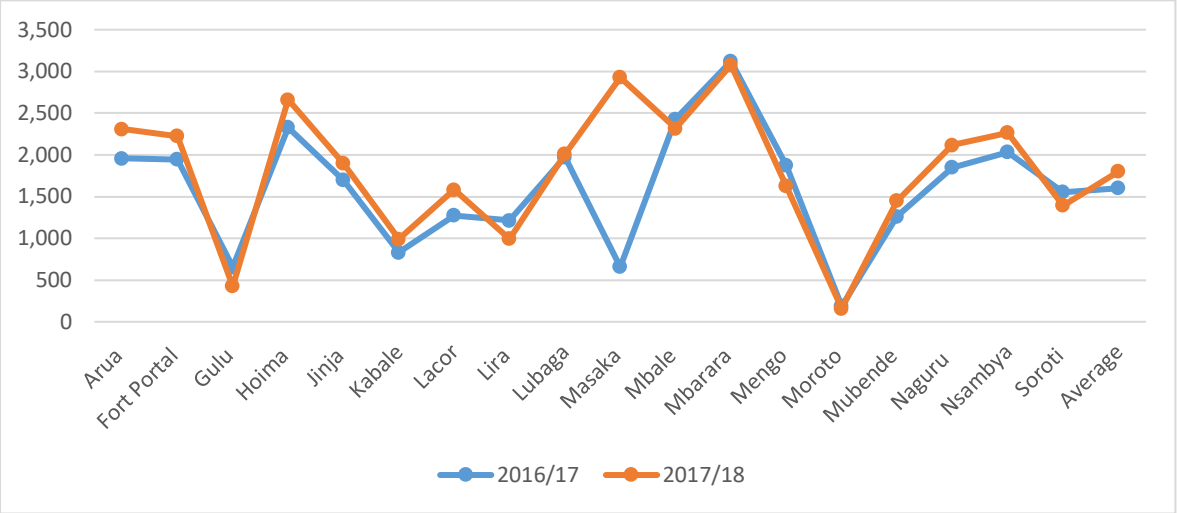
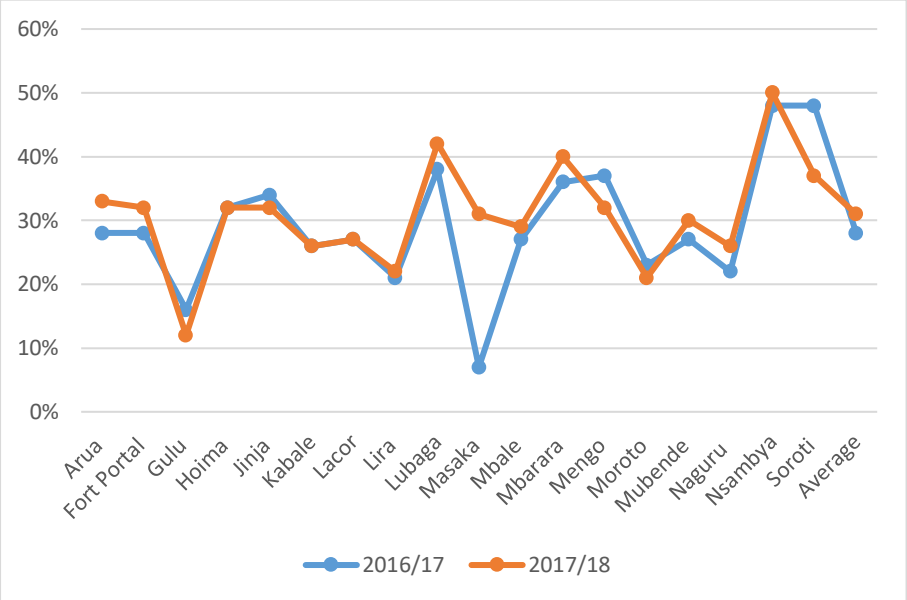


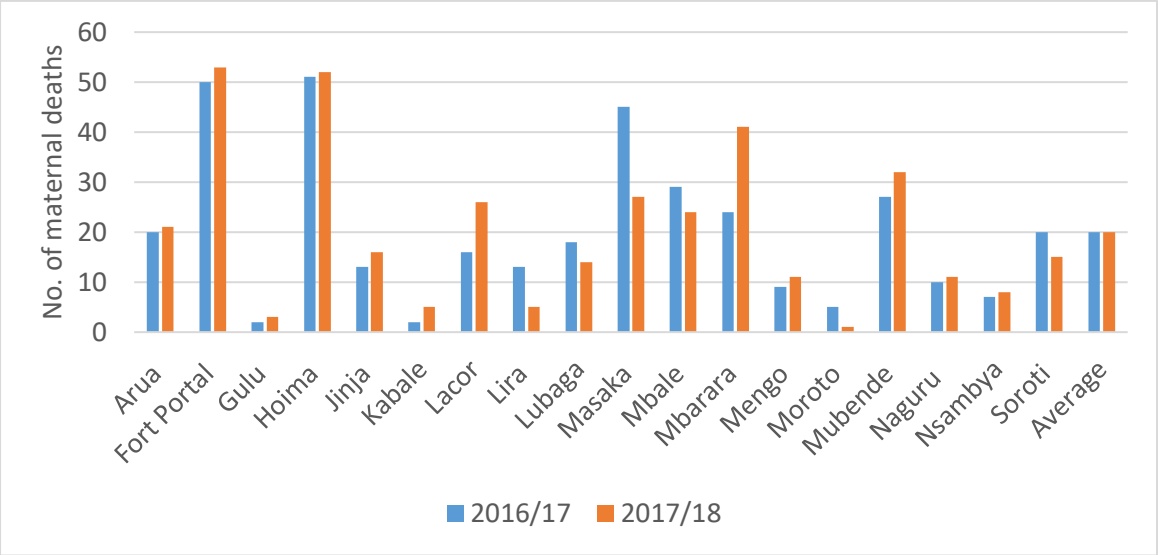
FIGURE 42: C/S RATE IN RRHS AND LARGE PNFP HOSPITALS



The average C/S rate per delivery in the RRHs increased to 31.4% in 2017/18 from 28% in 2016/17 FY. Nsambya hospital had the highest C/S rate of 50.3%, Lubaga 41.6% and Mbarara 39.9%. The lowest C/S rate was in Gulu RRH at 12.3%.

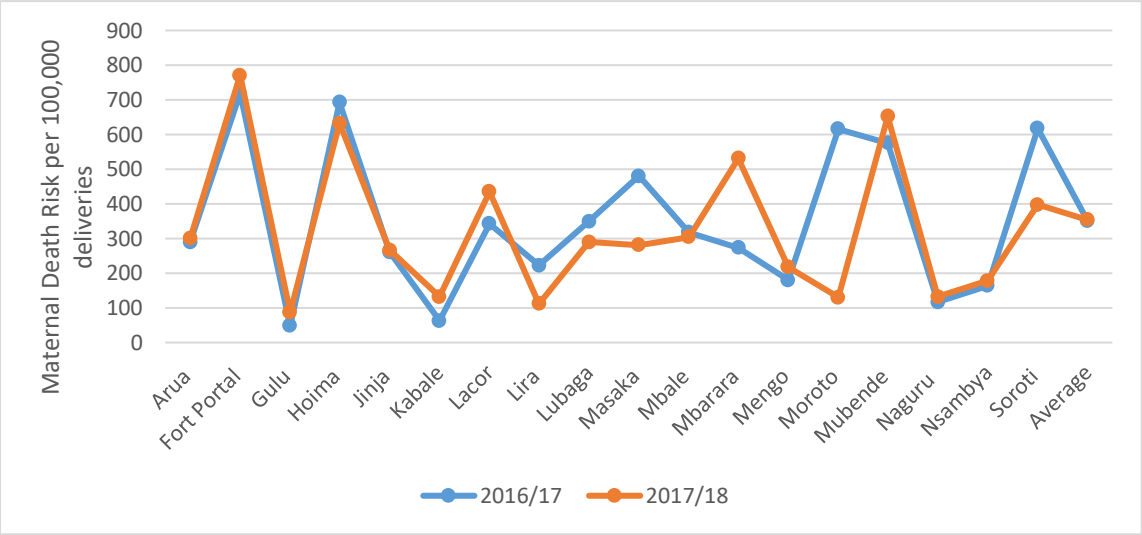
Maternal Mortality continued to be a major challenge in RRHs. The average number of maternal deaths in the RRHs was 20. Fort Portal (53) and Hoima (52) RRHs had the highest number of maternal deaths during the year and Moroto (1), Gulu (2) and Kabale (2) had the lowest. There was a significant increase in the number of maternal deaths in Mbarara RRH from 24 in 2016/17 to 41 deaths in 2017/18 whereas, Masaka RRH registered a decrease from 45 deaths in 2016/17 to 27 in 2017/18.

FIGURE 43: NUMBER OF MATERNAL DEATHS IN RRHS AND LARGE PNFP HOSPITALS



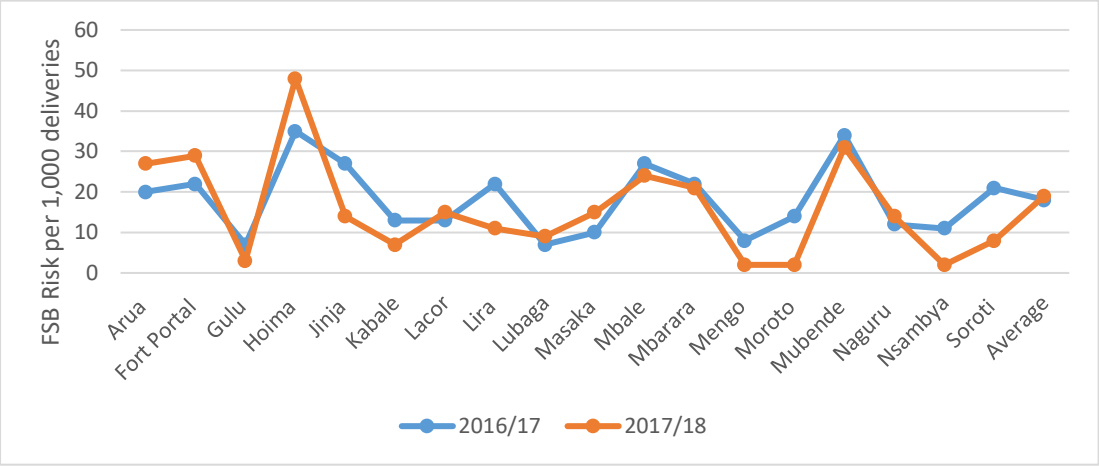
The average facility based Maternal Death Risk for RRHs was 354 per 100,000 deliveries in 2017/18 compared to 350 per 100,000 hospital deliveries in 2016/17. Fort Portal, Mubende and Hoima RRHs had the highest Maternal Death Risk of 771, 652 and 632 per 100,000 deliveries respectively while Gulu RRH has the lowest Maternal Death Risk of 87 per 100,000 deliveries.

FIGURE 44: TRENDS IN MATERNAL DEATH RISK RRHS AND LARGE PNFP HOSPITALS



Fresh Still Births (FSB) at RRHs also continued to be a major challenge with the highest of 48/1,000 deliveries in Hoima RRH followed by Mubende at 31/1,000, then Fort Portal and Arua RRHs at 29/1,000 and 27/1,000 hospital deliveries respectively. Moroto, Mengo and Nsambya had the lowest FSB rate at 2/1,000 deliveries.

FIGURE 45: TRENDS IN FSB PER 1,000 DELIVERIES IN RRHS AND LARGE PNFP HOSPITALS



2.9.3 General Hospital Performance

Information that is analyzed under general hospital performance was for the 129 public, PNFP and PHP general hospitals that report regularly through the MoH in DHIS2 compared to 116 hospitals analyzed in 2016/17 FY. This was mainly due to improved reporting by the private hospitals.

The total SUO for the General Hospitals[3] has been revised this FY by inclusion of major surgery as one of the variables to assess performance. The SUO for the 129 General Hospitals whose HMIS data was analyzed this FY increased from 17,418,297 to 17,508,504. There was a decline in the total OPD attendances and admissions in the hospitals but a very significant increase in the total immunizations.

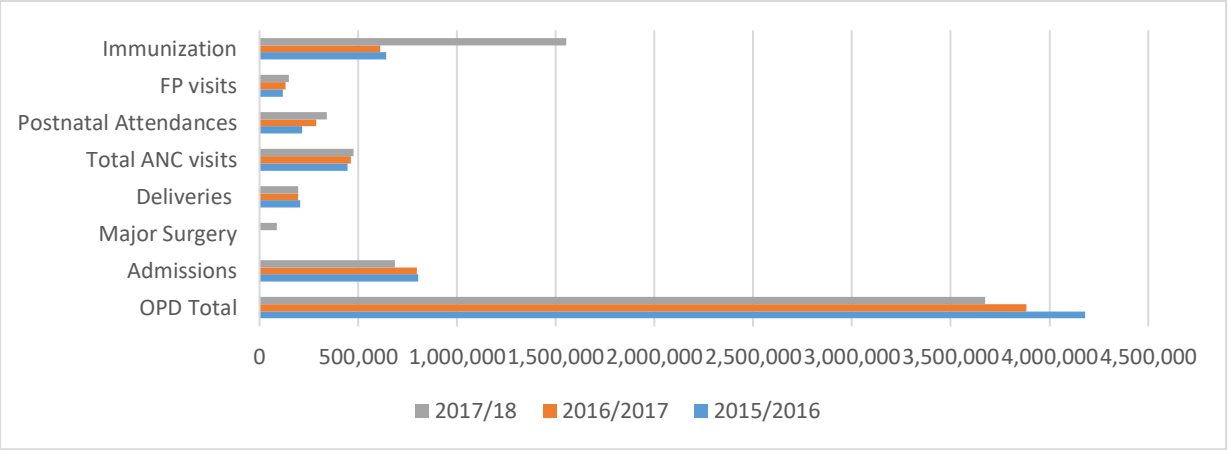
TABLE 44: SUO FOR GENERAL HOSPITALS

Output	2015/2016	2016/2017	2017/18
OPD Total	4,180,522	3,882,611	3,673,768
Admissions	804,850	797,216	686,405
Major Surgery			88,525
Deliveries	204,702	194,111	194,765
Total ANC visits	445,389	461,640	475,298
Postnatal Attendances	214,728	286,694	342,296
FP visits	118,183	132,495	149,519
Immunization	640,203	609,936	1,553,896
SUO	**17,793,973**	**17,418,297**	**17,508,504**

Source: MoH DHIS2

[3] General Hospital SUO total = ∑ (Outpatients*1 + (Total ANC Visits*0.5 + Postnatal Care attendances + Family Planning) *0.5 + Total Immunizations*0.2 + Deliveries*5 + Inpatients*15 + Major Surgery*20)

FIGURE 46: TRENDS IN SUO FOR THE GENERAL HOSPITAL 2015/16 – 2017/18



Source: MoH DHIS2

Iganga General Hospital has the highest SUO of 523,532 followed by Mityana Hospital with 386,533 SUO. The lowest ranked hospitals are predominantly private hospitals with no or irregular reporting through the national system. The detailed performance of each general hospitals is shown in the Annex 9.

TABLE 45: TOP 10 PERFORMING GENERAL HOSPITAL USING THE SUO PARAMETERS IN 2017/18 FY

No.	Hospitals	OPD attendance	ANC Visits	PNC Visits	FP	Immunization	Deliveries	Admissions	Major Surgery	SUO 2017/18	SUO 2016/17
1.	Iganga	128,814	13,348	7,143	2,784	34,201	6,326	19,146	2,871	**523,532**	580,406
2.	Mityana	88,388	10,930	6,701	4,294	27,760	5,833	13,227	2,703	**386,533**	385,165
3.	Kagando	26,410	6,493	3,173	2,868	17,575	2,771	17,388	2,411	**359,087**	315,977
4.	KIU Teaching	29,923	5,912	9,414	2,041	9,446	2,941	17,107	1,882	**349,446**	306,106
5.	Tororo	56,553	10,874	10,998	1,421	22,624	6,909	13,540	1,315	**336,669**	324,981
6.	Kawolo	79,193	10,647	5,405	4,982	24,651	3,966	11,619	1,347	**315,695**	314,053
7.	Entebbe	60,534	16,778	6,465	3,075	40,967	5,993	9,811	2,097	**300,956**	248,416
8.	Bwera	44,194	11,852	1,466	2,959	40,045	3,730	12,166	1,881	**299,102**	279,756
9.	Kagadi	21,976	9,810	8,624	1,325	26,055	4,669	13,182	1,720	**292,542**	284,216
10.	Kalongo Ambrosoli Memorial	26,891	6,045	1,905	2,379	15,263	3,547	13,460	1,150	**277,743**	362,714

Source: MoH DHIS2

Overall improvement was noted mainly in the private hospitals and this is attributed to improved reporting by the private hospitals. Nakesero hospital was the most improved hospital by 56% from SUO 85,101 in 2016/17 to 192,948 in 2017/18 followed by Kibuli (41% change), Mbarara Community (39%), Bethany Women & Family (37%), Rushere Community and Kabasa Memorial (30%).

TABLE 46: THE 20 HOSPITALS THAT REGISTERED THE HIGHEST CHANGE IN IMPROVEMENT IN 2017/18

No.	Hospital	SUO 2016/17	SUO 2017/18	Change
1.	Nakasero	85,101	192,948	56%
2.	Kibuli	143,774	242,389	41%

3.	Mbarara Community	16,659	27,231	39%
4.	Bethany Women and Family	11,592	18,435	37%
5.	Rushere Community	49,716	71,483	30%
6.	Kabasa Memorial	15,399	21,935	30%
7.	Senta Medicare Clinic	15,079	21,034	28%
8.	Mayanja Memorial	72,359	99,979	28%
9.	Mildmay Uganda	63,376	86,845	27%
10.	Moyo	142,205	190,639	25%
11.	Ruth Gaylord	27,107	35,801	24%
12.	Bwindi Community	125,815	165,716	24%
13.	St. Francis Naggalama	127,238	166,344	24%
14.	Bundibugyo	176,929	229,569	23%
15.	Virika	116,167	147,935	21%
16.	Kiwoko	167,019	212,270	21%
17.	Abim	113,990	143,567	21%
18.	St. Karoli Lwanga Nyakibale	135,784	169,721	20%
19.	Bombo Military	166,070	204,735	19%
20.	Bugiri	149,358	182,626	18%

2.9.3.1 Quality Parameters at the General Hospitals

The quality of care for the general hospitals was assessed based on some of the maternal health outcomes. Apart from the increase in the number of C/S carried out from 48,695 in 2016/17 to 60,071 in 2017/18; and number of major operations to 105,375 from 87,274 in 2016/17, and a slight reduction in the Fresh Still Birth risk from 16/1,000 to 15/1,000 facility deliveries the rest of the parameters showed that there was no improvement in the quality of services.

TABLE 47: QUALITY INDICATORS FOR THE GENERAL HOSPITALS IN 2017/18

Services	2015/2016	2016/2017	2017/18	% Change
Caesarian Sections	52,552	48,695	60,071	23%
C/S Rate	-	25%	28%	12%
Fresh Still births	3,303	3,027	3,164	5%
Macerated still births	3,147	3,131	3,156	1%
Maternal deaths	391	412	449	9%
Fresh still birth risk / 1,000	-	16	15	-6%
Maternal Deaths risk per 100,000	212	198	210	6%

Source: MoH DHIS2

The average C/S rate in the general hospitals increased to 28% in 2017/18 from 25% in 2016/17 FY. Nakasero Hospital had the highest C/S rate of 72% (1,069 C/S out of 1,481 deliveries), followed by Bethany Women and Family Hospital at 55%.

TABLE 48: 20 GENERAL HOSPITALS WITH THE HIGHEST C/S RATE IN 2017/18

Hospital	Deliveries	CS	C/S Rate
Nakasero	1,481	1,069	72%
Bethany Women and Family	238	131	55%
Mayanja Memorial	2,097	1,074	51%

Amai Community	293	150	51%
Villa Maria	879	448	51%
Ngora Ngo	312	159	51%
Virika	1,558	788	51%
Paragon Kampala	443	223	50%
St. Francis Nsambya	4,504	2,266	50%
Kagando	2,771	1,338	48%
Ruharo Mission	879	422	48%
Senta Medicare	201	95	47%
Buluba	1,311	593	45%
Kibuli	2,649	1,194	45%
St. Francis Naggalama	1,687	760	45%
St. Joseph Kitovu	1,921	856	45%
KIU Teaching	2,941	1,292	44%
Kuluva	1,267	556	44%
Mount Elgon	175	76	43%
Nyapea	1,509	650	43%
Maracha	1,052	452	43%
Kabarole	800	343	43%

Source: MoH DHIS2

Maternal Mortality continues to be a major challenge in the general hospitals as well. St. Mary's Lacor reported the highest number of maternal deaths at 26, followed by Kagadi (15); Kamuli Mission (14); Lubaga (14); Iganga (13) and St. Joseph Kitovu (13).

The hospital based maternal death risk for general hospitals in FY 2017/18 increased to 210 per 100,000 hospital deliveries compared to 198 per 100,000 in 2016/17. Dabani hospital still had the highest maternal death risk at 870 per 100,000 hospital deliveries, which is a decline from 1,442 per 100,000 in 2016/17, followed by St. Joseph Kitovu at 677/100,000, Kamuli Mission Hospital, 618/100,000 and Bukwo at 611/100,000. See Annex 10 for each hospital details.

TABLE 49: 20 HOSPITALS WITH THE HIGHEST FACILITY BASED MATERNAL DEATH RATIO IN 2017/18 FY

Hospital	Deliveries	Maternal Deaths	Maternal Death Risk per 100,000 deliveries
Dabani	805	7	870
St. Joseph Kitovu	1,921	13	677
Kamuli Mission	2,266	14	618
Bukwo General	488	3	615
Saidina Abubakar Islamic	166	1	602
St. Anthony's Tororo	174	1	575
Ruharo Mission	879	5	569
Villa Maria	879	5	569
Kaabong	904	5	553
Nkokonjeru	562	3	534
Virika	1,558	8	513
Kamuli	2,082	10	480
Kapchorwa	1,680	8	476
Yumbe	1,145	5	437
St. Mary's Lacor	5,976	26	435
Bundibugyo	2,113	9	426

Comboni	1,450	6	414
Nyapea	1,509	6	398
Kiryandongo	2,771	11	397
Buliisa	252	1	397

Source: MoH DHIS2

The fresh still birth rate for general hospitals reduced slightly to 15 per 1,000 hospital deliveries from 16 per 1,000 in 2016/17. Amai Community Hospital reported the highest fresh still birth rates of 82/1,000 hospital deliveries.

TABLE 50: 10 GENERAL HOSPITALS WITH THE HIGHEST FSB RATE 2017/18

Hospital	Deliveries	Fresh Still Births	FSB rate / 1,000 deliveries
Amai Community	293	24	82
Villa Maria	879	40	46
Dabani	805	36	45
Kamuli Mission	2,266	93	41
Bamu	497	20	40
Buikwe St. Charles Lwanga	1,288	47	36
Lwala	956	32	33
Kaabong	904	29	32
Bukwo General	488	15	31
Amudat	434	13	30

Source: MoH DHIS2

The average BOR was 45% with Iganga hospital having the highest BOR at 145% followed by Kagadi Hospital at 100% BOR.

The ALoS was 4 days with Mild May Uganda having the longest ALoS at 9 days, Matany and Kuluva 8 days and Kapchorwa, Kisizi and Murchison Bay Hospital having 7 days.

TABLE 51: HOSPITALS WITH HIGH BOR

	Hospital	BOR
1.	Iganga	145
2.	Kagadi	100
3.	Kagando	97
4.	Kisoro	97
5.	Kaabong	96
6.	Kapchorwa	95
7.	Bundibugyo	95
8.	Bwera	94
9.	Bukwo	93
10.	Masafu	92

Source: MoH DHIS2

2.9.4 Health Centre IV Performance

The HC IV serves as the first referral facility providing comprehensive obstetric and newborn care services in Health Sub-Districts (HSDs) where there is no Hospital. HC IVs on average have a catchment population of 100,000 people. 186 HC IVs were analyzed based on the HMIS report 108.

HC IVs generated a total of 13,161,745 SUO in 2017/18 compared to 14,432,943 SUO in FY 2016/17 and 13,780,782 in 2015/16. The reduction is largely due to the reduction on OPD attendances from 4,115,947 in 2016/17 to 3,597,388 in 2017/18 and admissions reducing from 571,653 to 503,888. There is a marked increase in total immunizations from 850,236 in 2016/17 to 2,101,126 in 207/18.

TABLE 52: SHOWING THE AVERAGE, LOWEST AND HIGHEST NUMBER OF SERVICES PROVIDED AND SUO FOR HC IVS 2017/18 FY

HC IV	Admissions	OPD	Deliveries	Total ANC	Postnatal	Total family planning	Immunization	SUO
Average	2,691	18,814	932	3,691	1,457	11,179	1,742	68,657
Lowest	18	1,216	-	7	-	-	-	6,455
Highest	10,168	58,395	7,690	19,902	16,342	113,451	7,123	253,225
Total 2017/18	***503,888***	***3,597,388***	***182,744***	***719,095***	***350,033***	***274,756***	***2,101,126***	***13,161,745***
Total 2016/17	***571,653***	***4,115,947***	***180,514***	***698,426***	***301,039***	***248,616***	***850,236***	***14,432,943***
Total 2015/16	***526,206***	***4,274,028***	***170,670***	***662,512***	***232,474***	***240,838***	***856,086***	***13,759,597***

Kisenyi HC IV ranked number one with 291,855 SUO, followed by Mukono T.C, Luwero, Kumi, Budadiri and Budaka HC IVs. Kisenyi HC IV had the highest OPD attendances (83,771), deliveries (9,608), ANC (39,397) and postnatal care attendances (18,747). The highest admissions were in Mukono TC HC IV (10,168) and the highest family planning visits were at Lwengo HC IV (16,342). The detailed outputs and outcomes from HC IVs are provided in Annex 12.

TABLE 53: TOP 10 PERFORMING HC IVS USING THE SUO PARAMETERS IN 2017/18

HC IV	Admissions	OPD	Deliveries	ANC	FP Total	Immunization	PNC	SUO
Kisenyi	8,022	83,771	9,608	39,397	5,412	39,678	18,747	291,855
Mukono T.C.	10,168	33,602	7,690	14,216	4,406	83,379	5,333	253,225
Luwero	6,253	44,512	2,584	11,256	2,456	26,510	4,643	165,707
Kumi	5,789	58,395	755	4,380	3,342	19,994	3,343	158,536
Budadiri	7,119	20,101	1,788	6,303	686	18,700	2,806	144,464
Budaka	6,267	26,981	2,063	6,010	1,012	12,454	667	137,636
Amuria	6,784	22,645	1,405	4,172	804	10,010	2,983	137,412
Serere	6,830	21,017	1,471	3,912	865	11,565	3,704	137,376
Mpigi	5,858	22,124	2,729	9,522	1,954	20,862	2,183	134,641
Kasangati	4,305	33,823	3,217	13,189	2,349	39,115	2,545	131,348

Source: MoH DHIS2

The bottom 10 HC IVs using the SUO parameters in 2017/18 are, Bushenyi, Mbarara Municipal Council, Nyamirami, St. Franciscan, Bukwa, Kataraka, Ntuusi, ASTU, Ayira Health Services and Hiima HC IV. Hiima HC IV, Ayira Health Services and ASTU have very low outcomes equivalent to HC III level. Kamukira, Kikuube, ASTU and Mbarara Municipal Council HC IVs did not provide inpatient services.

TABLE 54: BOTTOM 10 HC IVS USING THE SUO PARAMETERS FY 2017/18

HC IV	Admissions	OPD	Deliveries	Total ANC	Postnatal	Total family planning	Immunization	SUO
Bushenyi	278	17,629	242	2,017	811	4,263	680	25,616
Mbarara Municipal Council		15,231	355	6,229	706	12,389	5,070	25,486
Nyamirami	615	9,459	199	1,397	674	4,450	233	21,721
St. Franciscan	1,010	3,937	265	341	-	2,447	744	21,444
Bukwa	766	6,082	193	806	275	6,323	1,106	20,895
Kataraka	120	14,936	118	1,348	1,326	3,419	713	19,703
Ntuusi	240	11,151	241	2,972	1,444	6,490	365	19,645
ASTU		13,514	-	7	884	-	-	13,960
Ayira Health Services	694	1,216	2	8	-	1,879	1	12,016
Hiima IAA (UCI)	94	4,941	3	24	80	145	15	6,455

Source: MoH DHIS2

In 2017/18 FY a total of 17,729 C/S were performed by 78% (142/186) of the reporting HC. This was an increase from 14,994 C/S performed by 70.4% (131/186) in 2016/17. A total of 87 out of 186 (48%) HC IVs carried out C/S and offered blood transfusion during FY 2017/18 and are thus considered to have been providing CEmONC services. The HC IVs with the highest number of C/S were; Mukono Town Council HC IV (1,533), St. Paul HC IV (1,054), Rukunyu HC IV (803), Mpigi HC IV (585), Rwekubo HC IV (534) and Kyegegwa HC IV (506).

FIGURE 47: TRENDS IN HC IVS PERFORMING C/S AND BLOOD TRANSFUSION

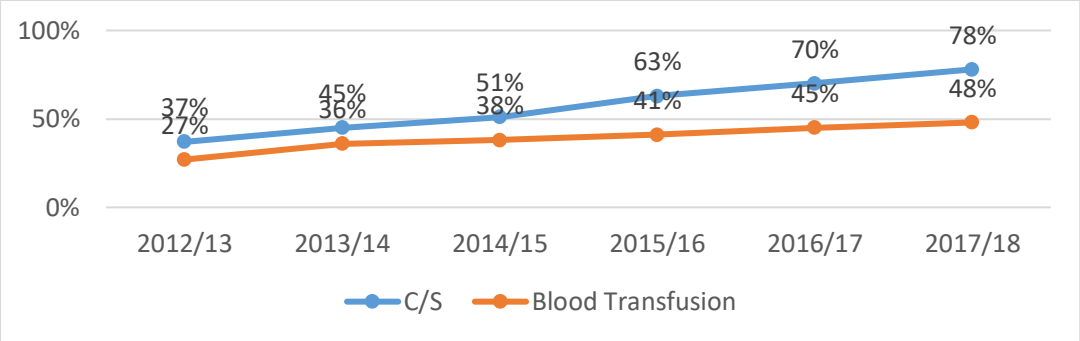


TABLE 55: HC IVS PERFORMING C/S IN 2016/17 TO 2017/18 FY

No.	HC IV	2016/17		2017/18	
		No. C/S	%	No. C/S	%
1.	Mukono T.C.	1,414	9.43%	1,533	8.65%
2.	St. Paul	553	3.69%	1,054	5.95%
3.	Rukunyu	715	4.77%	803	4.53%
4.	Mpigi	489	3.26%	585	3.30%
5.	Rwekubo	795	5.30%	534	3.01%
6.	Kyegegwa	274	1.83%	506	2.85%

No.	HC IV	2016/17		2017/18	
		No. C/S	%	No. C/S	%
7.	Mukono CoU	502	3.35%	493	2.78%
8.	Midigo	2	0.01%	426	2.40%
9.	Kisenyi	0	0.00%	392	2.21%
10.	Busaru	212	1.41%	366	2.06%
11.	Rugazi	255	1.70%	366	2.06%
12.	Azur	162	1.08%	333	1.88%
13.	Kakindo	322	2.15%	331	1.87%
14.	Bishop Asili Ceaser	355	2.37%	320	1.80%
15.	Rwesande	219	1.46%	307	1.73%
16.	Kakumiro	198	1.32%	285	1.61%
17.	Amuria	267	1.78%	271	1.53%
18.	Kiganda	183	1.22%	255	1.44%
19.	Budondo	92	0.61%	254	1.43%
20.	Serere	297	1.98%	240	1.35%
21.	Kyabugimbi	235	1.57%	215	1.21%
22.	Benedict Medical centre	166	1.11%	202	1.14%
23.	Luwero	183	1.22%	201	1.13%
24.	Ntara	114	0.76%	189	1.07%
25.	Budadiri	143	0.95%	186	1.05%
26.	Bishop Masereka Christian Foundation	180	1.20%	184	1.04%
27.	St. Ambrose Charity	272	1.81%	178	1.00%
28.	Kasangati	112	0.75%	176	0.99%
29.	Aduku	108	0.72%	173	0.98%
30.	Kassanda	202	1.35%	172	0.97%
31.	Magale	157	1.05%	166	0.94%
32.	Namayumba	129	0.86%	161	0.91%
33.	Ssembabule	112	0.75%	160	0.90%
34.	Anyeke	147	0.98%	149	0.84%
35.	Ngora Gvt	6	0.04%	148	0.83%
36.	North Kigezi	70	0.47%	145	0.82%
37.	PAG Mission	214	1.43%	144	0.81%
38.	St. Joseph of the Good Shephard Kyamulibwa Ngo	90	0.60%	143	0.81%
39.	Tokora	92	0.61%	140	0.79%
40.	Kangulumira	46	0.31%	135	0.76%
41.	Kakuuto	134	0.89%	134	0.76%
42.	Buwenge	155	1.03%	127	0.72%
43.	Kibuku	22	0.15%	127	0.72%
44.	Bukuku	106	0.71%	123	0.69%
45.	Muyembe	105	0.70%	119	0.67%
46.	Kigandalo	45	0.30%	117	0.66%
47.	Kibaale	169	1.13%	113	0.64%
48.	Kyangwali	0	0.00%	107	0.60%

No.	HC IV	2016/17		2017/18	
		No. C/S	%	No. C/S	%
49.	Budaka	132	0.88%	105	0.59%
50.	Kaberamaido	84	0.56%	102	0.58%
51.	Kojja	20	0.13%	102	0.58%
52.	Kinoni	24	0.16%	100	0.56%
53.	Buwasa	40	0.27%	98	0.55%
54.	Buyinja	51	0.34%	92	0.52%
55.	Wagagai	74	0.49%	91	0.51%
56.	Busia	102	0.68%	90	0.51%
57.	Kabwohe	194	1.29%	90	0.51%
58.	Bufumbo	101	0.67%	89	0.50%
59.	Apapai	44	0.29%	85	0.48%
60.	Bukulula	58	0.39%	85	0.48%
61.	Shuuku	66	0.44%	83	0.47%
62.	Mungula	114	0.76%	81	0.46%
63.	Rwashamaire	83	0.55%	81	0.46%
64.	St. Franciscan	68	0.45%	81	0.46%
65.	Bugono	0	0.00%	78	0.44%
66.	Kibiito	246	1.64%	77	0.43%
67.	Ruhoko	41	0.27%	74	0.42%
68.	Bwijanga	104	0.69%	73	0.41%
69.	Kabuyanda	235	1.57%	70	0.39%
70.	Kitwe	1	0.01%	69	0.39%
71.	Rubaare	87	0.58%	69	0.39%
72.	Kihiihi	41	0.27%	67	0.38%
73.	Padibe	15	0.10%	66	0.37%
74.	Aboke	106	0.71%	64	0.36%
75.	Bugembe	0	0.00%	64	0.36%
76.	Ishongororo	112	0.75%	64	0.36%
77.	Bugangari	42	0.28%	63	0.36%
78.	Busiu	52	0.35%	63	0.36%
79.	Kalangala	71	0.47%	60	0.34%
80.	Mitooma	110	0.73%	60	0.34%
81.	Bumanya	87	0.58%	57	0.32%
82.	Wakiso	50	0.33%	55	0.31%
83.	Kikyo	1	0.01%	53	0.30%
84.	Kotido	71	0.47%	53	0.30%
85.	Namatala	25	0.17%	53	0.30%
86.	Ntwetwe	80	0.53%	50	0.28%
87.	Kebisoni	30	0.20%	49	0.28%
88.	Bwizibwera	68	0.45%	48	0.27%
89.	Kapelebyong	34	0.23%	43	0.24%
90.	Nsiika	52	0.35%	43	0.24%

No.	HC IV	2016/17		2017/18	
		No. C/S	%	No. C/S	%
91.	Ogur	13	0.09%	39	0.22%
92.	Busesa	72	0.48%	38	0.21%
93.	Kiruhura	40	0.27%	31	0.17%
94.	Nyahuka	133	0.89%	30	0.17%
95.	Buwambo	28	0.19%	29	0.16%
96.	Buhunga	9	0.06%	26	0.15%
97.	Butenga	28	0.19%	26	0.15%
98.	Kyarusozi	73	0.49%	26	0.15%
99.	Dokolo	56	0.37%	25	0.14%
100.	Amolatar	33	0.22%	24	0.14%
101.	Bukwa	16	0.11%	23	0.13%
102.	Lalogi	9	0.06%	23	0.13%
103.	Nabilatuk	37	0.25%	23	0.13%
104.	Nakasongola	41	0.27%	23	0.13%
105.	Orum	0	0.00%	21	0.12%
106.	Kiwangala	16	0.11%	19	0.11%
107.	Chahafi	13	0.09%	18	0.10%
108.	Kazo	32	0.21%	18	0.10%
109.	Awach	0	0.00%	16	0.09%
110.	Karenga	13	0.09%	14	0.08%
111.	Nagongera	0	0.00%	13	0.07%
112.	Atitir	5	0.03%	12	0.07%
113.	Kalagala	14	0.09%	12	0.07%
114.	Karugutu	12	0.08%	12	0.07%
115.	Kiyumba	15	0.10%	11	0.06%
116.	Rubuguri	12	0.08%	11	0.06%
117.	Butebo	46	0.31%	10	0.06%
118.	Kityerera	0	0.00%	10	0.06%
119.	Alebtong	4	0.03%	9	0.05%
120.	Princes Diana	5	0.03%	9	0.05%
121.	Kiyunga	1	0.01%	8	0.05%
122.	Kyannamukaaka	9	0.06%	8	0.05%
123.	Buvuma	0	0.00%	7	0.04%
124.	Kyantungo	2	0.01%	7	0.04%
125.	Walukuba	0	0.00%	7	0.04%
126.	Lwengo	0	0.00%	6	0.03%
127.	Mwera	0	0.00%	6	0.03%
128.	Nyimbwa	6	0.04%	6	0.03%
129.	Pakwach	21	0.14%	6	0.03%
130.	Bukomero	16	0.11%	5	0.03%
131.	Ndejje	8	0.05%	5	0.03%
132.	Bugobero	22	0.15%	4	0.02%

No.	HC IV	2016/17		2017/18	
		No. C/S	%	No. C/S	%
133.	Kidera	10	0.07%	4	0.02%
134.	Pajule	13	0.09%	4	0.02%
135.	Kyazanga	0	0.00%	3	0.02%
136.	Namwendwa	159	1.06%	3	0.02%
137.	Omugo	6	0.04%	3	0.02%
138.	Rubaya	1	0.01%	3	0.02%
139.	Nankoma	3	0.02%	2	0.01%
140.	Hamurwa	0	0.00%	1	0.01%
141.	Madi-Opei	0	0.00%	1	0.01%
142.	Semuto	8	0.05%	1	0.01%
143.	Bbaale	0	0.00%	0	0.00%
144.	Bukasa	0	0.00%	0	0.00%
145.	Bushenyi	0	0.00%	0	0.00%
146.	Kanungu	0	0.00%	0	0.00%
147.	Kigorobya	0	0.00%	0	0.00%
148.	Masindi Military	0	0.00%	0	0.00%
149.	Maziba Gvt	0	0.00%	0	0.00%
150.	Mpumudde	0	0.00%	0	0.00%
151.	Namokora	0	0.00%	0	0.00%
152.	Ngoma	0	0.00%	0	0.00%
153.	Ntuusi	0	0.00%	0	0.00%
154.	Nyamirami	0	0.00%	0	0.00%
155.	Nyamuyanja	0	0.00%	0	0.00%
156.	Obongi	16	0.11%	0	0.00%
157.	River Oli	0	0.00%	0	0.00%
158.	Adumi	77	0.51%	0	0.00%
159.	Amach	0	0.00%	0	0.00%
160.	ASTU	0	0.00%	0	0.00%
161.	Atiak	0	0.00%	0	0.00%
162.	Ayira Health Services	4	0.03%	0	0.00%
163.	Bubulo	0	0.00%	0	0.00%
164.	Bugamba	1	0.01%	0	0.00%
165.	Bukedea	0	0.00%	0	0.00%
166.	Buliisa	0	0.00%	0	0.00%
167.	Busanza	0	0.00%	0	0.00%
168.	Hiima Iaa (UCI)	0	0.00%	0	0.00%
169.	Kamukira	0	0.00%	0	0.00%
170.	Kamwezi	0	0.00%	0	0.00%
171.	Kaproron	0	0.00%	0	0.00%
172.	Kataraka	0	0.00%	0	0.00%
173.	Kikuube	0	0.00%	0	0.00%
174.	Kumi	0	0.00%	0	0.00%

No.	HC IV	2016/17		2017/18	
		No. C/S	%	No. C/S	%
175.	Maddu	0	0.00%	0	0.00%
176.	Mbarara Mun. Council	0	0.00%	0	0.00%
177.	Mparo	0	0.00%	0	0.00%
178.	Muko		0.00%	0	0.00%
179.	Mukuju		0.00%	0	0.00%
180.	Mulanda		0.00%	0	0.00%
181.	Nankandulo	0	0.00%	0	0.00%
182.	Nsinze	0	0.00%	0	0.00%
183.	Rhino Camp	0	0.00%	0	0.00%
184.	Rugaaga	0	0.00%	0	0.00%
185.	Ssekanyonyi	0	0.00%	0	0.00%
186.	Yumbe	0	0.00%		0.00%
	Total	**14,994**	**100.00%**	**17,729**	**100%**

3 Annexes

3.1 Annex 1: Delivery of the Uganda National Minimum Health Care Package (UNMHCP).

This section details the progress on implementation of priority activities under the UNMHCP.

3.1.1 Health promotion, disease prevention and community health initiatives

The key objectives of the program are Prevention and control of communicable and non -communicable diseases (NCDs), capacity building of service providers, policies, laws, guidelines dissemination and plans and strategies, technical support supervision monitoring and supervision.

Achievements

- With support from UNICEF, have aired many radio spot messages on selected media stations country wide covering different health areas.
- 10 radios spot messages produced on: Family planning. Malaria prevention and control, Breastfeeding, Adolescent health, measles, polio, HPV and ANC on 30 radio stations country wide.
- Social mobilization using film vans carried out to increase community awareness in 102 districts on Meningitis, Malaria, Hepatitis B, SMC, Trachoma, HIV, HCT, Viral load, PMTCT, Fistula, Bilharzia & IRS.
- Social mobilization on Marburg outbreak. In 2 districts namely; Kapchorwa and Kween supported to control and prevent outbreaks. Activity supported by WHO and UNICEF.
- Social mobilization with 4 film vans on SMC, HCT, hygiene and sanitation, Malaria, TB, nutrition. In 10 districts namely Lira, Apac, Kagadi, Masindi, Kiboga, Mbarara, Kabarole, Kole, Yumbe and Hoima. Increased community knowledge and uptake of services on SMC, HCT, hygiene and sanitation, Malaria, TB, nutrition. Activity supported by MOH, SUSTAIN, Sanitation Fund and IRC.
- Social mobilization for film vans TB, HIV, Anthrax, SGBV, Adolescent, HTs, Immunization, Nutrition, Fistula, Measles, IDM. 15 districts; Kiruhura, Kween, Yumbe, Kabarole, Sironko, Kole, Kapchorwa, Tororo, Bulambuli, Manafwa, Bugiri, Bugiri, Kibuku, Kanungu and Jinja. Increased community knowledge and uptake of services. Activity supported by IRC, AFENET, UNFPA.
- Advocacy and social mobilization on routine immunization dialogue meeting with DHEs in western region districts of Mbarara, Ibanda, Isingiro, Sheema and Kisoro. Activity supported by UNICEF.
- Family planning communication strategy finalized and printed with support from UNICEF.
- Draft Hepatitis B Communication strategy developed, awaiting approval Top Management.
- Communication strategy for Palliative care developed and approved. Supported by Palliative Care Association of Uganda.
- Technical support supervision for Health Promotion and Education activities in 10 districts namely Ibanda, Rubirizi, Kasese, Buikwe, Kaliro, Iganga, Luuka, Kumi, Serere and Soroti.
- Technical support supervision for Crimean Congo Hemorrhagic fever preparedness in 9 districts namely Mpigi Luwero, Masaka, Soroti, Kumi, Bukedea, Iganga, Kamuli and Luuka.
- OBULAMU End line survey conducted.
- Carried out technical review of IEC materials on Immunization, family planning, EMTCT, Bio Mass smoke, Eye health and ANC.
- Distributed materials on Yellow Fever, Cholera, measles, HPV, ANC, Eye care and health promotion hand books in 30 districts of eastern, western and central region.
- Held 10 regional orientation meetings for DHOs, DHEs, District Education Officers & Community Development Officers on Human Papilloma Virus (HPV) social mobilization which covered all the 122 districts.
- Conducted EPI advocacy meeting on measles outbreak and Orientation of district and sub county extension workers on EPI communication in Busoga region.

- Orientation of 10 Central level staff and 30 District Health Educators on the Concept of Community of Practice in 7 regions held.
- 2 Regional meetings with media managers held on HPV and Polio.
- Developed and reviewed The National Umbrella Strategy for Health Promotion/ Social Behavior Change Communication strategy.
- Reviewed the Family Planning communication strategy.
- Technical support and monitoring implementation of Health Promotion in 100 districts.
- Monitoring of effectiveness of SBCC/ Health Promotion interventions on service delivery at health facilities in 37 districts.

3.1.2 Environmental Health

This component aims at contributing to the attainment of a significant reduction of morbidity and mortality due to: poor sanitation and hygiene, indoor pollution, poor food hygiene and supply, unsafe water accessibility and other environmental health related conditions. This was done through implementation of activities supported by the GoU, UNICEF and the Uganda Sanitation Fund (USF) Program.

Achievements

- National Sanitation and Hygiene Guidelines reviewed and disseminated in Karamoja and Busoga Sub-regions. Supported by John Hopkins University.
- ISH strategy reviewed and presented to Environmental Health and Health Promotion – (EHHP) TWG. Currently waiting for approval by SMC. Supported by AMOCOW.
- Environmental Health Strategic Plan 2018/19 - 22/23 was completed presented to EHHP-TWG and thus awaits presentation to SMC. Supported by WHO and UNICEF.
- Built capacity building to district staffs in Karamoja and Acholi Sub-regions
- Conducted four coordination meetings of stakeholders – National Sanitation Working Group.
- Public Health Act 2000 amended and draft cabinet memo in place.
- Conducted ten staff meetings during the period.
- Conducted five EHHP TWG meetings during the period.
- Participated in all the four quarterly reviews during the FY 2017/18
- Technical Support supervision carried out in the six districts of Ntoroko, Bundibugyo, Tororo, Busia, Kasese and Rubirizi.
- A total of six districts (Tororo, Busia, Bundibugyo and Ntoroko, Kagadi and Kakumiro) supervised and supported targeting four Open defecation free (ODF) villages per district.
- A total of 16 villages were declared ODF in the six districts implementing CLTS which were support supervised.
- 200 health workers from the districts of Abim, Amudat, Napak, Nakapiripirit, Moroto, Kaabong, Kotido and Pader successfully oriented and their skills developed in implement sanitation and hygiene activities using Follow-up Mandona (FUM). Supported by UNICEF.
- USAID through the US4H[4] project began supporting districts in sanitation and hygiene improvement with emphasis on supply chain management, in Acholi, Central and Eastern Sub-regions.
- The USF Program was implemented in 40 districts. At least 7,901 of the 11,354 villages targeted by the program have so far been declared ODF, reflecting an overall performance level of 70%. In FY 2017/18;
    - Among the USF supported districts, the average latrine coverage now stands at 96%.
    - A total of 575 villages were declared ODF. Additional 333,000 people added to the total number of people living in ODF areas.
    - A total of 30,341 new hand washing facilities constructed across all the 40 USF districts.
    - Six workshops held to train district 240 district staff in CLTS in 8 expansion districts.

[4] US4H-Uganda Sanitation for Health Project

- Five workshops held to orient 190 key district staff in Teso, Lango, West Nile, Eastern and Western regions on the new GSF results framework.
- One Sanitation Week celebration held in Kole district to create awareness about major issues related to good sanitation and hygiene in the country.
- Ten cluster meetings held across all the 40 across USF supported districts to share experiences in implementation of USF activities.
- Four PCM monitoring visits held in 4 USF districts to assess the quality of sanitation facilities in the districts.
- Four technical support supervision visits made to all USF districts to strengthen capacity of district staff to smoothly implement USF activities and improve performance.
- One Institutional Triggering conducted for Senior Management Staff at MoH to change their behaviour about good Sanitation and Hygiene.
- Three regional advocacy meetings held to share program performance among the districts in the different regions and mobilize resources for improved sanitation and hygiene activities.
- A draft report from a study conducted by the Makerere University School of Public Health (MakSPH) also revealed a downward trend in most sanitation related diseases across a number of USF supported districts over the last 7 years.

FIGURE 48: LATRINE COVERAGE AMONG USF SUPPORTED DISTRICTS 2011 - 2017

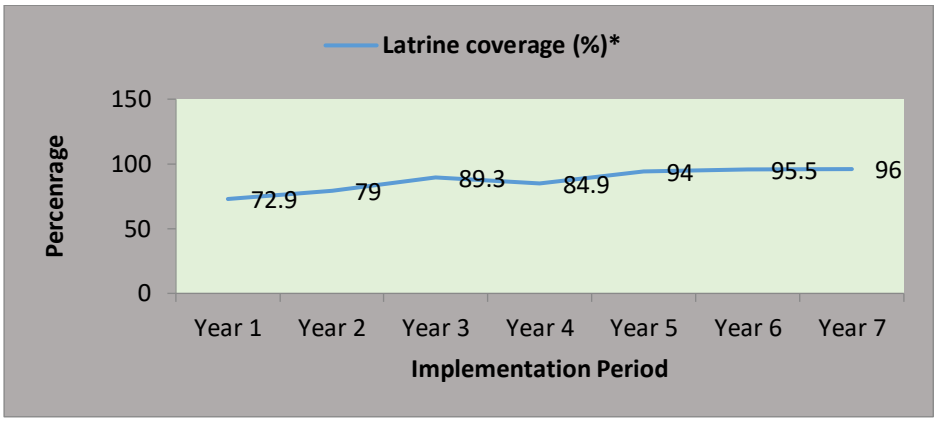
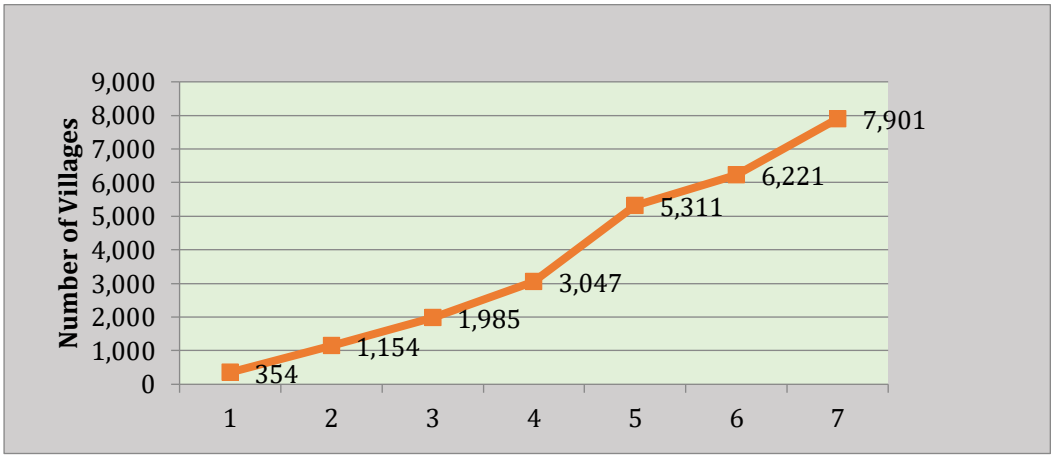


TABLE 56: TRENDS IN ODF VILLAGES



Access to Safe Water

The source of water is an important determinate of the health status of household members. Safe and clean water is a prerequisite for reducing many common killer diseases of both adults and children such

as diarrhea, dysentery and cholera. According to the UNHS 2016/17, overall, 79.8% of households in Uganda had access to improved sources of drinking water compared to 67.7% in 2012/13. 96% of households were within 3 km of the main drinking water source. The burden of fetching water rests on female adults and the girl child.

Lessons learnt

- Institutional Triggering, if conducted properly is a very powerful tool for changing the sanitation and hygiene behavior among the key personnel in any institution.
- Identification, strengthening and engagement of the natural leaders, Community Engineers and Community Champions motivates them and can scale up the achievement of program objectives especially with regard to ODF.
- School health provides a window of opportunity for advocacy for provision of facilities at home through the child to parent communication.
- Empowerment of community structures leads to the emergence of natural leaders who can play a very vital role in achieving and sustaining ODF status among communities.

Challenges

- Continued sub division of existing USF supported districts to create new ones which the program is unable to fund this FY.
- The program missed its allocation of funding for quarter 2 FY 2017/18 due to non-allocation of cash limit to the ministry of Health by MoFPED.
- The arrival of refugees in some districts in West Nile has led to the re-introduction of Open Defecation in villages which had initially been declared ODF.
- High slippage rates (averaging 50%) in some districts resulting from various factors including; heavy rains, destruction of pit latrines by termites and inconsistent post ODF monitoring.

Inconsistences in triggering among some Sub Grantees which undermines the pace of achievement of ODF communities.

3.1.3 Veterinary and Public Health

The Veterinary Public Health division coordinate and guides planning, standardization, implementation and monitoring and evaluation of initiatives for screening and management of zoonotic conditions by the different partners in Uganda.

Achievements

- Support supervision on control and management of rabies districts of the greater conducted in 21 districts, 6 in the greater Masaka, 7 districts from Eastern Busoga region. Another 8 districts were supervised to assess the surveillance systems and mechanisms in place control zoonotic diseases. These were Nakasongola, Masindi, Luwero, Kiryandongo, Hoima, Mubende, Kiboga and Kayunga.
- Steering committee meetings for Africa Sustainable Livestock 2050 majorly looking at Public Health, Environmental and socio economic/Livelihood impacts of livestock production systems.
- Participated in Cramean Congo Haemorrhagic Fever (CCHF) investigation in Luwero and Nakaseke and also part of the team that investigated unexplained illnesses/deaths with typical VHF presentations but were lab negative for any VHFs Also coordinated national response to RVF outbreaks in Mityana, Kiboga, Kiruhura, Buikwe, Arua and Kyankwanzi as incident commander.

Challenges

As Outbreak are controlled new outbreaks have been recorded in other districts in south western Uganda, that is, Ibanda, Isingiro (RVF and CCHF), Mbarara, Kasese, Sembabule and Mubende.

3.1.4 Maternal and Child Health

MCH cluster is composed of five sub programs: Sexual and Reproductive Health (SRH), Newborn Health, Integrated Child Survival and Development, Immunization and Nutrition.

3.1.4.1 Sexual and Reproductive Health and Rights

Achievements

- On job mentoring and coaching conducted in health facilities of 25 selected districts in different regions; 3 districts in Acholi, 3 West Nile, 7 districts of Karamoja 9 in eastern and 3 districts in the western regions, which improved the capacity of health workers on provision of Emergency obstetric and newborn care (EmONC) service and developed quality improvement plans.
- Disseminated the MPDSR guidelines and established committees in 29 districts; 16 in the South Western region and 13 in the Busoga region at facility and district level improving the proportion of maternal deaths reviewed for continuous quality of care improvement.
- Held the second National FP conference (2017) to raise awareness and mobilize support for the National FP agenda and supported 21 Districts to adopt District specific costed FP Implementation Plans to enable them mobilize support for FP initiatives to increase access and Utilization of FP services.
- Achieved 100% training of health workers (88) in the targeted 16 district on comprehensive FP service delivery to improve capacity and availability of all FP options.
- 663 health workers from 8 Humanitarian districts trained on provision of Adolescent health and sexual gender based violence increasing covering of Adolescent friendly services to 80% facilities.

3.1.4.2 Newborn and Integrated Child Survival and Development

The Sector's major strategy is to end preventable newborn and children under five deaths by increasing equitable coverage of high impact evidence based interventions in order to accelerate the attainment of SDG 3, and promote appropriate nutrition and proper growth and development of children and adolescents. The major target is to reduce the under five deaths from 64/1,000 to 47/1,000, infant deaths from to 43/1,000 to 32/1000 and neonatal deaths from to 29/1,000 to 15/1000 live births.

The sector performance on newborn and child integrated child survival is summarized in the table below;

TABLE 57: SECTOR STATUS OF CHILD AND NEONATAL HEALTH INDICATORS

Indicator	Status 1991	Status 2011	Status 2016	Target 2020	SDG Target 2030
Neonatal mortality (per 1,000 live births)	32	23	27	15	12
IMR (per 1,000 live births)	85	54	43	32	19
UFMR (per 1,000 live births)	156	90	64	51	25
Underweight among Under Fives	23%	14%	-		
Stunting among Under Fives	38%	33%	29%	22%	19%

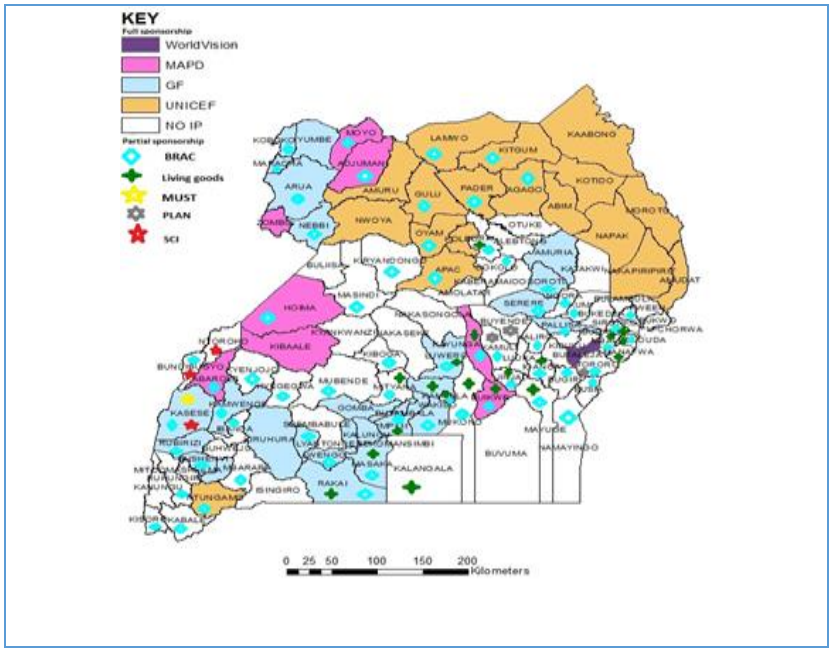
Achievements

- Accelerated implementation of the Sharpened Plan for MNCH including improving antenatal and postnatal care by providing comprehensive services, improving malaria prevention and

management, essential newborn care training and ICCM of common childhood illnesses, providing early infant HIV testing and counseling and Nutritional supplements.

- Intensification of community child health activities through the VHT and other structures, including ICCM which has been expanded to 70 districts and recently a newer focus on community childhood TB and HIV was included after a brief pilot. To support this program a community medicines drug distribution framework was developed and endorsed by the MoH. In the FY 2017/18, the MoH iCCM in 96 districts with 70 districts covered by the public sector and the remaining 26 private sector. The two sectors implementing iCCM current do it differently. While the public sector implementing partners (UNICEF, TASO, Malaria Consortium, Save the Children) cover whole districts, the coverage of private sector is partial and majorly in towns. The partners supporting iCCM in the private sector include; CHAI, World Vision, BRAC, Living Goods, Plan International, Children Investment Fund Foundation and Mbarara University of Science and Technology. The iCCM guidelines have been updated to add a community supply chain management to improve management and accountability of commodities at the community level.
- To promote healthy behavior and practices the Key Family Care Practices manual was updated to cover the whole MNCH life cycle and regional trainers trained in Gulu, Lira, Arua, Mbale and Soroti including MoGLD and MoES trainers. Training of community health promoters has already started.

FIGURE 49: ICCM COVERAGE IN UGANDA



- The Child Days strategy to provide supplementary packages in October and April each year continued and countrywide in October and April respectively.
- Adapted the new WHO Newborn and Child health quality of care standards, and baseline assessments, coaching and district inception meetings have been conducted in 10 districts. Based on the gaps identified through the assessment the MoH has already started re-equipping facilities in need.
- Designed and are in the process of establishing skills labs to improve clinical skills of health workers in child care and newborn resuscitation in order to improve. A total of a 2,630 health workers targeted and training begins October 2018.
- To enhance access and reduce disparities in service provision Catchment Area Planning and Action guidelines were developed and introduced, to identify target service areas and populations most in

need. These guidelines are also being used to develop action plans including outreach areas for newborn, child and adolescent health services.

- The Nutrition Program has also been scaled up with the aim of preventing severe macro and micro nutrition. The MoH has developed draft guidelines and messages to be disseminated widely to the population on healthy eating and lifestyle.

3.1.4.3 Nutrition Division

The key function of the Nutrition Division is promotion of good feeding habits, breastfeeding, and nutrition rehabilitation.

Achievements

- Conducted the national Nutrition stakeholders mapping and annual joint planning conference in July 2017.
- Conducted nutrition quality improvement mentorships and coaching in 24 districts including those of W. Nile, Karamoja and Busoga sub-regions.
- Initiated the digitalization of ration distribution for Karamoja and refugee communities, and conducted couching of 30 systems users in Moroto district.
- Designed, piloted and launched mass media clips and messages on good feeding practices as a means of increasing awareness on good nutrition for the 7 Karamoja region districts under UNICEF support.
- Updated counselling messages on nutrition along the Option B plus of PMTCT the tools await pre-testing.
- Re-enforced the integration of nutrition status screening at all contact points of health service delivery in 18 districts, provided protocols to health workers.
- Updated protocols for nutrition care in the context of HIV and TB, await funds for reproduction and dissemination.
- Developed tools for the management of acute malnutrition integration in OPD service delivery to involve VHTs in early case finding and referrals at community level, to be rolled out when tools are printed and disseminated.
- Instituted health facility GMP and designed modules for community-based GMP on going.
- Advocated for creation of breastfeeding corners at all workplaces (including Parliament), and commemorated the breastfeeding week in the first week of August 2017, held a Parliamentary Advocacy meeting with the Parliamentary Committee on Nutrition.
- Oriented and accredited Baby Friendly health facilities in 4 districts mobilizing more resources to scale up to a wider scope.
- Executed regional Training of Trainers (ToTs) in IYCF and IMAM for 3 regional referral hospitals, Mbarara RRH, Fort Portal RRH and Moroto RRH, awaiting more funding for the remaining.
- Harmonized nutrition indicators in the standard monitoring tool for quality improvement (QI).

Challenges

- Coordination of IPs in nutrition leading to parallel implementation of programs that compromises on quality of service delivered.
- Low reporting levels by IPs partly due to parallel reporting channels by some stakeholders.
- Inadequate funding to run all planned activities to satisfaction.
- Inappropriate translation of nutrition information and counselling messages in the local dialects.
- Inadequate human resource at all implementation levels i.e. regional, districts and at the center.

3.1.5 Control of Diarrhoeal Diseases (CDD)

The mandate of the CDD section is to promote interventions and initiatives for prevention, preparedness and control of epidemic diarrheal diseases at all levels.

Achievements

- Rapid response to prevent and control outbreaks was carried out to districts that reported cholera outbreaks and those at high risk of diarrheal disease epidemics. The following districts that had cholera were supported and outbreak successfully controlled: Kasese, Kisoro, Hoima, Kyegegwa, Kagadi, Amudat, Mbale, Mpigi, Busia and Tororo. Preparedness was strengthened in the following districts through development and implementation targeted action plans: Namayingo, Nebbi, Buliisa and Pakwach.
- New cholera prevention and control guidelines (2017) and cholera strategic plan were disseminated to stakeholders targeting cholera hotspot districts and those along the borders.
- Oral cholera vaccine launched in Hoima district.
- Cholera stakeholders meeting was held to operationalize the five-year strategic plan. Eleven (11) districts were identified for Oral cholera vaccination targeting approximately four million persons. Immunization started with Hoima district in which 360,000 persons were given Oral cholera vaccine.
- All (13) cholera outbreak reporting districts during the FY were supported with medical supplies (intravenous fluids, antibiotics, infection control supplies, ORS, gloves, etc.) from the MoH through NMS. In additional, medical supplies were also mobilized from development partners (UNICEF, WHO, MSF) to bridge the gap.

Lessons learnt

Additional resources to fill some of the identified gaps can be mobilized through collaboration and partnership with other sectors and stakeholder (WHO, UNICEF and others).

Challenges

- Population displacement from neighboring countries with ongoing cholera outbreaks leading cross-border cholera outbreaks. The ongoing cholera outbreak in 2018 started with displacement of over 50,000 refugees from Congo some of who came with cholera. This outbreak started in mid-January 2018 and by the time it was controlled in April 2018 over 2,019 cases with 44 deaths had been reported by Hoima district. This outbreak is responsible for over 80% of reported cholera cases during the FY.
- Inadequate access to safe water, sanitation and hygiene facilities especially in the district along the international borders. Propagation of cholera outbreaks in Kasese district (approx. 250 cases) and in Hoima district (over 2000 cases) were related to these inadequacies.
- Inadequate operation funds at central and district level – to support diarrheal preventive and control activities.

Recommendations

- Strengthen collaboration with other key stakeholder such as UNICEF, WHO, MoLG, Ministry of Water Natural Resource and Environment, MoES, religious leaders, private sector, etc. to provide water, promote sanitation and hygiene.
- Mobilize additional resources from partners to scale up preventive interventions targeting vulnerable groups as guided by disease morbidity data.

3.1.6 Uganda National Expanded Program on Immunization (UNEPI)

The goal of the UNEPI is to ensure that every child and high risk group is fully vaccinated with high quality and effective vaccines against the target diseases according to recommended strategies.

Achievements

- One STOP 50 member and 59 NSTOP members deployed in 38 low performing districts to reduce risk of Wild Polio Virus. No known case of polio in Uganda
- 6,376,386 children aged below 5 in 73 high risk districts vaccinated against Polio.
- 14 Solar Direct Driven vaccine storage refrigerators installed in West Nile and Northern Region and one at Mende HC III in Wakiso district.
- Conducted cold chain maintenance and supervision in Kabale, Rubanda, Kanungu, Mubende, Kamwenge and Kyegegwa, Nakawa Division-KCCA.
- Rapid response to breakdown of cold chain equipment for Sheema DVS.
- Trained 44 HWs and established 14 Regional Cold Chain Maintenance and Vaccine Management Teams. Moroto RRH was not represented.
- Five (5) new vaccine sentinel surveillance sites were functionalized.
- RED/REC Micro plans in 37 districts identified with inequities developed.
- 5,900 VHTs IN Kalungu, Otuke, Oyam, Bushenyi and Mbarara oriented on their roles in RI service delivery.
- 195 DITs trained in 4 Regional-level targeted trainings and deployed to mentor at district and health-facility level in Hoima, Jinja Soroti, Mbale (I) and Mbale (II) regions.
- In-depth assessment of EPI information management system, disseminate the report and develop a multiyear data quality improvement plan ongoing. Data collection done, Initial feedback meetings and Key Informant interviews done; Development of the multiyear data improvement plan is ongoing.
- Conducted an Operational Level Training for 41 health workers (Nurses, Nursing Aides, Clinical Officers, Midwives, IRC HAs and DCCTs) from Agago, Kitgum and Lamwo Districts at Kitgum's Jaflo Hotel.
- Conducted Follow up visits in 14 low performing districts on HPV.
- Conducted an integrated PIE of HPV, IPV, bOPV and fridge tags in 31 selected districts.
- 48 sub national level officers and five national AEFI committee members trained on EFI surveillance and causality assessment.
- Two districts conducted the pilot and two were controls on HPV CTC in close collaboration with PATH.
- Consultation meetings with Top Management and ToRs discussed on creating of the Immunization Coordination Committee.
- Procured vaccines. 522,180 / 1,437,600 HPV doses; 1,914,600 / 3,362,000 of PCV doses, 1,911,000 / 1,591,500 of Penta doses; 1,060,800 / 2,917,500 of Rotavirus doses and 1,713,600 of IPV doses.
- Construction of 19 medicine stores was completed and handed over in Ntoroko, Zombo, Nakaseke, Buikwe, Luuka, Pallisa, Serere, Napak, Nakapiripirit, Bukwo, Alebtong, Agago, Lwengo, Lyantonde, Isingiro, Buhweju, Sheema, Rubirizi and Buliisa.
- Construction of 26 health staff houses that accommodate 2 staffs each (semi-detached) was completed and handed over in 15 districts; Bundibugyo- 2, Kasese-2, Kanungu-2, Kisoro-2, Kakumiro-1, Kagadi-1, Mukono-2, Wakiso- 1, Namayingo-2, Mayuge-2, Bugiri-2, Kalangala-2, Buvuma- 2, Namutumba- 1 and Bulambuli-2

All activities under the Immunization program were implemented with support from GoU, GAVI WHO, UNICEF, CHAI, AFNET, and MCSP.

Challenges

- Increased need for cold chain maintenance services compared to available capacity at the centre.
- Implementation of GAVI HSS2 grant for Q1 (under calendar year – 2018), Q3 FY 2017/18 not done. Negatively because there is limited support for outreaches and it has led to inadequacy of EPI data tools.
- Mismatch in planning cycles of GoU and GAVI, secondly, there were in country stocks of vaccines procured in previous year quarters.

3.1.7 School Health

School Health targets the health needs in educational institutions at all levels beginning with pre-school up to institutions of higher learning. Protecting the health and safety of children adolescents and young people in schools is an important part of the GoU comprehensive education and public health plan.

Achievements

- Supported the districts of Mukono, Budaka, Wakiso, Mbale, Iganga, Butebo, Pallisa, Alebtong and Otuke in selected Primary schools using the Focusing Resources for School Health Tool (FRESH) and the malaria control checklist.
- Schools have been advised on development of schedules of health talks to be discussed to the pupils during school assemblies, constituting First Aid Kits with emergency sanitary towels inclusive, ensuring strategies for keeping a malaria free school environment and advocating for hand washing facilities in schools.
- Reviewed the School Health Register and included variables that will enable track learners' health status through the school and their progression in growth and performance.
- There is positive impact on the health indicators since learners being aware of their health can influence the community to demand for health services while unwell (New OPD utilizations); they are good vehicles for preventive services (change agents) thus contributing to reduction in common illnesses like malaria cases.

Tuberculosis and Leprosy Control

The goal of the National Tuberculosis and Leprosy Control Program (NTLP) is to reduce the incidence of TB by 5%, and to reduce the incidence of Grade 2 disabilities (Gr2D) among new leprosy cases from 2.3 per million populations in 2014 to less than 1 per million populations by 2019/20.

The national overall TB case notification was 52,485. TB/HIV Co-infection rate during the year was 41%, ART uptake of 98% with regional variations. There was general improvement in partner coordination, internal reorganization with a new TWG for Surveillance, Monitoring, Evaluation and Research; as well as engagement with districts to improve implementation through guidance in development of action plans.

3.1.7.1 TB Case Notification

The number of all TB cases notified has continued to rise since the reversal in 2016/17 which saw an increase from 43,858 in 2015/16 to 45,900 that year. This time round preliminary data shows an increase of 6,585 cases bringing the annual notification to 52,458 (DHIS2). The case notification rate was 113/100,000 which translates to a Case Detection Rate (CDR) of 56% against planned target of 78% for the year. The DTLS data stands at 45,881 without Q4 April to June 2018 which is currently being entered.

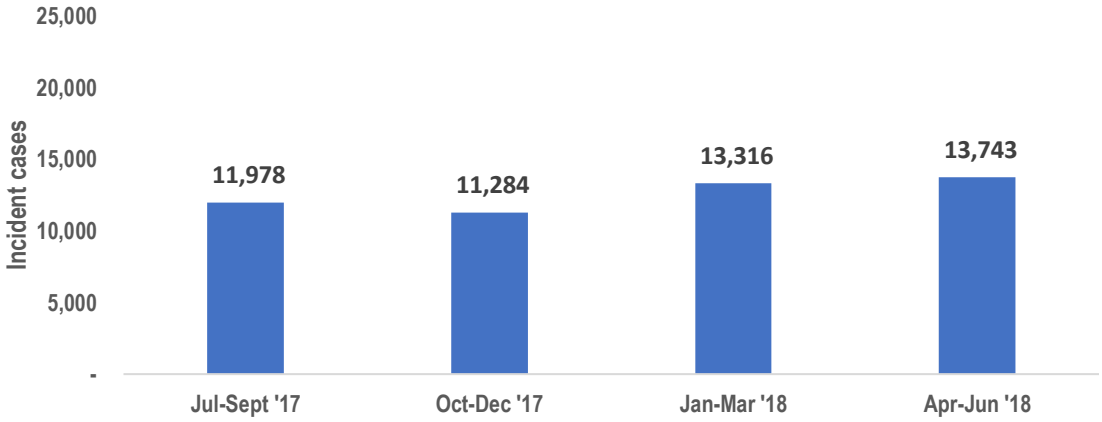
TABLE 58: SHOWING CASE NOTIFICATION FOR FY 2017/18

ZONE	(P-BC)	(P-CD)	EPTB	Total
Arua	2,292	1,202	365	3,859
Fort	1,835	896	139	2,870
Gulu	1,765	985	235	2,985
Hoima	1,982	1,969	94	4,045
Jinja	2,138	2,277	208	4,623
Kampala	7,812	6,297	1,251	15,360
Lira	2,216	844	137	3,197
Masaka	1,716	1,118	207	3,041
Mbale	1,875	1,077	170	3,122
Mbarara	2,853	1,649	286	4,788

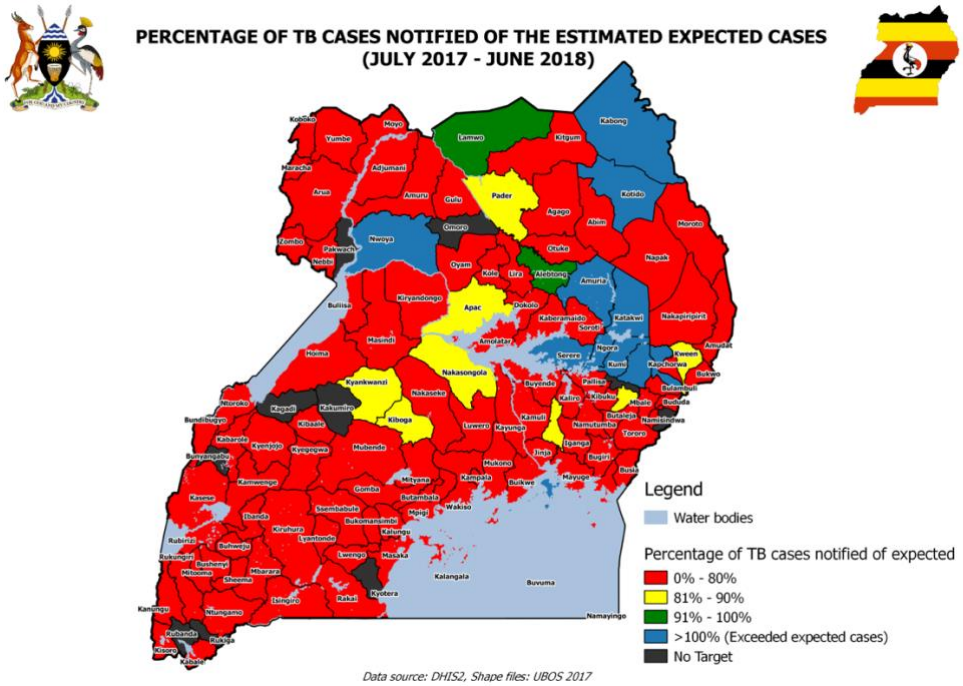
Moroto	1,749	466	536	2,751
Soroti	923	719	202	1,844
Total	**29,156**	**19,499**	**3,830**	**52,485**

Source: DHIS2, 2018.

FIGURE 50: TB CASE NOTIFICATION BY QUARTER



TB notification remained below expected in all districts with most of the districts notifying less than 100 new TB cases per 100,000 population.



Partly as a result of these interventions, in FY 2017/18 pediatric TB comprised 11% (5,100 cases) of all incident TB cases up from 9% (4,004 cases) in FY 2016/17. Isoniazid preventive therapy (for under five contacts) uptake increased from 11% in FY 2016/17 to 16% in FY 2017/18. Treatment success rate among children diagnosed with TB remained stagnant at 76% compared to the previous year.

3.1.7.2 TB Treatment Outcomes

Out of the 29,242 cases notified in 2017/18, 17,978 (61%) completed treatment while 14,348 (49%) cured, bringing the Treatment Success Rate (TSR) to 70%. There was a decrease in TSR from 80% in 2016/17 to the current 70%. Lost-to-Follow up has also increased from 11% to 20% whilst death increased from 5% to 9%. The Failure rate has stagnated at 1%. A clearer picture will emerge once the Program data set is complete.

3.1.7.3 TB/HIV Collaborative activities

The NTLP held four coordination meetings with its TB/HIV implementing partners during which it developed action plans to i) harmonize & scale up implementation of Isoniazid Preventive Therapy, ii) increase utilization of rifabutin, iii) roll out online monitoring of distribution of TB guidelines, IEC materials, SoPs & tools.

Out of the 52,485 notified cases, 52,556 (99%) had their HIV status documented. Of these 21,306 (41%) were found to be positive. Of these that were positive, 20,929 (98%) were enrolled on ART which is higher than the national target of 94% for the year, while 20,918 (98%) were started in CPT. This performance is attributed to availability of ART services and rollout of ART guidelines during the year.

3.1.7.4 Infection Control and IPT

Whilst 328,563 packs of INH 100mg, and 65,341 of INH 300mg for IPT were ordered some of the medicines have been received. Quantities received before late June 2018 were sufficient for 39,729 PLHIV 0-14years & U5 contacts of PBC TB patients, and isoniazid 300mg tablets sufficient for 16,836 PLHIV>15years. Due to the insufficient quantities for nation-wide use, the NTLP developed & shared with the NMS allocation list of 35 & 70 priority health units for IPT implementation. To improve monitoring of the IPT intervention, the NTLP designed a IPT monthly reporting form & received support to develop an online database & IPT dashboard. It developed standard operating procedures to aide health workers to quantify isoniazid for TB prevention. It worked with NMS to provide timely updates to districts on isoniazid health unit deliveries to inform capacity building and isoniazid redistribution. As a result, 17,568 PLHIV & 2,512 U5 contacts of PBC TB patients were enrolled on IPT.

TABLE 59: UNITS OF ISONIAZID RECEIVED OVER THE LAST FY 2017/18

Item	Quantity in units	Pack Size	Quantity in Packs	Expected time of Arrival	Status
Isoniazid 100mg dispersible tablets	202,700	100	2,027	31-Oct-17	Received
	11,716,100	100	117,161	25-Jan-18	Received - 29/Mar/18
	11,716,100	100	117,161	01-Mar-18	Received - 22/June/18
Isoniazid 300mg film uncoated tablets	2,828,448	672	4,209	28-Feb-18	Received

The NTLP supported the development of the revised MoH guidelines on Infection Prevention and Control. It shared its TB Infection Control guidelines, SoPs and IEC materials with its partners for printing and dissemination to health facilities. As a result, the number of TB patients notified that were health workers declined from 170 in 2016/2017 to 151 in 2017/2018. This notification of 147/100,000 health workers was higher than the reported notification rate in the general population of 139/100,000 population in 2017/2018, an indication of ongoing transmission of TB in health facilities. This underscores the need for all actors to prioritize implementation of TB Infection Control measures in all health facilities and for promotion of health facilities designs (open waiting areas) that ensure adequate ventilation.

TABLE 60: HEALTH WORKERS FOUND WITH TB AND CHILDHOOD CONTACTS OF P-BC PATIENTS

ZONE	Health Workers with TB	TB Smear Positive Patients	Under 5 Contacts of TB	Under 5 Contacts of TB on IPT
Arua	13	1,673	1,405	128
Fort	5	1,467	1,043	285
Gulu	24	1,226	1,415	81
Hoima	5	1,639	1,321	140
Jinja	11	1,640	1,342	213
Kampala	34	4,767	2,596	685

Lira	8	1,781	1,377	231
Masaka	4	1,216	978	73
Mbale	4	1,048	826	218
Mbarara	32	2,383	1,391	162
Moroto	7	1,322	1,378	229
Soroti	4	734	885	67
Total	**151**	**20,896**	**15,957**	**2,512**

3.1.7.5 Programmatic Management of Drug Resistant TB

In 2016, the incidence of RR/MDR – TB was 4.7/100,000 population, translating to 1,900 incident RR/MDR-TB cases. In 2017 only 26% (489/1,900) were notified and an even smaller number enrolled on treatment.

MDR-TB remains a major emerging problem in Uganda with expected incidence of 4.7/100,000[5] population, translating to about 1,900 incident multidrug/rifampicin resistant TB (MDR/RR-TB) in 2016. In 2017 the country notified 489 incident TB cases, which was only 26% (489/1,900) cases found.

During the FY the number of MDR treatment initiation sites was increased from 15 to 17 with the addition of Jinja and Moroto RRHs. Preliminary data coming in this Calendar Year 2018 indicates that so far 229 of MDR cases were enrolled on second line treatment bringing the total number of cases ever enrolled to 1,791. In terms of FY, the total enrolment in FY 2016/17 was 427 Cases. There has been a slight decrease to 422 cases in 2017/18 although some of the data is still missing. There have been some challenges with the reporting system for DR TB although these are almost resolved especially to with reporting speed and reliable supply of internet data at the treatment initiation sites. The treatment success rate was 74%, 74% and 70% for the 2013, 2014 and 2015 cohorts respectively.

This last quarter April-June 2018 has witnessed increased activity around DR TB. Alongside a total of 129 cases that were found, a total of 1,948 of their contacts were traced, 1,541 of whom were evaluated and 15 found to be positive for MDR TB. The average yield from contact tracing per MDR treatment initiation site stands at 0.97%.

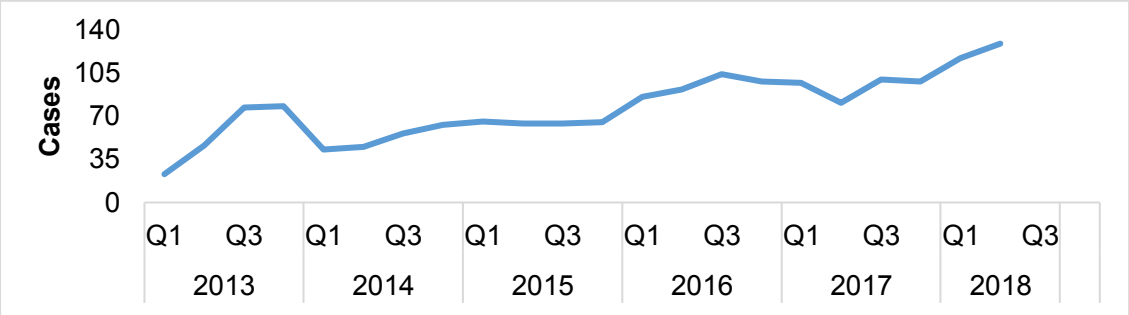
TABLE 61: MULTI-DRUG TB PATIENTS EVER ENROLLED ON TREATMENT

Facility	2013	2014	2015	2016	2017	Jan to June 2018
Arua RRH	12	11	20	18	32	16
Fort Portal RRH	15	7	4	16	17	7
Gulu RRH	18	5	11	16	15	9
Hoima RRH	2	2	6	14	18	12
Iganga GH	12	10	8	15	16	2
Jinja RRH						7
Kabale RRH	2	5	9	7	8	9
Kitgum GH	36	20	12	28	13	9
Lira RRH	2	27	41	50	59	33
Masaka RRH	4	8	15	16	17	5
Matany GH			3	11	23	9
Mbale RRH	14	14	11	37	24	20
Mbarara RRH	23	18	11	24	21	18
Moroto RRH						3
Mubende RRH	1	4	5	6	14	2
Mulago NRH	97	82	105	136	129	63
Soroti RRH	4	5	16	11	14	5
Total	**242**	**218**	**277**	**405**	**420**	**229**

[5] Uganda Tuberculosis Profile accessed from https://extranet.who.int/sree/Reports?op=Replet&name=/WHO_HQ_Reports/G2/PROD/EXT/TBCountryProfile&ISO2=UG&outtype=PDF

MDR/RR-TB cases enrolled on treatment have been increasing over the years.

FIGURE 51: QUARTERLY MDR-TB ENROLLMENT 2013 - 2018, UGANDA

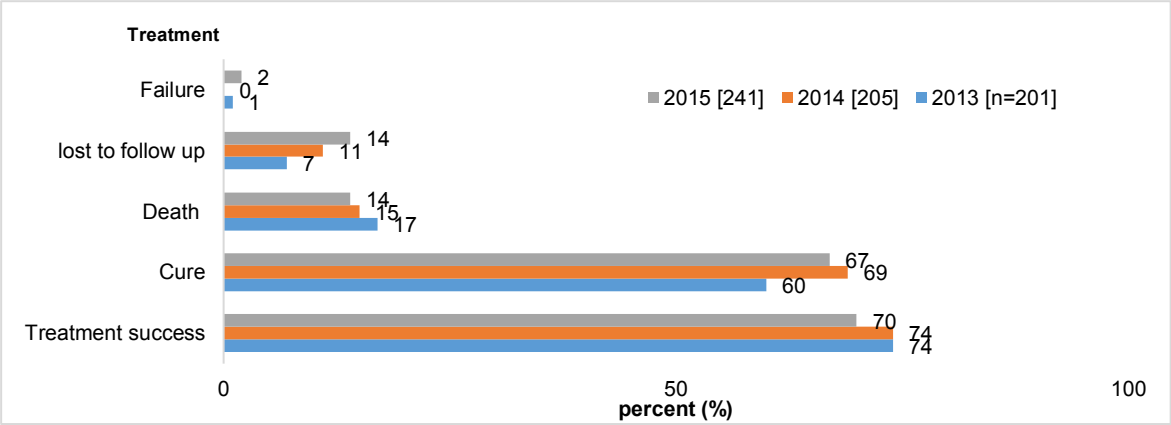


MDR – TB and refugees

- Uganda hosts more than 1 million refugees settled in urban Kampala, Northern, Western and North Western Uganda. The program is in the process of understanding burden of TB/RR/MDR-TB among these populations, however they are classified as Most at Risk populations for TB. Data from routine NTLP program surveillance indicates that urban refugees contribute to unfavourable [loss to follow up] treatment outcomes in Kampala. Data from two regions indicates that Hoima 9% [4/45] and Arua 33% of the patients were refugees.

Whereas death rates have slightly decreased over the three cohort, loss to follow up has been increasing in the same time-period. This calls for increased patient support and monitoring as patients on treatment increase.

FIGURE 52: MDR-TB TREATMENT OUTCOME UGANDA, 2013 - 2015 COHORTS



STR for RR/MDR-TB

- To improve treatment outcomes, the country adopted WHO recommendation for use of the Short course regimen (STR) for MDR-TB for patients with RR/MDR-TB without additional resistance to injectable agents and or fluoroquinolones.
- STR for RR/MDR-TB was launched in March 2018, since then 52% of the newly enrolled RR/MDR-TB patients are using the STR regimen.

3.1.7.6 Supply Chain Management & Logistics Support

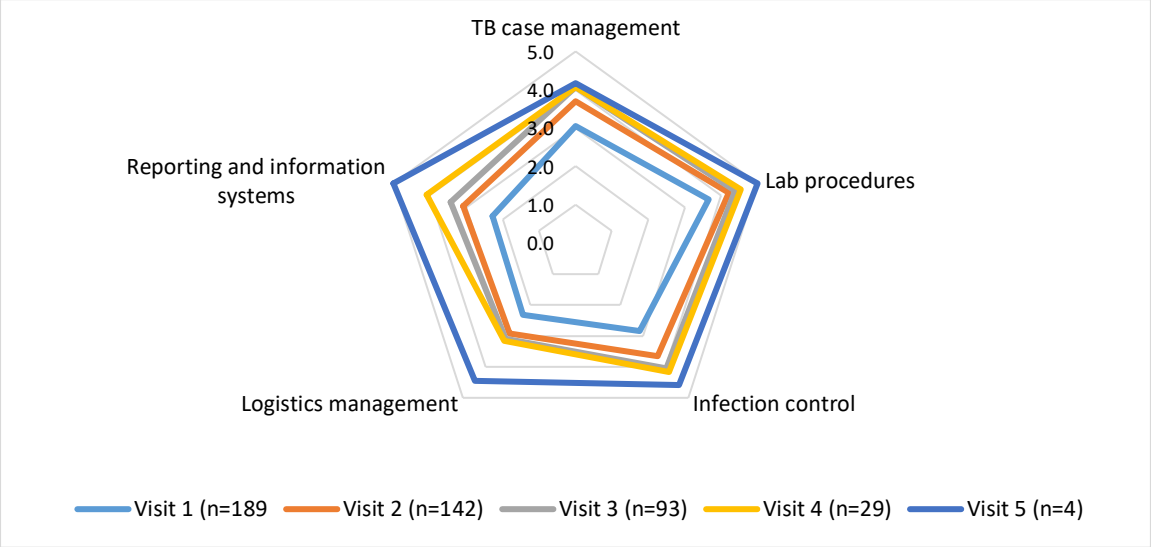
The NTLP has continued to receive logistics support from UH Placement of orders for year 1 of the GF grant; follow up of orders through coordination with GDF and NMS; clearance of shipments of TB medicines

and supplies in coordination NMS and NDA; National level bimonthly stock status monitoring in coordination with MoH, Quantification and Procurement Planning Unit (QPPU). Six bimonthly reports compiled and shared; monthly monitoring of the stock of MDR TB medicines and provision of guidance on redistribution of stock where necessary; Introduction of new fixed dose combinations (FDCs) for treatment of childhood TB. These provide favorable dosing of pediatric TB patients and reduce the number of pills to be swallowed; and transition to the shorter MDR-TB regimen. The required medicines procured and distributed to facilities. However, there has been a global shortage of the active ingredient of Rifampicin resulting in delays in shipments of first line TB medicines.

The NTLP successfully transitioned to the TB medicines Web based Ordering System (TWOs). This was preceded by training of trainers from Pharmacy Division, RRH logisticians, IP logisticians, Regional TB supervisors and NMS staff; training of all district biostatisticians; pretesting of the TWOS using facility data and subsequent rectification of the inaccuracies; and the revision and printing of TB medicines order forms.

Under the TB supervision, performance assessment and recognition strategy (TB SPARS), there was training of District TB/Leprosy Supervisors (DTLS) and District Laboratory Focal Persons (DLFPs) from 20 selected districts; a total of 457 supervision visits were completed by end of June 2018. Comparison with control districts showed a 42 percent increase in TB case notification in TB SPARS implementing districts. Performance in the 5 assessment areas by visit number is shown in the spider graph below.

FIGURE 53: TB SPARS PERFORMANCE BY VISIT NUMBER



The assessment areas are measured on a scale of 5. The graph shows a significant improvement across all assessment areas from the baseline (Visit 1) to visit 5. The greatest improvement is in reporting and information systems which assess the accuracy and timeliness of TB medicines orders and the HMIS 106a quarterly reports.

3.1.7.7 Laboratory Network

Use of new diagnostic technologies by end of June 2018, 240 GeneXpert systems covering 200 health facilities across 122 districts were available in country. Robust sample referral System from persons presumed to have TB: Through the NPHLN, MoH has established a sample referral system where samples are picked from all facilities to the GeneXpert machines and results relayed back using the same system. Samples that require additional tests are transferred from these hubs to the national TB reference laboratory (NTRL). The country also has built capacity for testing for extensively drug resistant TB using second line molecular tests like Line Probe Assay S-LPA) in addition to routine culture and DST. During the FY, 926 second line LPA tests were done. The NTRL was accredited as a supranational laboratory and currently

supports more than 20 countries in the region in strengthening TB diagnostics. The number of microscopy centers remained 1,543 units performing either bright field or fluorescent microscopy for TB diagnosis and treatment monitoring. The Microscopes contributed about 65% of all the bacteriologically confirmed TB that were notified during the financial year. NTRL established a National External Quality Assessment scheme (NEQAS) by blinded rechecking to ensure reliability of results from the Nation-wide microscopy diagnostic network in the year 2008 with a total participation of 801 TB diagnostic units by the end of 2016 a total of 1,543 health units were registered in the whole country with a quarterly participation rates of at least 1,379 (89%). Although there was increase in the number TB Diagnostic units in 2017 to 1,587 the participation in EQA was at the same rate 89% (1,406).

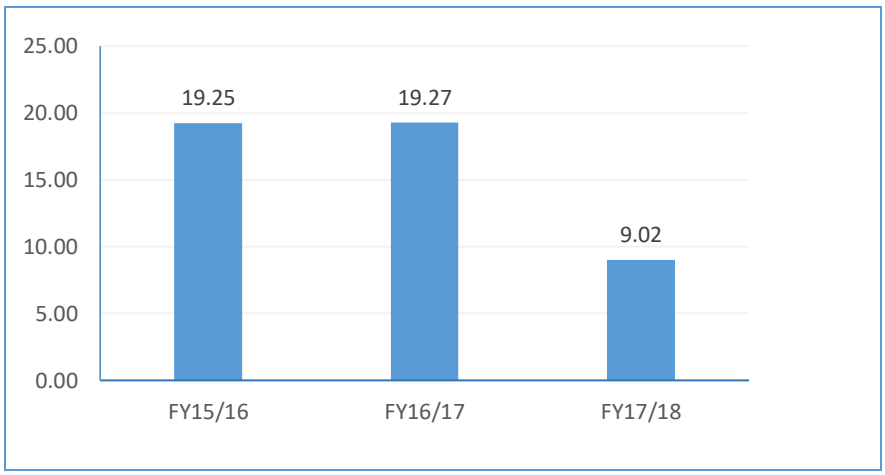
3.1.8 Malaria Control and Prevention

Malaria mortality Rate	Incidence of Confirmed Malaria	Test positivity Rate	Malaria cases as Proportion of all OPD	Malaria deaths as proportion of all deaths
9	**191**	**39**	**51**	**5**
Deaths per 100,000 pop.	Confirmed Case/1,000 pop	(%)	(%)	(%)

3.1.8.1 Malaria mortality

In the FY 2017/18, 3,503 malaria-related deaths were report in Uganda, signifying a 52% reduction from the figure reported in FY 2016/17 and 50% reduction from the FY 15/16. The reduction in malaria-related deaths resulted in a 53% reduction in the malaria mortality Rate. The district of Lira, Soroti, Kyotera, Hoima, Masaka, Kabarole, Kasese and Arua report more than 100 malaria related deaths in the period under review.

FIGURE 54: MALARIA MORTALITY RATE



3.1.8.2 Malaria Incidence

In the FY 2017/18, the reported incidence of malaria was 191 case per 1000 population compared to 272 case per 1,000 population in FY 2016/17. However, up to five district (Yumbe, Moyo, Adjumani, Lamwo and Namayingo) reported malaria incidence greater than 450 cases per 1,000 population. Compared to FY 2016/17, in FY 2017/18, the eight districts of Moyo, Yumbe, Kaabong, Kotido, Moroto, Abim and Arua, reported increase in incidence of malaria in excess of 50 cases per 1,000 population. Thirteen districts also reported increase in incidence of malaria between 1 and 50 cases per 1,000 population. All other district reported reduction in incidence of malaria.

The Uganda Malaria Reduction Strategy target required that by FY 2017/18, Uganda should be reporting just 5 inpatient malaria per 10,000 population. The reported number of inpatient malaria cases per 10,000 population moved from 219 cases per 10,000 population in FY 16/17 to 128 cases per 10,000 population in FY 2017/2018.

FIGURE 55: TRENDS IN MALARIA INCIDENCE RATE

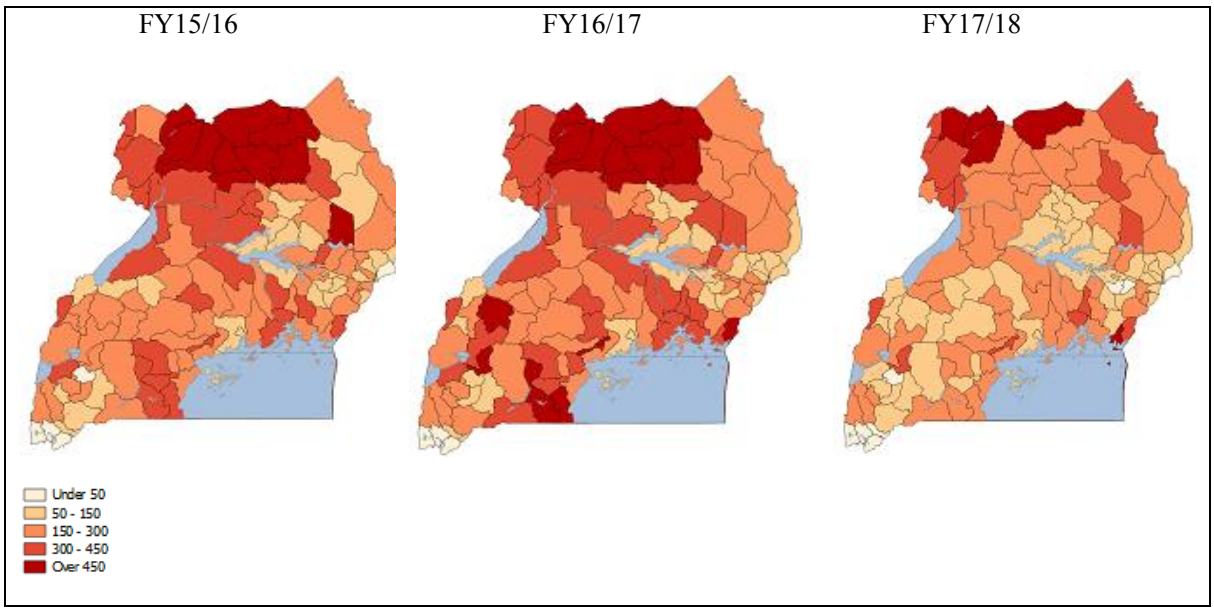
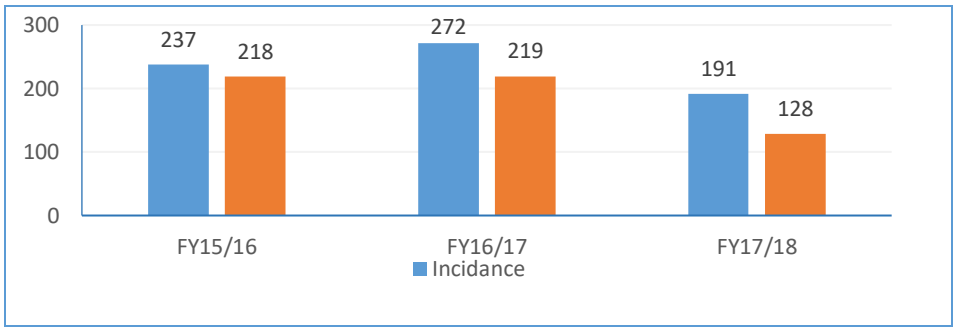


FIGURE 56: TRENDS MALARIA INCIDENCE RATE



3.1.8.3 Test positivity rate (TPR)

Reported TPR in Uganda reduced from 49% in the FY 2016/17 to 39% in FY 2017/18. The reported reduction in TPR is observed in all regions of the country except Karamoja. Following the 2015 malaria epidemic in northern Uganda, TPR in this area remained upwards of 60% in the FY 2015/16 and FY 2016/17. However, in the FY 2017/18 we see major reduction in TPR in this region. In Busoga and western Uganda, reported TPR for the FY 2017/18 mostly ranged between 30% and 50%.

FIGURE 57: MALARIA TEST POSITIVITY RATE FY2016/17 AND FY2017/18

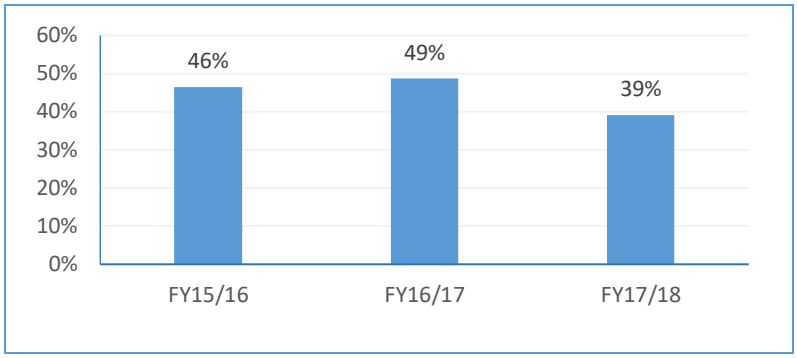
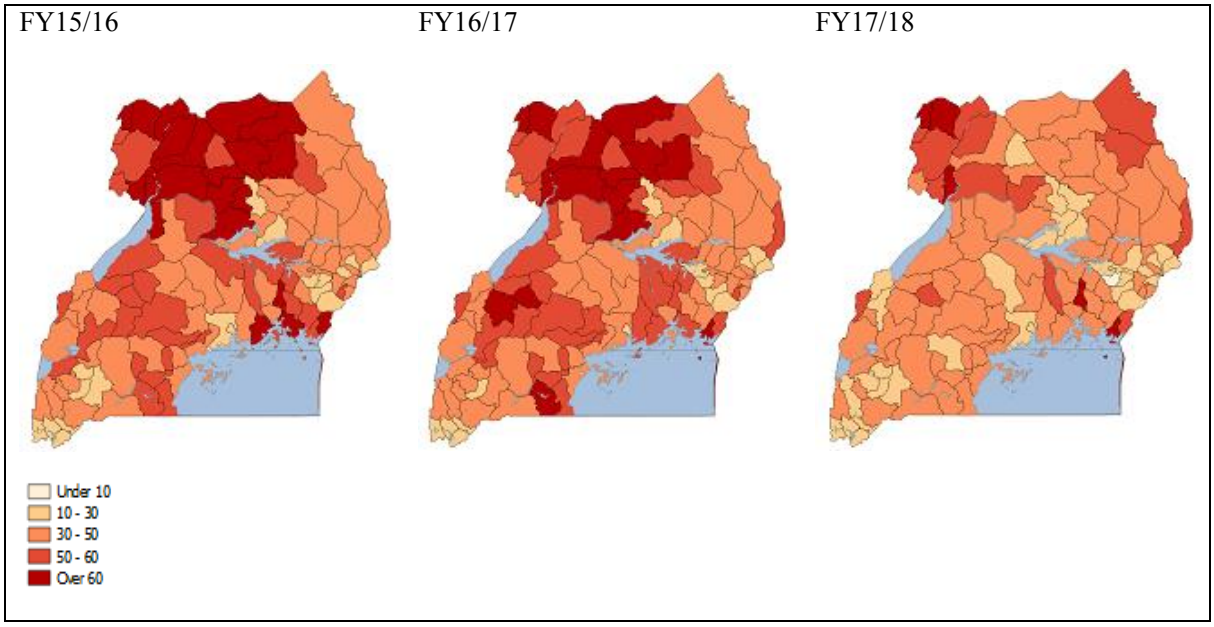


FIGURE 58: TRENDS IN MALARIA TEST POSITIVITY RATE



3.1.8.4 Integrated Vector Management

During FY 2017/18, the country also implemented larval source management on a pilot basis. The implementation of LLINs in both through routine channels and LLIN mass distribution campaigns. The Abuja target for LLIN and/or IRS coverage is 60%.

Indoor Residual Spraying (IRS)

In the FY 2017/18, the MoH with support from partners sprayed 1.3 million housing units with IRS protecting 17% of Uganda's population. However, the level of protection was far below the UMRSP target for this year of at least 30% of the population protected.

IRS was conducted in 15 districts in Eastern Uganda and the Lango region including the districts of; Amolatar, Alebtong, Butaleja, Butebo, Dokolo, Pallisa, Namutumba, Budaka, Serere, Bugiri, Kibuku, Otuke, Lira, Kaberamaido and Tororo sprayed with Actellic 30S insecticide with supported by USAID/PMI and DFID. A total of 1,280,593 (94.9 %) of the planned 1,348,862 houses were sprayed, and protected 4,339,137 (96.6 percent) people out of the total population found (4,553,942). The protected population included 120,847 children under five and 886,137 pregnant women.

The MoH also conducted IRS in 11 districts in northern Uganda as part of an epidemic response with support from the Global Fund. These districts included; Gulu, Nwoya, Oyam, Kole, Kitgum, Omoro, Pader, Lamwo, Agago, Amuru and Apac (Kwania) also sprayed with Actellic 30S insecticide. A total of 632,305 (90 %) of the 748,333 houses found in the 11 districts were sprayed. With support from PILGRIM, the MoH also conducted IRS on a pilot basis in the two sub-counties of Toroma and Kapujan in Katakwi district.

LLIN

As reported in the UDHS 2016, 62% of children under-5 years slept under an ITN while 64 percent of pregnant women slept under an ITN. During the FY 2017/18 the GoU with support from partners concluded the LLIN mass campaign where a total of 26.5 million LLINs were distributed country wide. Recent decreases in the incidence and test positivity rate of malaria in Uganda can be attributed largely to increased LLIN coverage following this just concluded mass campaign.

Preliminary results from this exercise show high coverage rates of over 95% in all districts. The MoH also continued to provide LLINs through routine distribution channels (ANC/EPI). A total of 1.2 million nets were distributed pregnant women and children under-5 years through health facilities.

Following the development and subsequent approval of the school nets distribution guidelines in the FY 2017/18, the MoH with support from PMI/USAID/MAPD conducted a large scale School LLIN Distribution pilot to explore this additional routine channel to sustain the LLIN coverage post mass campaign. In May/June, the MoH distributed LLINs through public Primary Schools in 22 districts in 5 regions in Uganda namely: Hoima, Rwenzori, Kampala (Central 2), Masaka (Central 1), and West Nile regions. A total of 640,569 Primary one and Primary four pupils from 2,727 schools were registered to receive LLINs. A total of 616,238 LLINs were distributed to registered students achieving coverage of 96% of the targeted population. The MoH plans to start distribution of nets through this channel in the FY 2018/19.

Larval Source Management

In the FY 2017/18, all larval source management activities were implemented on a pilot basis. Three sites in three districts (Wakiso, Nakasongola and Nakaseke) were reached with this intervention using different chemicals at each of the three sites for comparison. By the end of the year, this pilot was still on going and the results are yet to be published.

3.1.8.5 Entomological monitoring and surveillance

The MoH in collaboration with the PMI VectorLink Project Uganda conducts routine entomological monitoring in selected sites to provide data for decision-making. Data generated is used to justify decisions such as the type of insecticide to be used and selection of target areas for IRS. It also helps to assess the quality and impact of the vector control intervention. Tests conducted during the FY 2017/18 included the following:

- IRS quality assurance and decay rate monitoring in one sentinel site in each of the current 15 IRS districts.
- Bionomics studies to assess vector density, species composition and behaviour in five selected sites in eastern and northern Uganda Bugiri, Otuke, Tororo, Apac and Soroti.
- Pre-IRS pyrethrum spray catches (PSCs) to assess indoor resting vector density and species composition prior to IRS and post-IRS PSCs to assess impact of IRS in one selected site in each IRS district in eastern and northern Uganda.
- Insecticide resistance monitoring in 4 sentinel sites of Bugiri, Lira, Gulu and Soroti.

3.1.8.6 Capacity Building

The MoH NMCD with support from the DFID/UNICEF/WHO Capacity Development grant and in partnership with the MoH Vector Control Division and malaria development partners built capacity of Vector Control Officers and other staff at the Sub National level to conduct entomological surveillance, monitoring and on use of entomological data for decision making. Entomological training was conducted in 23 districts reaching 35 Vector Control Officers. Training was conducted in November 2017 in the Acholi/Lango Sub regions and in March 2018 in South Western region in response to the malaria epidemics in those regions.

As part of the IRS implementation in both the I5 Eastern and Northern Uganda IRS districts and the 11 Northern Uganda epidemic districts, a series of trainings employing the cascade model were conducted. Cadres of staff trained included: MoH staff, district Malaria Focal persons, Vector Control Officers, IEC Officers, Environmental Health Officers, District Biostatisticians, District Supply Officers, subcounty supervisors, parish store keepers, team leaders and parish supervisors. Similarily, ahead of LLIN distributions UCC and School distribution comprehensive trainings were conducted for staff managing operations at National, Subnational levels and the community/schools using approved training guidelines.

3.1.8.7 Policies and guidelines

Documents developed, approved and printed include the following;

- Integrated Vector Management Strategy for Malaria Reduction in Uganda, February 2017.
- Integrated Vector Management Implementation Guidelines for Uganda, February 2017.
- Insecticide Resistance Management Plan for malaria vectors in Uganda, May 2017.
- School-based long-lasting insecticidal nets distribution guidelines, January 2018.

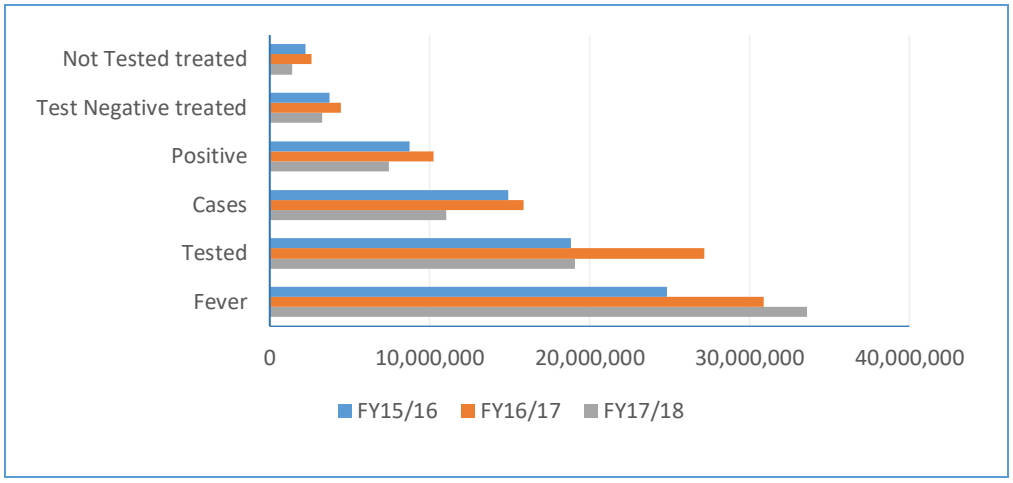
In the FY 2018/19 the NMCD and malaria development partners will disseminate, distribute and operationalize the guidelines developed.

3.1.8.8 Case Management

This strategic objective aims to ensure that at least 90% of all malaria cases in the public and private sectors as well as in the community receive prompt diagnosis and treatment according to the National Malaria Policy.

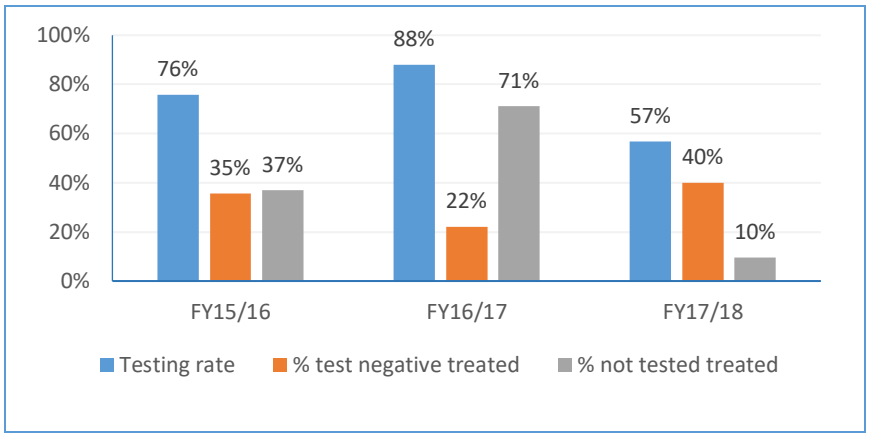
Uganda is currently implemented the Test-Treat-Track policy. In line with this policy, is the provision of treatment only after a confirmed diagnosis of malaria. The UMRSP target for the percentage of suspected malaria cases that had a parasitological test for the FY 2017/18 is 80%. The testing rate for malaria was only 57% in the FY 2017/18 down from an impressive 88% in FY 2016/17.

FIGURE 59: TRENDS IN PATIENTS WITH FEVER TESTED AND POSITIVITY RATE



Uganda also continues to grapple with the problem of treating test negatives. In the FY 2017/18, the percentage of test negative that received treatment for malaria was 40%, up from just 22% the previous FY. The MoH with its partners should gap this wasteful habit if Uganda is to optimize its investment in Malaria prevention and control.

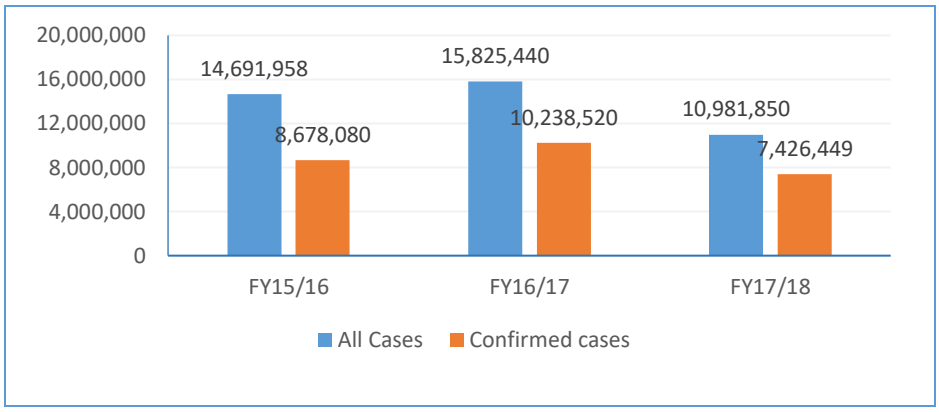
FIGURE 60: MALARIA TESTING RATE, % TEST NEGATIVE TREATED, AND NOT TESTED CASES TREATED



Treatment of uncomplicated malaria

In the FY 2017/18, there were 20 million people treated for malaria (both confirmed and presumptive) down from 31.7 million in FY 16/17, a 35% reduction. About half of all OPD cases were due to malaria in FY 17/18 down from 67% in FY 16/17. During the FY 2017/18, 32% of the malaria cases were clinical compared to the UMRSP for the FY of 25%.

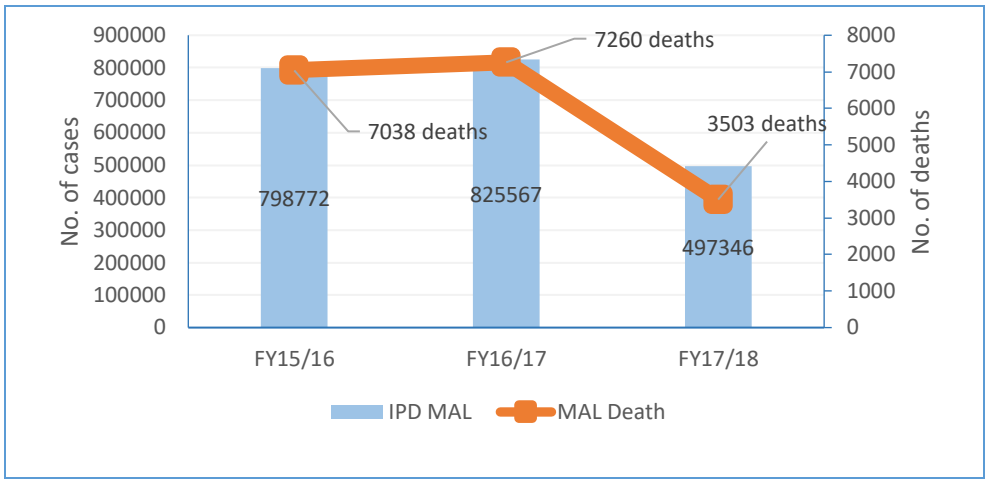
FIGURE 61: MALARIA OPD CASES



Treatment of severe malaria

Similar to the observed reduction in the reported number of outpatient malaria cases between FY 2016/17 and FY 2017/18, there was a reduction in the reported number of inpatient malaria cases and malaria deaths. The reported number of inpatient malaria cases reduced from about 826,000 in FY 2016/17 to just over 497,000 in the FY 2017/18. The number of deaths reduced from 7,260 in the FY 2016/17 to 3,503.

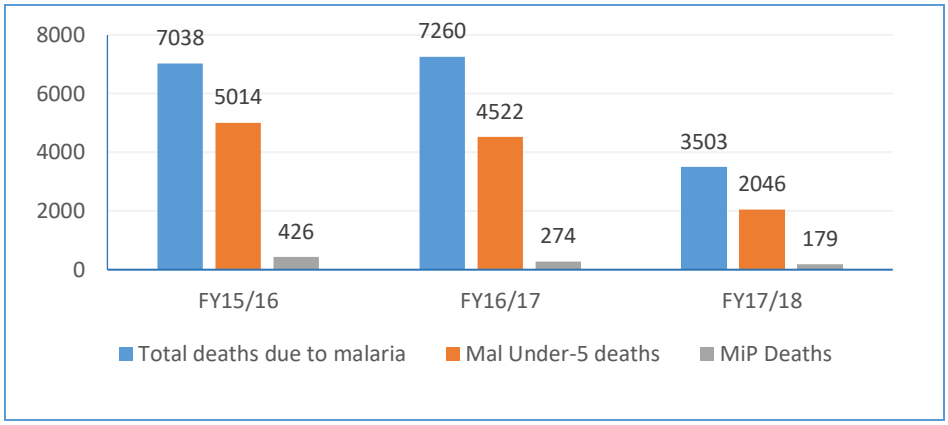
FIGURE 62: MALARIA IPD CASES AND DEATHS



A breakdown of the reported number of malaria deaths shows similar trends in the number of reported deaths among children Under-5 years of age and pregnant women. In the FY 2017/18, malaria deaths in children under 5 years reduced to 2,046 from 4,522 in FY 2016/17 and 5,014 in FY 2015/16. Among pregnant women malaria related deaths reduced from 426 in FY 2015/16 to 274 in FY 2016/17 and finally 179 in the FY 2017/18.

As observed earlier, a consistent supply of anti-malarial medicines, improvements in confirmation of malaria among other recently scaled up interventions were critical in ensuring this marked reduction in malaria deaths.

FIGURE 63: MALARIA MORTALITY TRENDS

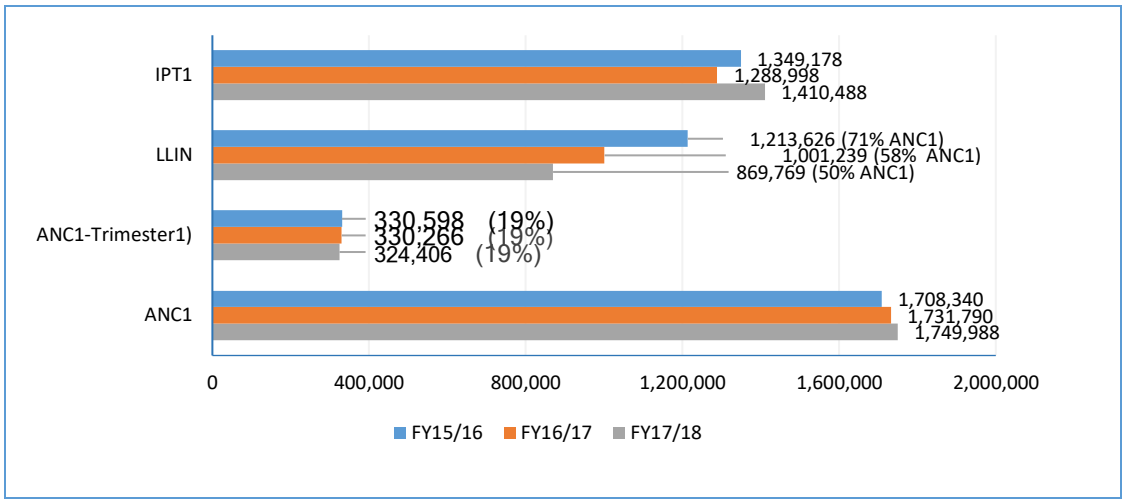


The MoH continues to provide quality service to inpatient malaria cases with minimal case fatality rate reported in the last three financial years. Since the FY 2015/16 reported case fatality rate has remained below one percent. Case fatality rate in the FY 2017/18 was 0.7% a slight reduction from the 0.9% reported in FY 2015/16 and FY 2016/17.

IPTp

The Uganda Malaria reduction strategy target states that by the FY 2017/18, 79% of pregnant women attending ANC1 receiving one or more doses of IPTp. However, the reported proportion of pregnant women attending ANC1 receiving one or more doses of IPTp in the FY 2017/18 was 68%, a significant increase from 57% in the FY 2016/17.

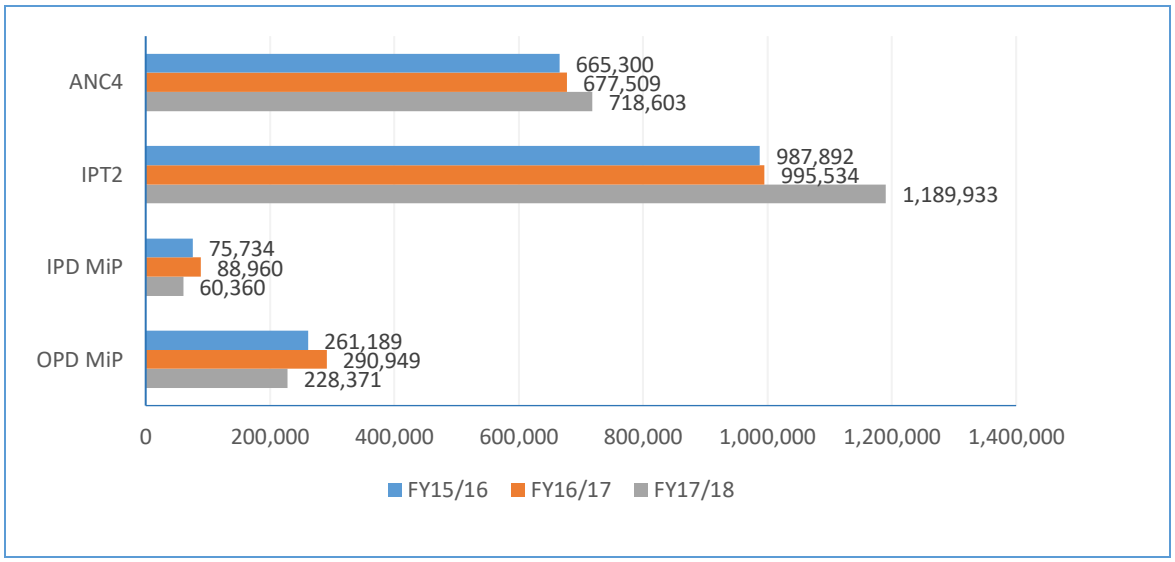
FIGURE 64: PREVENTION MIP



During the FY 2017/18, there 1.7 million pregnant women attending ANC1 of these, 19% of the pregnant women who attended ANC1 did so in their first trimester of pregnancy. Attendance of ANC1 in the first trimester has remained constant in the last three financial years. While the number of women attending ANC1 has increased in each Financial Year since FY 2015/16, the number and proportion of women receiving LLIN has reduced. In the FY 2017/18, the proportion of pregnant women receiving LLIN was 50% down from 58% in FY 2016/17 and 71% in FY 2015/16. In the FY2017/18, 1.4 million pregnant women received IPTp1 and 1.2 million pregnant women received IPT2

In the FY 2017/18, there were 228,371 OPD malaria in pregnancy cases down from 290,949 in in the FY 2016/17. The IPD malaria in pregnancy cases reduced from 88,960 cases in FY 2016/17 to 60,360 in FY 2017/18.

FIGURE 65: TRENDS IN MIP OPD, IPD



3.1.8.9 BCC

In the FY under review NMCP;

- Launched the Parliamentary Forum on Malaria as well for the MAAM initiative. During this launch, His Excellency the President of Uganda Y.K Museveni was the Guest of Honour.
- Reached-out for the purpose of their participation in the fight against malaria to religious and cultural leader.
- Held advocacy meeting with the MoES.

- Conducted seven Mass media campaigns throughout the Country, largely focused on the LLIN distribution exercise and involved over 63 radio stations and five TV stations airing messages on the LLIN.
- Engaged in mass media campaigns for the promotion of ACTs with a Green Leaf.
- Launched the Live your Dream campaign with support from MAPD with a focus on Malaria in pregnancy and Net use.
- With support from Partners, orientation for VHTs, as well as Religious, Opinion and Cultural leaders on community dialogues for action using local existing resources within the community. Relatedly, Village Malaria prevention/health Club were formed in a number of districts with support from MAPD.
- Orientation in inter personal communication was conducted for health workers, Champions and Head teachers in 46 districts.
- With support from MAPD, placed 38 TV screens outpatient departments at selected health Facility as a way to engage patient with correct messages while they await service at health facilities.
- As part of MAAM implementation, supported the establishment of Malaria clubs in schools with an objective of using pupils as malaria champions and change agents. School activations through Music Dance Drama (MDD), school debates/quizzes, branded sports completions and orientation of Teachers were also with support from partners.
- Working with partners, developed and disseminated 36 IEC messages for all the Malaria intervention areas.
- Developed; counselling guide for VHTs and Health providers, Talking points Malaria Champions and Posters with support from Communication for Healthy Communities.
- Held the 13thworld malaria day commemoration celebrations celebrated which took place in Mpigi district with over 100 people in attendance. The theme of the day was "End malaria for good" and the slogan was "children against malaria". The occasion was graced by Hon. Sarah Opendi, the State Minister for Health as the Guest of Honour.

3.1.8.10 Capacity Building

- Conducted orientation of VHT and community leaders on formation of malaria clubs in 46 districts.
- Trained cultural leaders in 46 districts on their role in malaria prevention and control.
- Held a ToT of health workers on inter personal communication.
- Trained teachers in preparation for the School net distribution campaign on malaria prevention and control as well as on development of malaria clubs and use of children as agents of change in health. This was done with the aim of creating a critical mass of school children that can be malaria agents of change.
- A national ToT for malaria surveillance done with over 30 participants. A regional ToT was done in which 14 districts participated.
- In collaboration with USAID supported MAPD project, over 45 DHTs were trained in malaria data use and analysis.
- National ToT refresher for EPR for Malaria with CPD/WHO/DFID was done and 25 National level trainers trained.
- With support from CPD/WHO 529 health workers trained from 82 districts 10 regions venues (Jinja, Soroti, Mbale Tororo, Lira, Arua, Gulu, Hoima, Mbarara and Kabale.
- Training on conducting Therapeutic Efficacy studies on-going.

3.1.8.11 Policies, guidelines and SoPs

Developed Guideline for LLIN distribution in refugees and schools – BCC component and designed the communication plan.

3.1.8.12 Resource Mobilization

During this period the MoH was awarded a Global Fund Grant of $185m to combat malaria. The Ministry also received support from DFID worth $60M for Strengthening Uganda's Response in Malaria (SURMA)

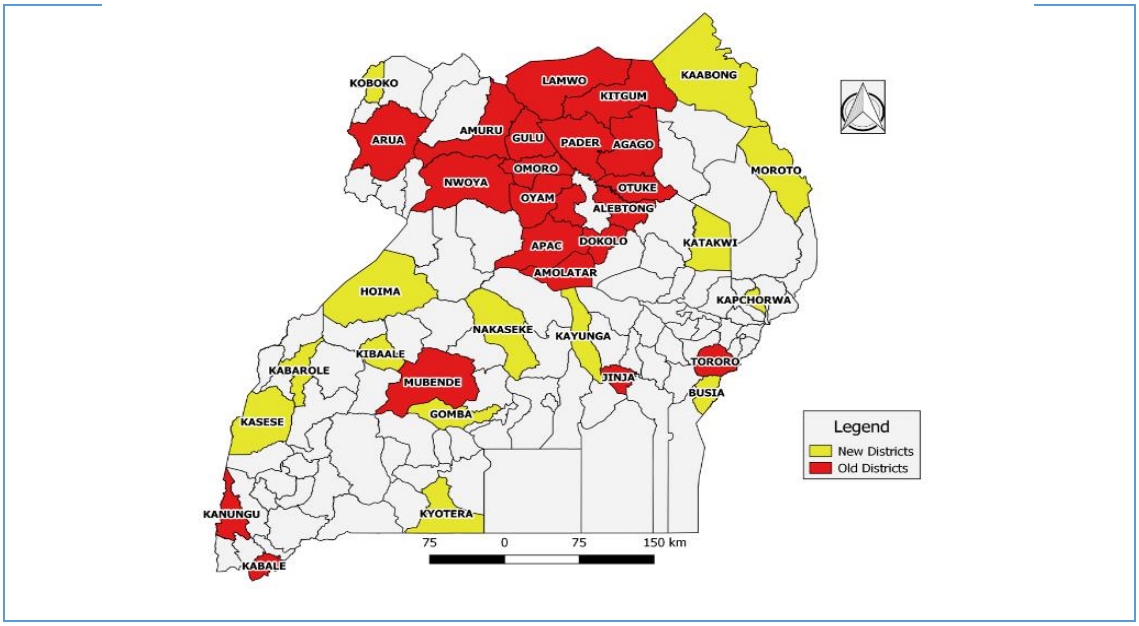
project that will cover 25 districts in Northern and Eastern Uganda. PMI/USAID has also agreed to support Malaria reduction efforts with a grant of $30m.

During the FY under review, 24 million doses of ACTs, 3.7 million vials of Artesunate, and 27.8 million Rapid diagnostic tests were distributed to the public and private not for profit facilities. An End User Verification Survey done in July 2017 showing that 97% of the health facilities had adequate stock of anti-malaria medicines.

3.1.8.13 Sentinel surveillance

In FY 2017/2018, the Uganda Malaria Surveillance Program (UMSP) expanded the malaria-sentinel site surveillance program from 21 to 35 outpatient health facilities located in 32 districts in the country with support from PMI/USAID/MAPD and in collaboration with IDRC.

FIGURE 66: LOCATION OF SENTINEL SURVEILLANCE SITES IN UGANDA



3.1.8.14 Epidemic detection and Response

The MoH responded to malaria epidemics in Kisoro, Nwoya and Black water fever upsurge in Manafwa. The Malaria cases in Kisoro were reduced to pre-epidemic levels. The program is currently responding to Nwoya and Manafwa epidemics.

3.1.8.15 Reporting, Reviews and evaluations

During the FY under review, the MoH with support of partners conducted a mid-term review of the Uganda Malaria Reduction Strategy (2014V- 2020). The review recommended a Mass-Action-Against-Malaria as a framework for accelerating the implementation of the UMRSP.

MoH produced two Quarterly Bulletins on Malaria, 51 Weekly Malaria Status reports and one malaria Executive Briefs as tools to track progress in malaria control and it shared these with relevant stakeholders. The MoH also initiated a malaria-death audit process to as part of its efforts to achieving zero deaths due to malaria.

The program in collaboration will ALMA developed a malaria scorecard to facilitate performance monitoring and management decision making in the same period. It also as part of her international commitment, submitted Uganda data for the production of the world malaria report in the same FY.

3.1.8.16 Operational Research

- A Piperonyl Butoxide (PBO) study is ongoing in 48 districts to compare the efficacy of nets impregnated with Butoxide with those that were not in the country for possible roll out of the new intervention.
- Entomological studies including: Insecticide susceptibility status, Insecticide resistance mechanisms, insecticide resistance intensities in 4 districts of Arua, Apac, Tororo and Kanungu.
- IRS Susceptibility studies and Insecticide Resistance monitoring conducted.
- Pilgrim study conducted Health Facility Surveillance and Entomological monitoring as part of evaluation of intervention MDA+IRS+LLINs, vs IRS+LLINs vs LLINs vs LLINs.
- A Scientific Colloquium and IDRC malaria stakeholders' dissemination meetings were held in which several studies were discussed and shared with malaria implementing partners.

Challenges

- A resurgence of malaria after cessation of interventions. This is critical in resource limited settings like Uganda. As part of the epidemic response in Northern Uganda, all 11 districts received one round of IRS with Actellic. However, at the end of this FY we saw a rebound of malaria in all the districts.
- Limited resource envelope to comprehensively respond to epidemics. The response is still piece meal because mobilizing funds for interventions such as IRS, Larviciding and Mass Drug administration is a very arduous task at district and National level.
- A number of communities do not have good coverage of the health system such as Karamoja and highland areas.
- The surveillance system for the private sector and community is still weak. This means outbreaks are sometimes detected late.
- The unstable political environment of neighbouring countries leading to mass influx of refugees and populations along borders that are not having access to malaria interventions.

Recommendations

- Advocacy and mobilization of resources of contingency funds at district and National level for epidemic response.
- Scale up and Fast track implementation of interventions of malaria reduction for eventual elimination.
- Strengthening iCCM and increased investment in facilities and health system building blocks to cover vulnerable populations.
- Development of a holistic private sector and community strategy to strengthen surveillance and response.
- To sustain the gains in reducing malaria cases and mortality, NMCP and partners should promote integrated program approach and strengthen health care delivery system to ensure at all levels: prompt diagnosis, appropriate treatment, tracking and timely referral as and when required.
- There is need to emphasize data use at subnational level and point of collection through training and mentorship and in with collaboration with the Division of Health Information.
- Based on the positive lessons learned from the limited IRS programs, MoH and partners should prioritize IRS in some districts while rolling out across a wider geographic coverage in a cost effective manner to rapidly reduce vector density and transmission with a clear plan for sustainability of the gains upon exit.
- NMCP should urgently implement a plan for mass action against malaria using and engage multi-sectoral approach at individual, household, community, district, institutional, national and international level; to create a mass movement against malaria in line with the framework for "malaria smart" families and communities, for zero malaria death by 2020 and a malaria free Uganda by 2030.

3.1.8.17 Prevention and Control of HIV and AIDS

During 2017, Uganda continued to work towards sustainable HIV epidemic control. The HIV burden in the country is still high with approximately 1.34 million adults and children living with HIV in 2017. Adults aged 15 years+ accounted for 93% of this burden, with 60% of HIV-infected adults being women, of whom,

95,490 were pregnant women. It is estimated that about 50,360 new HIV infections occurred during the year, 42,800 among adults. Young adults 15 – 24 years accounted for 41% of new HIV infections, with male: female ratio of nearly 1: 3. AIDS-related mortality claimed approximately 26,000 adults and children, 61% of whom were adult men aged 15 years+.

The 2016/17 Uganda Population based HIV Impact Assessment (UPHIA) revealed adult HIV prevalence of 6.2% among adults, with women more disproportionately affected (7.5% versus 4.3%). HIV prevalence varied among geographical regions from 3.1% in West Nile region to 8% in South Buganda and South Western Uganda. The Urban: rural disparity of prevalence continues with 7.1% versus 5.5%.

Despite of the high burden, Uganda has made considerable progress in recent years, rolling out effective HIV prevention and treatment services and reducing new HIV infections and AIDS-related mortality. Uganda has signed up to the UN political declaration on the Fast Track and to end AIDS by 2030 and His Excellency the President launched the Presidential Fast Track to end AIDS by 2030 in July 2017. The ambitious targets for HIV prevention and treatment including the triple 90-90-90 by 2020 were recently elevated to 95-95-95 by 2020.

The AIDS Control Program in MoH continued to provide technical leadership to the public health response to HIV. The Program provides: i) Technical leadership through developing technical policies, guidelines and standards for HIV epidemic control based on the latest scientific; ii) Capacity building of sub-national entities and resource mobilization for HIV services; iii) Monitoring implementation of epidemic control services to ensure that no population group is left behind; and iv) Coordination of partners involved in the public health response. The summary of performance according to the main thematic areas is as follows:

1. **HIV Treatment**:

Antiretroviral treatment services aim to achieve high levels of viral suppression, clinical improvement and consequently reduce viral transmission. The main achievements during the year comprised of:

- **ART Enrolment**: Adults and children enrolled on HIV treatment increased to 1,1140,550 by June 2018, a coverage of 85% of all HIV-infected individuals, surpassing HSDP target of 80% for 2017. Of these, 93% are adults 15 years+, while 7% were children aged 0 – 14 years.

- **Roll out of New HIV Treatment Guidelines**: During the year, the 2016 Consolidated Guidelines for HIV Prevention and Treatment that introduced universal HIV "*Test and Treat*" were rolled out countrywide and adopted by 90% of HIV treatment facilities. In total, 1,669 (83% of) facilities providing HIV treatment were mentored in the use of the new guidelines. Two rounds of support supervision of this activity were conducted, findings of which were fed back to DHT, facility teams and IPs and used to refine the roll out process

- **Revision of the HIV Treatment Guidelines:** During the FY, owing to emerging evidence, the 2016 Consolidated Guidelines were further revised to provide for more efficacious Dolutegravir (DTG)-based treatment regimen as the preferred first-line regimen for Uganda; revised guidelines for management of advanced HIV disease, and other aspects of HIV treatment. The revised guidelines and training materials will be rolled out through training of trainers, regional, district and facility teams during the FY.

- **Improved Paediatric HIV Treatment Formulations and Guidelines**: The Ministry adopted the use of LPV/r as the optimized treatment formulation for paediatric HIV. During the FY, LV/r pellets was provided to 30% of facilities offering paediatric ARVs services, falling short of the target of 50% due to stock out of the pellets. About 1900 children (60% of those on ART under 3 years) were started on LPV/r – based regimens.

- **Adolescent HIV Treatment Services**: During the FY, the Program expanded Adolescent HIV training to 30 more facilities thereby increasing coverage of training to 70%. As a result, adolescent friendly services were made available in 59% of facilities from 39% in 2015/16.

- **Viral Load Monitoring**: The Program continue to refine strategies for provision of VL testing services for monitoring antiretroviral treatment. The coverage of viral load testing increased to 80% of ART

clients, 88% of whom achieved viral suppression. During the FY, the training curriculum for Viral Load monitoring was revised, two national training were conducted; regional training of facility staff is due next FY.

- **Decongestion of HIV Treatment Facilities**: As part of the new HIV treatment guidelines, the Ministry adopted the Decentralized Service Delivery Model (DSDM) during the FY, where stable clients should have less frequent clinical assessment visits. The Program developed implementation guidelines, job aides and training materials, and roll out of DSDM commenced with 5 national level training of 205 national trainers. In additional, 224 facilities had on-site training, and 121,428 or 11.2% of ART clients countrywide have been enrolled on various DSDM approaches.

- **Guidelines for Pyscho-social Support**: To improve adherence and retention on ART – critical elements for meeting the 90-90-90 targets, the Program developed standard guidelines for psychosocial support of clients on ART and indicators for tracking psychosocial support were introduced in the HIV treatment card. In addition, the Program adopted the ANECCA training curriculum on paediatric and adolescent psychosocial support and conducted one national training of trainers and a regional training in Karamoja region.

- **Scaling up provision of Third-line ART**: With increasing clients failing second-line ART regimens, the Program is scaling up capacity for the more expensive salvage therapy. A National third-line ART Committee was constituted by DGHS and had bi-weekly meeting, reviewed HIV genotyping results of individuals failing on second-line regimens and made third-line treatment recommendations. Stakeholder meetings were held between ACP, PEPFAR and the HIV genotyping laboratories (UVRI and JCRC) leading to HIVDR testing being available to eligible patients in public health facilities. The clinical committee also reviewed the backlog of HIVDR test results at CPHL, and 897 out of 1,197 of the results reviewed were communicated to facilities through IPs. In addition, to build capacity for third-line, 60 health workers were trained using a case-based approach.

2. HIV Testing Services

During the FY, the Program shifted focus from general population-wide testing to a diagnostic approach that requires more focused testing to identify the remaining undiagnosed HIV-infected individuals in order to move efficiently towards the first target of triple 90-90-90 cascade. As part of this broad outlook, the following were achieved.

- **Updated of HIV testing Guidelines**: HIV testing guidelines were updated to incorporate more efficient testing approaches including Assisted Partner Notification (APN) that is associated with higher yield rate, HIV self-testing for some population groups, and the use of the screening tools for adults and children respectively.
- The total number of HIV tests conducted during the year decreased to about 8 million tests in 2017, with a test yield of 2.9%, a significant fall from 11,742,311 tests during the previous year. However, even with targeted testing, test yield of 2.9% was lower than the previous year.

3. IEC Messages Development and Dissemination

During the FY, the Program continued collaboration for IEC/BCC activities to promote uptake and adherence to HIV prevention and treatment services as well as primary prevention of HIV transmission. The program worked with Communication for Health Communities (CHC) project and developed and disseminated educational message through various channels including mass media, road-side bill boards, posters and leaflets covering different themes. IEC/BCC coordination meetings to harmonize IEC/BCC messages were also supported by the Program.

4. Condom Programming

During the FY, 120 million male condoms were procured and distributed in the public and private sector. Unfortunately, this fell short of the national need for the year. This gap was compounded by delayed deliveries from the Global Fund and by National Drug Authority (NDA) post shipment testing and clearance. The findings of the assessment of the comprehensive condom programming conducted with support from the Global Fund in conjunction with the MakSPH that revealed significant shortfalls in supply at community level were released. They informed the distribution of condom dispensers in various places across the country.

5. PMTCT

By the end of 2016, all district in the country were implementing Option B+. Significant gains have been made in averting vertical infections and Uganda is on the verge of virtual elimination of mother-to-child transmission. To confirm these findings, a PMTCT impact evaluation study commenced during the FY with baseline data collection in facilities sampled from across the country. The committee appointed to conduct data validation as part of the WHO mechanism for independent certification of eMTCT commenced its work and will provide an independent report on how far the country's eMTCT targets have been achieved.

6. Safe Medical Circumcision

During the FY, approximately 878,000 young men were circumcised in facilities across the country bringing the cumulative number circumcised since 2012 to 3.8 million. This represents slightly increased outputs, perhaps due to the recent policy shift where the number of Tetanus Toxoid (TT) booster immunizations required before surgical circumcision is conducted were reduced from two doses four weeks apart, to only one at time of surgery. The UPHIA data on the coverage circumcision of men aged 15-49 years revealed an increase from 26% in 2011 to 43% in this survey. However, there was wide regional variation on coverage of circumcision from 14% in Mid Northern region to 69% in Mid-Eastern region.

7. Strategic Information for HIV Epidemic Control

Provision of accurate strategic information to guide strategic planning and monitoring of HIV epidemic control continued as area of focus during the FY and the following were achieved:

- **Spectrum Estimates**: National and subnational estimates of new HIV infections, AIDS-related mortality, etc. were obtained through triangulation of epidemiological data and Spectrum modelling, and were used for our international reporting obligations, quantification of supplies, focusing of interventions and monitoring of HIV testing and treatment cascade.
- **UPHIA**: Testing and analysis of the data arising from this national HIV survey whose field work completed last FY was conducted and a draft survey report prepared. The survey has provided vital information on current dynamics of the HIV epidemic including the HIV testing and treatment cascades, magnitude of new HIV infections, viral load suppression, HIV drug resistance, PMTCT and HIV testing indicators, sexual behavior, etc. This information has informed refinement of prevention and treatment strategies in the country
- **2017 Annual HIV surveillance round**: The annual HIV surveillance round for this FY was funded through from Global Fund rant. Blood samples were collected from 30 antenatal sentinel surveillance sites, and laboratory testing is still underway at UVRI. The data will continue the trend observation that now spans over 30 years, and also contribute to triangulation in Spectrum to obtain national and subnational estimates of HIV magnitude.
- **Case-based surveillance**: HIV Case-based surveillance which involves longitudinal follow up of individuals through the sentinel evens of HIV-infection, diagnosis, enrolment into treatment, ART initiation, viral suppression, and eventual death is the future of HIV surveillance systems. However, it requires substantial investment in information systems. This FY, the Program with support from WHO developed national guidelines for case-based HIV surveillance, and continued to collaborate with CDC-supported METS project on the pilot for CBS in Kabarole and Hoima districts including use of unique case identifiers.
- **Revision of HMIS tools**: The 2016 Consolidated Guidelines for HIV Prevention and Treatment, and the need to better track HIV epidemic control, called for update of HMIS HIV patient information systems. ACP conducted consultative meetings to update HMIS tools, draft versions of which are awaiting piloting and eventual adoption roll out.
- **Quarterly cleaning of HMIS data:** The online DHIS-2 facility reporting system is the main source of routine HIV other health services data from public health facilities. To partially address quality concerns of data through this system, the Ministry conducted quarterly regional and national data review meetings with facility and district teams. ACP staff were integral part of the activity that has improved the quality of data that is subsequently used for planning and evaluation of HIV services.
- **Setting of Annual National and District Level Targets for HIV Epidemic Control**: In order to better inform planning and monitoring of HIV epidemic control efforts in the country, for the first time, ACP conducted objective setting of annual national and district level targets of critical HIV services. With UNICEF support through ANNECA, ACP provided targets on ART enrolment, HIV testing, SMC, Condom distribution, HIV prevention for young people etc., that will fill a void in national and district HIV epidemic control efforts. The activity involved mathematical modeling with Spectrum Goals and

other models and triangulation of data from various sources, as well as national and regional consultative meetings. The targets await dissemination in next FY.

- **New Health Sector HIV/AIDS Strategic Plan 2018 – 2023**: To provide strategic guidance for HIV epidemic control in the health sector, ACP developed a new HIV/AIDS strategic plan for the public health response. This activity involved technical consultations supported by GoU, CDC and WHO. A draft plan awaits endorsement by MOH Senior Management.
- **Surveillance of HIV Drug Resistance**: Emergence of antiretroviral drug resistance is the inevitable consequence of widespread use of ART. The Ministry collaborating with UVRI set up a surveillance system to track HIVDR through various activities including HIVDR surveys. The levels of HIVDR determined in 2016/17 UPHIA was >15%. This along with HIVDR data from the other sources informed the Ministry's adoption of DTG-based combinations as the preferred first-line regimen for Uganda.
- **Mortality Analysis:** During the preceding FY, ACP obtained a grant from the Catalytic Funding stream of Global Fund to conduct a trend analysis of HIV/AIDS, TB and Malaria morbidity and mortality as part of the impact assessment of about 15 years of intensive support for the three diseases. Field work for this analysis which should harness these "*low-hanging fruits*" for impact evaluation, was conducted by Makerere University School of Public Health. Findings will be disseminated during the next FY.

3.1.9 Epidemiological Disease Surveillance (ESD)

Achievements

- EPI-IDSR was carried out in (Mityana, Kagadi, Kibaale) districts, these were poorly performing districts in reporting. Supervision was also carried out in Nebbi and Pakwach and these are new districts in which capacity building for surveillance was needed Nakaseke District.
- There was an outbreak of CCHF that stared in July 2017. It was controlled.
- 240 Health Workers were trained in Epidemic preparedness and response in west Nile region (Adjumani, Yumbe, Koboko, Arua, Nebbi and Zombo) districts. Supported by AFENET.
- 50 Health Workers trained in Hoima region in Cholera outbreak and response. This was sponsored, by government of Uganda, WHO, UNICEF, MSF & Uganda Red Cross.
- IDSR capacity building for Health Workers in Yumbe, Koboko, Adjumani, and Kiryandongo followed by community based surveillance training in the same districts. sponsored by Action Against Hunger (AAR).
- Participated in Cholera Prevention and control workshop, a one-day workshop was held in Faculty of Food Science and Technology, Makerere University supported by UNICEF.
- Participated in Regional surveillance workshop in Vaccine Preventable Diseases (VDPs) in Masaka supported by WHO.
- ESD ably responded to Marburg outbreak in Kween and Kapchorwa, Cholera outbreak response and control in Hoima, central and Eastern Regions and Anthrax in Arua, Kween and Kiruhura districts.
- Responded to CCHF in Nakaseke, Luwero, RVF in Mityana, Kiboga and Kiruhura. Together with UNEPI, ESD ably participated in the planning and implementation of the OCV campaign in Hoima District.
- Two ESD Coordination meetings were held.

Challenges

- Lack of Emergency Operational Fund that is readily accessible
- ESD is extremely understaffed, however, Biostastician, Senior Research Officer and Secretary have been recruited but we still lack critical staff.

Recommendation

Re-establish emergency rapid response fund.

3.1.10 Vector Control

Key functions of the Vector Control Division;

- Develop standards and guidelines related to vectors and vector borne disease control.
- Participate in control/elimination of vectors and vector borne diseases/NTDs including investigations, monitoring and evaluation.
- Provide technical support related to vector and vector borne disease control.
- Resource mobilization for control of vectors and vector borne diseases/NTDs.

Achievements

- 591 district Officials were met and 372 ToTs trained on bilharzia.
- 5,821,380 people treated during Bilharzia Mass Drug Administration (MDA) in 82 districts. Supported by USAID/RTI Envision and SCI.
- Bilharzia and Worm Control Program (SWCP) data review meeting held with officers of 26 schistosomiasis low and high endemic districts.
- Parasitological re-assessment of Bilharzia prevalence done in 18 districts supported by USAID/RTI/EBVISION.
- International Schistosomiasis Global Alliance (SGA) meeting was successfully held in Kampala supported by SGA & SCI, UK.
- A standardized a multi-parallel PCR diagnostic test against Kato-Katz Stool test during transmission assessment survey (TAS) was done in three districts of Bundibugyo, Ntoroko and Amuria supported by GlaxoSmithKline, Task Force for Global Health-Neglected Tropical Diseases Support Center, Decatur, GA, USA, Smith College, Northampton, MA, USA.
- 595 hydrocele, 101 hydrocele-hernia co-morbidity, 83 lymphedema and 92 elephantiasis cases were confirmed successfully in pilot districts supported by Sight savers/UKaid/DFID.
- IEC materials for LF Morbidity management and Disability Program (MMDP) and other NTDs developed and translated successfully supported by Sight savers/UKaid/DFID and USAID /RTI/ENVISION.
- Trained district officers and supervisors on line listing of Lymphatic filariasis cases for MMDP services supported by Sight savers/UKaid/DFID.
- Organized 2 meeting on Dossier preparation for LF supported by USAID /RTI/ENVISION.
- Trachoma Rapid (TRAs) and Impact (TIAs) assessments conducted in 27 and 7 districts respectively supported by USAID /RTI/ENVISION.
- Trachoma impact assessments of TT and TF prevalence was conducted successfully in 15 districts.
- A high-level advocacy meeting for Karamoja region held in Moroto.
- Face and hand washing baseline surveys conducted in 17 trachoma endemic districts supported by The Carter Center.
- Cross-border meeting on Trachoma elimination held in Kenya attended by the Program Managers from both countries. Supported by Sight savers/UKaid/DFID.
- TRAs were conducted successfully in the 19 refugee settlements supported by USAID /RTI/ENVISION.
- Workshop for Trachoma surgeons conducted in Iganga hospital supported by Sight savers/UKaid/DFID.
- Passive surveillance for Human African Trypanosomiasis (HAT) focusing on early detection was strengthened in 146 health facilities of West Nile region.
- HAT cross-border meetings held in Kampala and Juba. The meetings agreed on implementing collaborative activities in refugee camps of three districts (Adjumani, Yumbe and Moyo) and areas on border points. Supported by FIND & BMGF.
- Out of 41,794 persons screened, one was confirmed a HAT case by the medical team led by HAT Program Manager, a South Sudanese refugee residing in Itula. The case was successfully treated in Moyo Hospital.
- 348 health workers from peripheral health workers and 24 lab technicians were competently re-oriented onto HAT case detection and diagnosis by HAT Program Manager. Supported by FIND & BMGF.
- HAT Program Manager and his MoH counterpart successfully attended a training session of application of Atlas software in Addis Ababa, Ethiopia. WHO promised to donate computers and accessories to MoH for supporting Atlas software.

- Onchocerciasis Mass Drug Administration (MDA) conducted and 1,808,573 people were treated in 21 districts during each MDA cycle. Over 90% MDA coverage was achieved in each endemic district.
- Country elimination data reviewed in 2017 by Uganda Onchocerciasis Elimination Expert Advisory Committee (UOEEAC) and concluded that Onchocerciasis was eliminated in seven foci and transmission interrupted in eight foci while transmission is ongoing in two foci. MDA was halted in 18 districts which eliminated or interrupted Onchocerciasis transmission and 4,555,099 people are no longer at risk of disease.
- Simulium black fly population controlled in river breeding systems across three districts via application of Temephos Larvicide. Black fly biting density reduced from 19 man-bites per day in 2013 to 6 man-bites/day in 2018.
- A cross-border meeting of officers of Uganda with South Sudan counterparts to establish collaboration on Onchocerciasis elimination was held successfully and an action plan developed for 2018/2019.
- Onchocerca volvulus prevalence assessment among refugee settlement camps in two districts (Hoima and Lamwo) was done. No case with Onchocerca volvulus microfilaria was detected among refugees in Lamwo and Hoima districts by skin snip microscopy.

Challenges

- Dilapidated building, leaking roof.
- Inadequate funds for planned activities, most of the accomplished ones were those supported by partners.
- Many positions left Vacant after retirement of several officers.
- Officers de-motivated due to lack of promotion.
- Lack of vehicles, computers, laboratory field equipment for M&E e.g. microscopes.

3.1.11 Disability and Rehabilitation

The mandate of Disability and Rehabilitation Unit is to decrease the morbidity and mortality due to disabilities from visual, hearing, movement and age related impairments. These can arise from damage or harm suffered by a person before or after birth. Such deprivation or loss of competence includes conditions like deafness, blindness, physical disability and learning disabilities.

Achievements

- Disseminated Eye Care Strategic Plan & Clinical Guidelines to the districts for implementation.
- Received & distributed donated 770 wheelchairs from Later Day Saints church and the Rotary Club of Nsambya.
- Trained 30 clinicians and technicians in wheelchair assessment and maintenance.
- Carried out advocacy for Eye care services during commemoration of International World sight day 14 October 2017 held in Gulu District. The theme was ***"Make Vision Count"*** and key message from the Hon. Minister of Health to the people was to seek medical assistance from qualified eye health workers in case their eyes are not fine.
- Carried out advocacy for friendly older persons' services during commemoration of International Older Persons Day held in Kiboga District. The Speaker of Parliament requested for development of guidelines on the Health care of older persons in the country.
- Carried out advocacy for persons with disabilities during International Disability Day 3rd December 2017 in Kamwenge District. The key message was to improve access to PWDs to information, accessible buildings and sign language. The Chief Guest was His Excellence, The President of Uganda.
- International Spinal Bifida and Hydrocephalus day 25th September commemorated in Kampala district with call to parents to love the disabled children and empower them with education and maximize their potential.
- Carried out support supervision to ENT departments in the RRHs to scale up early screening and intervention to prevent deafness.

- Carried out advocacy meetings with district leaderships for inclusion of rehabilitation services to people with disabilities and the elderly in their budgets.

Challenges

- Inadequate support to orthopeadic and optical workshops.
- Over dependence on donated assistive devices like wheelchairs, crutches, Low vision devices, Spectacles for people with disabilities.

Recommendations

Mobilize resources from the MoFPED as per the Presidential directive for direct & protected funding to the orthopeadic and Optical workshops. This will solve both problems.

3.1.12 Non-Communicable Diseases

The mandate of the NCDs program is to coordinate all efforts geared to prevent and control NCDs in Uganda including but not limited to:

1. Make policies and multi-sectoral strategic plans for prevention and control of NCDs
2. Create awareness on NCDs and their risk factors
3. Make guideline on prevention and management of NCDs
4. Support Regional and General Hospitals and HC IVs to prevent, treat and control of NCDS.
5. Train health workers in prevention, treatment and control of NCDs.
6. Participate in mobilizing resources for the prevention, treatment and control of NCDs.

H.E President Y.K Museveni launching the National Physical Exercise Day on June 8th 2018 at Kololo Independence Grounds

Achievements

- Made the final draft for the NCDs multi-sectoral strategy that awaits costing.
- His Excellence the President of Uganda, Y.K Museveni launched the National Physical Exercise Day on June 8th, 2018.
- Raised NCDs awareness by commemorating World Diabetes Day and World Sickle Cell Day.
- Held a cancer awareness campaign in Bushenyi and a Diabetes walk in Gulu
- Held support supervision visits to 11 RRHs of Mbale, Soroti, Moroto, Fort Portal, Gulu, Lira, Mubende, Hoima, Arua, Jinja and Mbarara.
- Held support supervision visits in 27 General Hospitals / HC IVs including Kiryandongo Hospital, Tororo hospital, Mityana hospital and Kisoro Hospital. Others include Kigorobyo, Kikube, Kyangwali, Bwijanga, Buliisa, Nyamiyanja, Rwekubo, Rugaaga, Kinoni, Bwizibwera, Walukuba,

Bugembe, Buikwe, Nakapiripirit, Kyegegwa, Bukuku, Kibito, Kasanda, Kikanda, Muko, Rushoroza, Rukungiri and Kebisoni HC IVs.

Lessons learnt
The population is not aware on NCDs and their risk factors and therefore more effort needed to sensitize the community on what to do to prevent and control NCDs.

Challenges
- In adequate funds to implement planned activities
- In adequate human resource to implement planned activities
- Lack office space

Recommendations
- Prioritize NCDs in the next budget
- Strengthen collaboration with other key stakeholder such as UN agencies and other government sectors for prevention and control of NCDS.
- Mobilize additional resources from partners.
- HSC should recruit staff as per approved structure.

3.1.13 Integrated Curative Services

Achievements
- Marked National Palliative Care and Hospice event. Awareness on palliative care increased.
- Held stakeholders meeting to promote collaboration in promoting access to palliative care medicines and drug harm reduction.
- Palliative Care Policy Cabinet memo submitted to MoFPED for financial implications clearance. Comments from MoFPED being incorporated/addressed.
- Participated in End of Life Care meeting in Salzburg Austria.
- 8 Medical board meetings were held. 56 civil servants examined and 22 were recommended for early retired on medical grounds. 18 patients referred aboard for medical treatment.
- The World Hepatitis Day commemorated in Dokolo. Created public awareness about Hepatitis B in the community and mass screening/vaccination done in the district.
- 11 districts in Busoga region started Hepatitis B vaccination. Prevalence rate is 6%.
- 200 health workers trained on the use of Selexion machines. Positive clients can now be further evaluated for treatment for Hepatitis B.
- 39 districts supervised on the Hepatitis B activities. Tools used in sensitization, screening and vaccination disseminated to the health workers.
- Training and support supervision to health facilities and DHOs' offices on Infection Prevention and Control conducted in 6 WHO supported districts visited. All the 60 SDS/GLSL supported districts visited by the Teams.
- 2 out of 4 Obstetric Fistula TWG meetings held.
- World Obstetric Fistula Day commemorated in Kibuku district.
- 8 fistula camps were held in selected hospitals. 125 surgeries done.
- 2 support supervision visits to fistula camps
- Participated in the Surgical camp in Mubende region conducted by the Association of Surgeon of Uganda (ASOU).
- Specialized clinics in Soroti, Mbale and Jinja RRHs assessed.
- Specialist outreach to 10 health facilities in hard to reach areas coordinated.
- 2 stakeholder meetings held to finalize the Alcohol Control Policy.
- Commemorated the World Mental Health Day celebrated on 25th Nov 2017 at MoH HQS. Public awareness raised about the theme: "Mental health first aid", as a means of prevention of overt mental illness.
- Terms of reference for the tobacco control committee developed, No smoking signage drafted, regulations on tobacco product labeling and packaging drafted.
- Tobacco Control regulations finalized.

- Revised the Hospital Board and Health Unit Management Committee guidelines.
- Supervised Mubende, Fort Portal, Masaka, Mbarara and Kabale, Jinja and Arua RH Mental Health Units.
- Supervised dental units in 6 RRHs Mbarara, Masaka, Kabale, Mubende, Fort Portal and Hoima. Inventories assessed and requirement gaps identified.
- 20 Dentists trained of injection safety and control of hepatitis infection.
- One stakeholders meeting held to review oral health policy.
- 3 out of 10 primary school children screened for oral diseases.
- Attended 1 conference on re-integrating oral health into general health attended in Nairobi (Sponsored by UNIVERSIY OF Colombia).
- Finalized the Medical Internship guidelines.
- 18 members of the Uganda Medical Internship Committee (UMIC) were appointed.
- Held 4 UMIC meetings and deployed 964 medical interns in 34 internship training centers
- Paid allowances to 970 medical interns in all the internship training centers.
- All 33 training internship centres were supervised and data was collected.

Challenges
- Irregular meetings for early retirement of civil servants on medical ground.
- Lack of data collection tools for Hepatitis B.
- Difficulty in sensitization of the population and training of health workers on Hepatitis B.

3.1.14 Emergency Medical Services (EMS)

These are emergency services dedicated to providing out of hospital acute medical care and transport to definitive care.

Achievements

- A national survey on the state of EMS in Uganda was conducted by MakSPH with support from German Ministry of Cooperation through Malteser International. The survey established that these ambulances lack most of the lifesaving medicines and equipment for monitoring and treating patients during transportation, and lack of a nationally coordinated structure for all EMS services in the country.
- EMS policy has been developed awaiting approval by Top Management and Parliament. To develop EMS Strategic plan in FY 2018/19.
- Draft EMS guidelines and manuals developed. Tools incorporated in the revised HMIS.
- National Guidelines on Referral system and referral of patients abroad developed and ready for presentation to Top Management.
- 290 health workers from hospitals and HC IVs were trained supported by MKCCAP and KOFIH.
- Scholarships under URMCHIP advertised for 14 MMED Emergency Medicine and 15 Diploma in Emergency Medicine.
- Pulse Lab Kampala and partners have developed a system using Global Positioning Systems (GPS) to evaluate in real time the use of the ambulances and is being piloted in 15 districts in West Nile and Rwenzori region. The application utilizes trackers installed in the vehicles. Phase 1 of the pilot has been completed and found to be effective in monitoring the movements of the ambulance in its catchment area.
- Participated in the review of the HMIS to include emergency medical services data from the prehospital level to accident and emergency units in hospitals.

3.1.15 Nursing Department

The Nursing Department is charged with the responsibility to maintain the quality of nursing services in the country in accordance with the government policies and priorities.

Achievements

- Conducted 13 technical support supervision visits to: 3 RRH Fort Portal, Hoima Gulu & Moroto, 8 general hospitals, Kamuli, Iganga Bundibugyo, Kasese, Bushenyi Kitgum, Amudat, Matany Kaabong, Masindi, Kiryandongo, Kiboga, Abim, Lyantonde and CURE Pediatric hospital, HC 1Vs Kamwenge, Kenjojo, Rushere, Buyende, Buikwe, Budaka, Lamwo, Kotido and Isingiro. HC IIIs, Lorengedwat and Karita. Refugee camps, Kiryandongo, Nakivale. Nurses and Midwives are motivated to work as a result of our supervision visits.
- Nursing Scheme of service has been finalized, endorsed awaiting costing and cabinet memo.
- Nurses and Midwives are well informed on retirement processes and professional issues.
- Documentation has improved partographs are now about 65% managed in the health facilities visited.
- Neonatal corners are functional
- Strengthened Leadership and management skills
- There is improvement in code of conduct, absenteeism and attitude is fair.
- After dissemination of uniform standards most nurses and midwives are dressed in uniform.
- Nurses and Midwives now understand the new scheme of service.
- Nurses and midwifery international events were successfully implemented in Jinja and Kitgum districts. (Research papers were presented and clinical audits done - Mulago & Jinja.

Challenges

- Transport – only one vehicle in a poor mechanical condition.

3.1.16 Central Public Health Laboratories (CPHL) and National TB Reference Laboratory (NTRL)

CPHL/UNHLS is the technical arm of the MoH responsible for Stewardship and Governance of Health Laboratory services in the country, with a vision: "Quality Laboratory Services available and accessible to all people in Uganda".

Achievements

1. HIV VIRAL LOAD (VL) MONITORING AND EARLY INFANT DIAGNOSIS

a) Number of viral load samples tested

In FY 17/18, a total of 1,045,514 samples were received at CPHL, Mildmay Uganda back up lab and Arua MSF point of care test centre, of which 1,033,456 samples were tested and 12,058 samples were rejected (0.3%). This translates to an average of 85,000 samples tested for VL referred from 2,095 health facilities both public and private. VL testing at CPHL is done in an accredited laboratory, ensuring high quality and reliable results.

With annual target of 1,200,000 VL tests, we achieved 86% of the target for the year and **907,489 individual** clients on ART accessed a VL test in the review period.

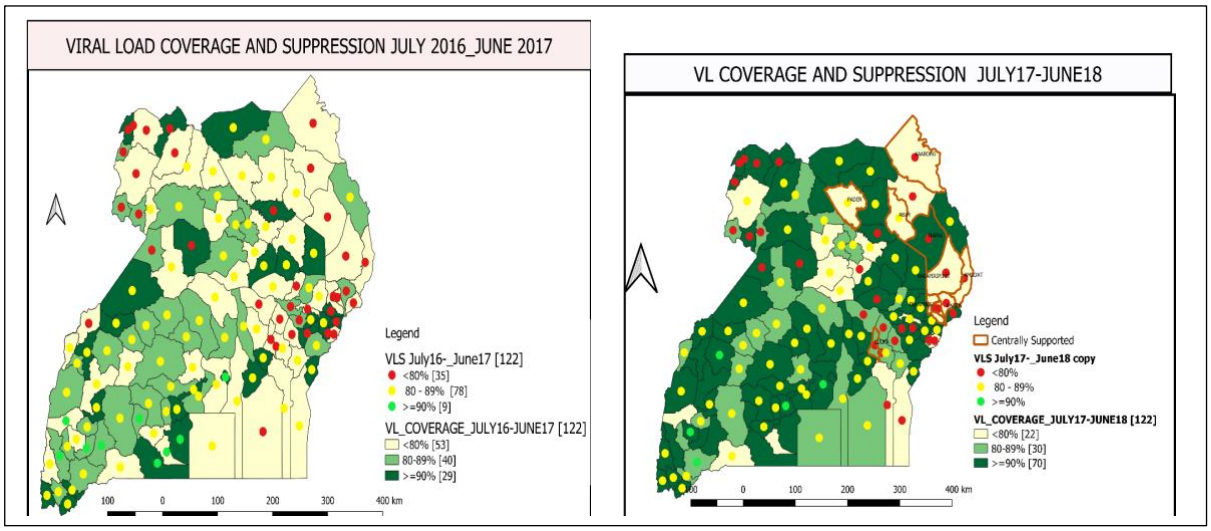
In FY 17/18 all the 100 hubs and health facilities within the Kampala region were transitioned from DBS to plasma sample collection as a result of improved infrastructure at the laboratory hubs, and we were therefore able to meet the 1:1 target of DBS to Plasma ratio as per the quantification and procurement plan.

b) Viral load coverage

The country recorded 89% VL coverage in FY 17/18, with regional variation as demonstrated in the graph below. Whereas the previous year July16 – June 17 had only 29 districts with greater or equal to 90%, this year July 17 – June 18, 70 districts (in dark green) scaled up VL testing to over 90% in line with the UNAIDS 90-90-90 targets. Lango, Karamoja, East Central and Mid-Eastern regions had lower virological coverage of their clients on ART compared to the other regions. Kalangala and Arua districts continue to have low VL coverage rates below 80%.

This improvement in program performance could be attributed to a number of factors including: strong commitment from Top Management of MoH, adequate financial and technical support from partners,

effective partner coordination with monthly data review meetings, focused mentorships, strong community participation and advocacy of PLHIVs, intensified district-led viral load demand creation campaign efforts, and efficient laboratory system strategy, VL commodities security, a reputable sample referral system and results network as well as a robust monitoring system, and visualization dashboard.



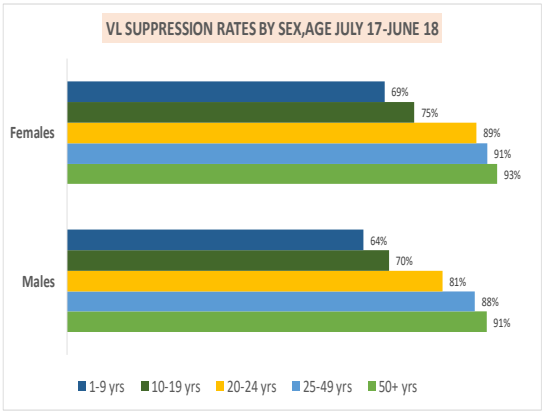
c) Viral suppression

At national level, 88.3%(799,529/ 907,489) of individuals on ART that received a viral load test were suppressed. There were geographical variations noted across the country in the West Nile (77.7%), North East (84.4%) and Mid-Eastern (84.7%) regions recorded lower suppression rates than Kampala (91.2%) and South Western Uganda (90.9%) in this reporting period. There were more marked variations in suppression rates by age and sex, with men having lower suppression than women while children less than 10 years have the lowest suppression rates (69% females and 64% males) among the age categories. CPHL with support from partners has been implementing viral load quality improvement collaboratives to address non-suppression and low viral load coverage. The promising /best practices from the collaboratives will be scaled up to the identified high viraemic health facilities for intensified mentorship and support to achieve 90-90-90 for accelerated epidemic control.

A ten-point package to address non-suppression has been developed and will contribute to achieving epidemic control once implemented effectively.

FIGURE 67: VIRAL SUPPRESSION RATES JULY 2017 – JUNE 2018

% SUPPRESSED						
REGION	<10yrs	10-19 yrs	20-24 yrs	25-49 yrs	50+ yrs	Total
Central 1	72.0%	77.5%	88.8%	91.5%	94.0%	89.9%
Central 2	65.0%	71.2%	87.5%	89.6%	91.8%	87.6%
East Central	55.6%	64.2%	82.4%	86.9%	88.9%	84.3%
Kampala	81.2%	82.2%	88.0%	92.1%	95.1%	91.2%
Mid Eastern	61.2%	67.0%	80.3%	86.8%	89.6%	84.7%
Mid Northern	57.0%	61.9%	86.0%	88.7%	90.2%	85.8%
Mid Western	65.0%	74.2%	89.8%	90.4%	92.4%	88.4%
North East	58.5%	60.7%	82.0%	87.3%	89.4%	84.4%
South Western	69.6%	79.2%	89.5%	92.3%	94.8%	90.9%
West Nile	47.4%	50.9%	79.0%	80.5%	83.4%	77.7%
National	66.5%	72.8%	87.5%	90.1%	92.0%	88.3%



SOURCE: CPHL DATABASE JUNE'18

d) Sample rejection rate

Viral load sample rejection is a quality indicator for continuous quality improvement by the referring health facility regarding quality of sample referred, fidelity to the VL testing algorithm as well as proper

documentation of patient information accompanying the referred sample. High rejection rate results in sample recollection hence high result turn -around time and high costs of retesting. The sample rejection rate for the reporting period averaged at 0.3%. Concerted efforts had been put in place to reduce these inefficiencies through mentorships, CQI projects and data review meetings to bring it down from as high as 7% in the previous years to 0.3% which was below our set target of 1% for FY17/18.

e) Results turnaround time

In FY17/18, the viral load results mean turn-around time improved from an average of 4-6 weeks to ≤ 2 weeks in 70% of the health facilities visited during support supervision activities in the reporting period. This was achieved by implementing electronic results delivery at the 100 laboratory hubs as well as in over 300 other health facilities.

f) HIV drug resistance testing

In FY17/18, CPHL referred over 1,000 samples to JCRC and UVRI for HIV drug resistance Genotyping and facilitated the third line committee to hold capacity building trainings for RRH teams to interpret results and choose optimal regimens for third line for the over 150 patients with major second line mutations identified during the review period.

g) HIV Early Infant Diagnosis (EID).

A total of 131,822 samples of babies referred from all over the country were tested for HIV using the DNA-PCR at CPHL, 74,444 (56.5) of which were first PCR and 51,859 (39.3%) were 2nd PCR; and the overall positivity rate was 3.2% (4261) for all the samples.

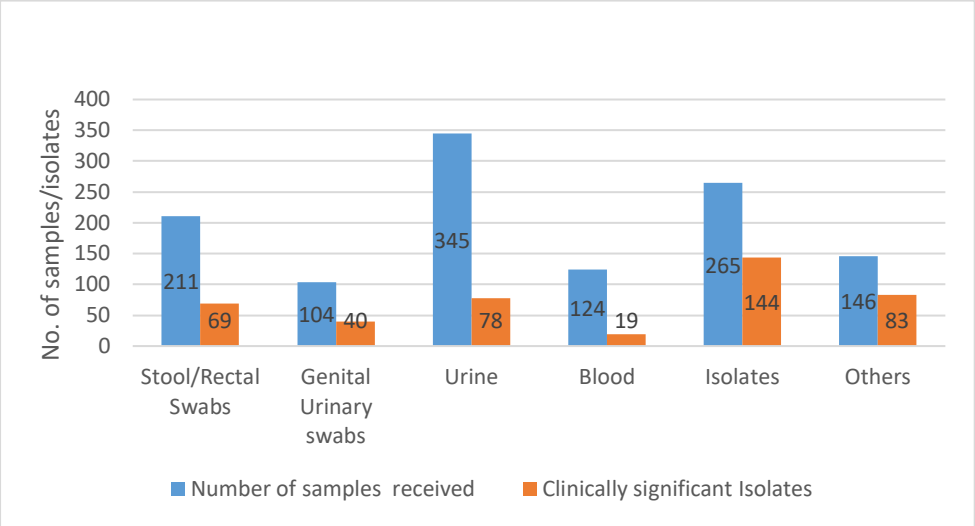
2. BACTERIAL DISEASE OUTBREAK INVESTIGATION AND ANTIMICROBIAL RESISTANCE TESTING

a) Bacterial isolates

The National Microbiology Reference Laboratory (NMRL) at CPHL receives samples referred for both disease outbreak investigations and routine clinical diagnosis for patients' management and care. The Laboratory also receives bacterial isolates from some of the RRHs (Arua, Jinja, Kabale and Mbale) which are being strengthened to provide bacterial culture and sensitivity testing for quality assurance purpose. All samples and isolates received go through culture and sensitivity testing processes.

During the FY 2017/18, a total of 1,046 samples were received, 246 (23.5%) of which were bacterial isolates sent for quality assurance purpose. 433 (41.2%) samples had clinically significant bacterial organisms isolated from them. The major pathogens identified during the period includes Vibrio Cholerae (samples from Kampala, Hoima, Kyegegwa, Mbale and Kween), Shigella dysenterea (samples from Kyegegwa), Streptococcus pneumoniae, Klebshiella pneumoniae, and Staphylococcus aureus, isolated in samples mainly from Kampala and isolates referred from the RRHs.

FIGURE 68: TOTAL SAMPLES RECEIVED AND THE BACTERIAL PATHOGENS ISOLATED FROM EACH SAMPLE TYPE

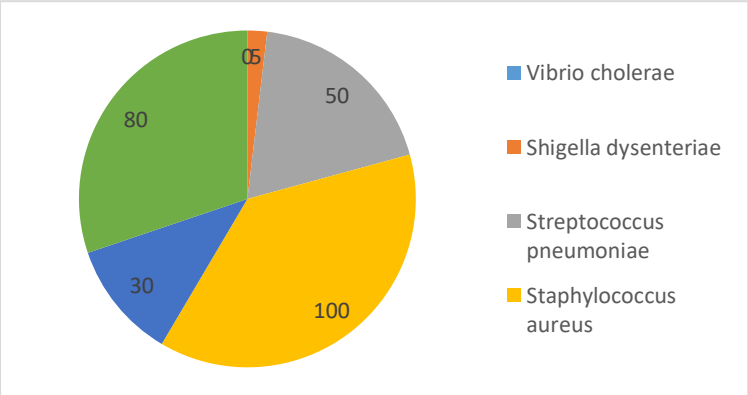


As shown in the graph, only 144 (54.3%) of the bacterial isolates had clinically significant organisms recovered, while the rest were either normal bacterial flora or contaminants. This means that the hospitals sending the isolates needed more technical support to be able to distinguish between pathogens and normal flora in the particular sites.

b) Antimicrobial resistance (AMR)

A systematic review of up to 10 isolates of each of the bacteria common in disease outbreaks, community and hospital-acquired infections were identified and their antimicrobial resistance patterns studied against most basic antibiotics used in treating them. The common bacteria Vibrio cholera and Shigella dysenteriae were studied against Tetracycline; Staphylococcus aureus and Streptococcus pneumonia were studied against Penicillin, while Escherichia coli and Klebsiella pneumoniae were studied against Ciprofloxacin.

FIGURE 69: COMMON BACTERIAL ISOLATES AND THEIR RELATIVE ANTIBIOTIC RESISTANCE



As shown in the pie chart, Staphylococcus aureus were the most resistant, followed by Klebsiella pneumonia, Streptococcus pneumoniae, Escherichia coli and Shigella dysenteriae, while all the Vibrio cholerae isolates were sensitive to tetracycline.

3. HEPATITIS B SCREENING AND VL TESTING

a) Hepatitis B Screening

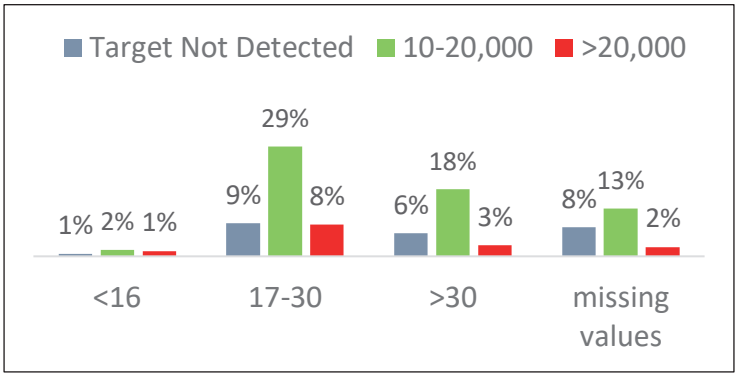
CPHL provides screening and testing services for Hepatitis B virus and sickle cell in the community of Butabika and surrounding areas as part of corporate social responsibility. We also provide testing services on special occasions such as world Hepatitis B day among others. In the year 2017/18, we tested a total of 22,400 people, 7% (1568) of whom were positive all of whom were referred to Kiruddu Hospital for evaluation and treatment were necessary.

b) Hepatitis B viral load testing

Within the FY 2017/18, we performed a total of 2,629 Hepatitis B VL test out of which 398 (15.1%) had VL above 20,000 International Units (IU) per milliliter (ml) of blood, 1,602 (60.9%) had the VL between 10IU/ml and 20,000 IU/ml and the rest had undetected VL. Below is a graph showing the Hepatitis B VL

test results segregated according to age group. The majority (46%) of the people tested were in the age group 17-30 years while 23% of the patients did not have their age indicated in the request forms.

FIGURE 70: RESULTS OF HEPATITIS B VIRAL LOAD TEST ACCORDING TO AGE GROUP, JULY 2017 TO JUNE 2018



4. SICKLE CELL RAPID SCREENING AND HAEMOGLOBIN ELETROPHORESIS TEST

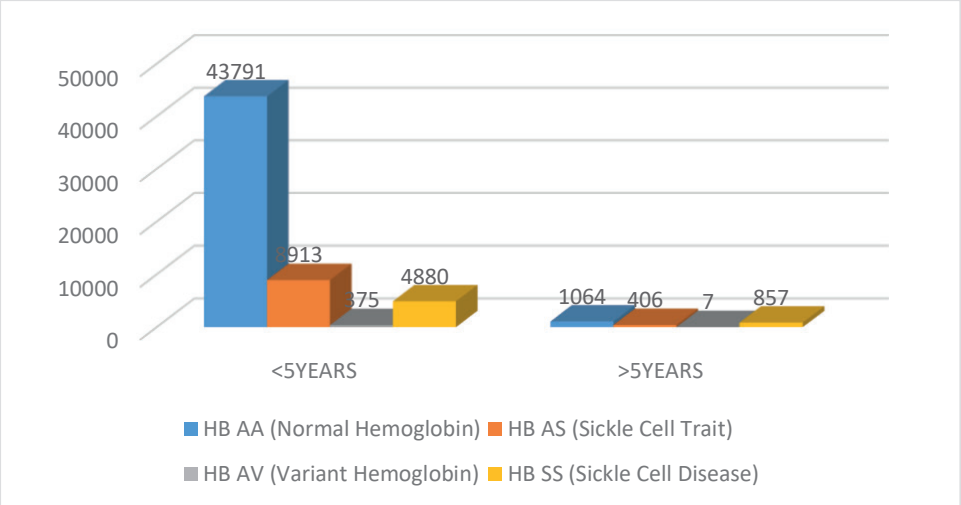
a) Sickle cell rapid screening test

CPHL undertook a number of sickle cell campaigns in partnership with CSOs and health facilities around the country to create awareness about the genetic disorder in the community during which a total of 15,113 people were tested using rapid sickle cell screening kits, majority of whom were unmarried youth. 10,517 (69.6%) of those tested had normal hemoglobin (Hb AA) while 4,416 (30.4%) were carriers (Hb AS).

b) Sickle cell hemoglobin electrophoresis testing for early diagnosis

In the FY 2017/18, CPHL did a total of 60,293 sickle cell testing using Hb electrophoresis as part of its early infant diagnosis program, 44,855 (74.4%) of whom had normal Hemoglobin (Hb AA), 9,319 (15.5%) were sickle cell carriers, 5,737 (9.5%) had sickle cell disease (Hb SS), and 382 (0.6%) had hemoglobin variants other than that of sickle cell. The samples were routinely referred from health facilities all over the country.

FIGURE 71: SICKLE CELL HB ELECTROPHORESIS RESULTS



Other Achievements

- Biosafety/Biosecurity curriculum was formulated to tackle the challenges that was identified during the national-wide audit that found only 33% of laboratories meeting standards.
- Pilot of three Point of care testing equipment for EID was initiated in 32 health facilities countrywide in attempt to increase access to EID testing for HIV infected babies.
- Works have commenced on building the nitrogen plant which will help to improve cold chain in sample transport system.

- The national EID and VL Laboratory at CPHL was assessed and maintained International Accreditation to ISO 15189 Standards.
- The National EID and VL backup laboratory at Mildmay Uganda received International Accreditation to ISO 15189 standards through South African National Accreditation System (SANAS).
- Three (3) Hospital Laboratories (Kayunga Hospital, Kiryandongo Hospital and Nsambya Hospital) were assessed and recommended for International Accreditation to ISO 15189 standards.

Challenges

- Low demand for VL testing from health workers especially in PMTCT clinics, and patients, poor clinician-laboratory interface and inadequate viral load data utilization at the health facility to inform patient management.
- Identifying disease causing organisms when samples are taken after antibiotic initiation is a major challenge in bacterial disease outbreak investigation. We had to refer samples to WHO testing Laboratory in France and CDC Atlanta to diagnose bacterial meningitis using molecular techniques in two occasions when CPHL Lab could not isolate the organisms using bacterial culture methods
- Transportation of emergency outbreak samples is still a challenge.
- Stock out of reagents and supplies for haematology and chemistry tests in all the laboratories in the network due to non-commitment of resources by the stakeholders. This one challenge that is crippling the operations of laboratories in the country at the comment.

3.1.17 Uganda Blood Transfusion Services (UBTS)

UBTS has a network of Seven Regional Blood Banks in Arua, Fort Portal, Gulu, Kitovu, Mbale, Mbarara and Nakasero (Note that Arua and Masaka are not yet purpose built); eight collection centers in Hoima, Masaka, Kabale, Rukungiri, Jinja Lira, Angal and Soroti; 22 mobile blood collection teams attached to Regional Blood Banks.

- Cumulatively, a total of 209,633 / 240,000 units of blood collected.
- 300,000 regular blood donors recruited.
- 62,782 units of blood tested for TTI's
- Community mobilization through mass gathering were conducted in all regions and by physical contacts for blood donation talks.
- All blood collected was tested for all parameters, stored under controlled temperatures ready for distribution.
- Equipment was maintained. Cleaning and sanitation of all Laboratories done and also maintained.
- Audit Support supervision undertaken in 7 regions and 8 Blood Collection and Distribution Centers.
- Purchased a blood collection van.

3.1.18 Mulago National Referral Hospital

Mulago serves as a National Referral for the entire country, teaching hospital to Makerere University College of Health Sciences and a general hospital as well as HC IV, III for the Kampala metropolitan. The official bed capacity of the hospital is 1,500 beds but due to the ever increasing number of patients over the years, the actual bed numbers are 1,840 beds inclusive of Kawempe and Kiruddu although the hospital houses over 3,500 patients daily.

Achievements

- A bill for autonomy was drafted and consultative meetings held.
- Construction of an organ transplant unit in final stages, remodeling of wards, expansion of theaters; (centralized operating theater, Accident & Emergency, ICU) machinery and Medical equipment have been acquired and installation is ongoing.
- Framework for stakeholder engagement established.

- Top management meetings held.
- The following outputs were realized;
    - 170,956 admissions
    - 766,376 inpatient days
    - 30,941 deliveries
    - 40,837surgical operations
    - 639,483 outpatients
    - 14,041 renal dialysis sessions
    - 45,390 Emergencies
    - 1,058,463 laboratory tests
    - 71,873 images
    - 142,407 Immunizations

Challenges

- Low patient attendances are due to health workers' demonstration in the second quarter.
- Shortage of reagents and limited documentation skills.

3.1.19 Butabika National Mental Referral Hospital

Achievements

- 4 Hospital Management board meeting
- 12 Senior Management meetings
- 4,757 / 5,984 male and 3,744 / 3,366 female patients admitted
- 28,712 / 30,800 investigations conducted in the lab
- 0 investigations conducted in x-ray as there is no functional x-ray machine.
- 1,776 / 2,200 Ultrasound scans conducted
- All 8,501 / 8,500 inpatients provided with 3 meals a day
- 8,501 / 8,500 inpatients provided with uniforms and beddings.
- Two researches conducted – Overview of the Health and Economic impact of alcohol and drug abuse in Uganda and Assessment of Knowledge and practices of nurses in Butabika Hospital towards the management of patients with adverse drug reaction.
- 14,220 / 14,696 male and 14,556 / 14,696 female attended to in the Mental Health clinic.
- 2,747 / 2,613 male and 2,298 / 2,316 female attended to in the Child Mental Health Clinic
- 399 / 845 male and 41 / 36 female attended to in the Alcohol and Drug Clinic
- 30,480 / 44,000 Medical (general, Dental, Orthopedic, Family planning, HIV/AIDS, TB, STD, Eye clinic, Trauma unit Theatre/minor) outpatients attended to.
- 60 outreach clinics conducted in the areas of Nkokonjeru, Nansana, Kitetika, Kawempe Katalemwa and Kitebi. 2,425 male and 2,429 female patients seen in the clinics.
- 24 visits to RRHs mental health units. Visited 2 Jinja, 2 Mbarara 2 Fort Portal, 2 Mubende, 2 Arua, 2 Lira, 2 Soroti, 2 Mbale, 2 Masaka, 2 Gulu, 2 Hoima, Kabale and Moroto.
- 316 patients resettled within Kampala/Wakiso and 914 patients resettled upcountry.
- 9,246 Children immunized.
- Completed the expansion of the Alcohol and Drug Unit- Work in progress at 98%
- Procured on double-cabin pick up.

Challenges

No functional x-ray at the hospital.

3.1.20 Uganda Cancer Institute (UCI)

The institute is mandated to undertake and coordinate the management of cancer and cancer-related diseases in Uganda. The UCI is critical to the evolution of a National Centre of Excellence, providing specialized treatment and care for all types of cancer using all the available subspecialty expertise possible, as well as engineering oncology-centered research and training.

Achievements

- Clinic master was rolled out to link to all applicable instruments & departments for quick service delivery. 100% electronic data entry for all patients from 2016 to 2017 entered into clinic master. HMIS data entry ongoing.
- 5 peer review publications in internationally peer reviewed journals.
- 183 oncology scholarships were awarded.
- Training plan was developed and approved by the training committee.
- 13 established fellowship training programs submitted for accreditation by the UMDPC.
- Scientific Review Committee was established and is now functional, Community Advisory Board was established.
- The UCI research policy was developed but not ratified.
- The Mayuge Community Cancer Registry is operational. Two monitoring visits were conducted in Mayuge.
- 1,747 physiotherapy sessions were conducted.
- 91 dispatches of Cytotoxic waste were made.
- 145 Prostheses fitted.
- 1,699 social support sessions were carried out throughout the year.
- 1,687 specialized procedures were carried out.
- 31,493 patient files were retrieved and availed to the clinical team for patient care and documentation.
- 53,430 out-patient days of comprehensive cancer clinical care were provided.
- 18,249 imaging investigations were carried out.
- 219 major and 608 minor surgical and gynecological operations were carried out.
- 3,376 counseling sessions were conducted.
- 4,621 new patients were attended to and initiated on appropriate treatment.
- 50,256 in-patient days of clinical care were provided.
- 59,753 infusions were carried out.
- Four surgical camps were conducted.
- Four offsite visit to Mbarara RRH were conducted.
- 1,500 copies of National Guidelines for cancer health education and risk reduction for health educators were produced, launched and distributed to health workers in 50 districts.
- A draft National guidelines for cancer screening and early detection was developed.
- The draft Uganda National guidelines for Cancer survivorship was developed.
- 3,500 Fliers/Leaflets/Brochures on cancer were produced and distributed to the public (e.g. Martyrs' day Namugongo).
- 35 short distance outreaches conducted throughout the year. 3668 clients were screened; Males = 1,104 and Females = 2,564, With 96 (M=26, F=70) cases of screened positive/abnormal test results/ pre and early cancers. Number of health educated & risk screened during short distance outreaches: 6,348,661 educated; M = 6,453,187, F=15,344.
- 257 static cancer awareness and screening clinics days conducted at UCI throughout the year; Number Examined: 6,612, clients screened; Males = 1,079, and Females = 5,515, with 1071 (M=287, F=725) cases of screened positive/abnormal test results / pre and early cancers. Number health educated & cancer risk screened: 12,904,25 educated; M = 7,144, F=16,998.
- 18 long distance outreaches were conducted throughout the year. (Arua, Jinja, Mbale, Tororo, Kiruhura, Mpigi, Luwero-Zirobwe s/c, Zirobwe C.O.U, Luwero- Busiika, Bugema SDA Church Mitooma district, Kabira Subcounty, Kabira HC III, Iganga, UCI & Lions club outreach Namutumba, Kumi, Kabale, Masaka, Gombe, Western region- 4 3Cs schools, Eastern Region-5 3Cs schools and Northern - 73Cs schools). Number examined during long distance outreaches: 6,770 clients; Males = 1,906 and Females = 4,864 336 (M=105, F=231) cases of screened positive/ abnormal test results/ pre and early cancers.
- 34 TV talk shows and 20 radio talk shows on cancer risk factors, early detection and access to treatment shows were conducted throughout the year.

- 118 District health teams were oriented on the national cancer health education and risk reduction, cancer screening and early detection and cancer referral guidelines.
- 510 patients treated using CT-Simulator.
- 286 brachytherapy insertions conducted.
- A total 0f 186 radiation therapy education sessions were provided to patients.
- 27,091 treatment sessions on cobalt 60 machine conducted.
- The construction of the radiotherapy bunkers was at 97% of the civil works, left with electrical installations, and the false wall.
- OPD ward rehabilitated and remodeled to accommodate more Clinical Officers.
- Final designs for the multipurpose building for the East Africa Oncology Institute were submitted to AfDB for approval of the tendering process.

Challenges

- Inadequate supply of medicines, sundries and other consumables
- Inadequate specialized diagnostic capacity, for instance, lack of MRI, etc.
- Lack of a surgical ward for post-operative patients. This in effect limits the number of surgical operations whilst administering post-operative care.
- Limited radiation oncology – there is urgent need for need a linear accelerator (LINAC) machine to address the radiation therapy needs of the many patients that need such a service.
- The breakdown of the Cobalt 60 machine delayed service delivery until December 2017.
- The Institute is still grappling with understaffing.

3.1.21 Uganda Heart Institute (UHI)

Mandate is to undertake and coordinate the management of cardiovascular disease in Uganda.

Achievements

- 9 research papers on Rheumatic Heart Disease done with international collaborations published.
- Arrhythmia Registry, Acute Myocardial Infarction Registry, Pediatric Cardiology, hypertension registry ongoing**.**
- 100 open heart surgeries carried out.
- 447 / 600 interventions (68 closed heart surgeries and 379 catheterisation procedures) carried out. Less patients were operated due to limited space in ICU/CCU and ward.
- 641/ 500 ICU/CCU admissions. Over performance was due to increased demand for critical care services.
- 1,471 / 1,200 inpatient admissions. High demand for cardiac care services.
- 21,165 / 20,000 outpatient attendances.
- 10,776 / 13,000 ECHOs performed.
- 8,840 / 12,000 ECGs performed.
- 45 stress tests, 96 holter monitoring, 113 pacemaker programming and 821 x-rays performed.
- Super specialised skills transferred to UHI staff through in house health camps (Chain of Hope, Samaritan Purse, etc.).
- 3 staff undergoing training in areas of cardiac surgery, cardiac anaesthesia and critical care and 1 staff completed training in cardiac surgery.
- Weekly Continuous Medical Education sessions and clinical audits conducted at UHI.
- Support supervision visits to 9 RRHs carried out in Soroti, Moroto, Mubende, Jinja, Kiwoko, Mbarara, Hoima, Masaka and Arua.
- Enhanced awareness of heart diseases through media talk shows on UBC, NTV and NBS.
- Participation in health camps organised by Ministry of Gender, Labour and Social Development, among others.
- Participated in commemoration of international health days such as the World No Tobacco Day organised by No Tobacco Program.
- Participated in World Heart Day celebrations organised by UHI.
- UHI Board of Directors meetings facilitated.

- 20 computers and 2 heavy duty printers, 1 office printer, 1 access control, 12 back up batteries procured.
- 1 Clinical Chemistry Analyzer, 1 Centrifuge, 2 Blood gas analysers, 40 syringe pumps, 10 infusion pumps, 10 patient monitors, 1 ventilator machine procured and delivered.
- 1 cell saver machine, 1 heart lung machine, 1 heavy duty Echo machine, haemostasis analyzer, 1 portable ECG machine, 5 temporary pacemakers procured.
- 8 Metallic open shelves, 10 bed pans, 1 drug trolley, 2 apron stands, 3 multipurpose ladders, 1 office cabinet, 3 shelves containers procured.

Challenges

UHI is facing a challenge of inadequate space for inpatient and CCU admissions which has impacted on the number of cardiac operations performed.

Recommendation

Need to acquire more space for UHI services: construct and equip UHI Home (USD 70 million). UHI is in the process of developing a feasibility study.

3.2 Annex 2: Integrated Health Sector Support Systems

During HSDP 2015/16 –2019/20 the Ministry will focus on health systems strengthening through its core functions of health investments, information management, supervision and monitoring to ensure there is improved access to health services.

3.2.1 Finance and Administration

Achievements

- 12 press briefings and 4 breakfast media engagements
- Cabinet briefs made
- 32 supervisory visits
- Facilitated and attended national functions.
- Processed and paid staff emoluments, salaries, gratuity and pension.
- Repaired and serviced ministry vehicles.
- Made necessary improvements and repairs on the Ministry premises. Renovated and rehabilitated MoH H/Qs 3rd Floor Burnt area and HRM offices completed. Completed and handed over MoH Service Bay, Repaired and restored lifts, procured furniture for Board Room.
- Serviced and repaired Ministry equipment including generators, lifts, printers, computers, telephones & photocopiers.
- Paid medical bills and commiserated with the those who became incapacitated, died or lost beloved ones.
- Facilitated travel abroad.
- Secured Ministry premises, delivered documents to the relevant destinations.
- Procured 4 motor cycles.
- Contributions paid to WHO & ECSA and transferred funds every quarter to the Health Regulatory Councils.

3.2.2 Planning and Policy

Under this function, the MoH is responsible for general strategic planning and policy framework, resource mobilization, coordination of projects and development assistance, Information management, Human Resource Management and Development, Public Private Partnerships, international engagements among others.

Achievements

- Finalized the Annual Work Plan FY 2017/18 and compiled draft Annual Work Plan FY 2018/19.
- Prepared the AHSPR 2016/17
- Held the 23rd Joint Review Mission and finalized the Aide Memoire.

- Participated in 2 regional Pre-JRM meetings in Rwenzori and West Nile.
- Compiled and submitted the Government Annual Performance Report to OPM.
- Compiled and submitted progress on implementation of the NDP II matrix.
- Compiled and submitted progress report on implementation of the NRM Manifesto to Office of the President.
- Compiled Health Sector Negotiation issues with LG FY 2017/18
- Compiled and submitted;
    - Budget Framework Paper 2018/19
    - Ministerial Policy Statement 2018/19
    - Quarterly budget performance (PBS) reports
- Developed the draft MoH Health Strategic Plan awaiting presentation to Top Management.
- Developed concept note and initiated the HSDP 2015/16 – 2019/20 Mid Term Review.
- Developed the PHC conditional grant guidelines 2018/19
- Revised and disseminated the LG Health Planning Guidelines.
- Conducted 12 regional planning meetings to enhance sector planning,
- Held 11 SBWG meetings to review budgets, Project proposals and Development project progress.
- Carried out 12 support supervision visits to 60 LGs on implementation of their work plans
- Monitored the capital development projects in 8 RRHs and 26 general hospitals and HC IVs receiving PHC Development Adhoc grant to ensure infrastructure standards, quality and guidelines are adhered to.
- Carried out budget execution monitoring visits.
- Carried out technical supervision of capital development projects in 8 RRHs and 26 general hospitals and HC IVs to ensure infrastructure standards, quality and guidelines are adhered to.
- Finalized and disseminated the National Health Accounts (NHA) report for the FYs 2014/15 and 2015/16. NHA time series for the last 10 years was prepared and disseminated.
- Cabinet memo for establishment of National Health Insurance Scheme (NHIS) was prepared and submitted to Cabinet.
- An Infrastructure Support Project proposal developed for Karamoja region for funding under the Italian Soft Loan.
- Mapping of development partner activities at National, Regional and district level is ongoing. This is very crucial for coordination of Development Partner support to the sector.
- Compiled the Regulatory Impact Assessment Report for the NHIS with support from African Development Bank.
- NHIS advocacy meetings held with Parliamentarians and CSOs.
- Community based organizations in 3 regions in the country were mapped and a report produced with support from Enabel.
- Conducted training on quantum geographical information system in 24 Districts in Rwenzori and West Nile regions with support from Enabel.
- Conducted Strategic planning trainings for 62 health facilities in West Nile and Rwenzori region to enhance facility level planning and budgeting in the health sector with support from Enabel.
- Health sector national standard indicators were reviewed, updated and submitted to UBOS.
- PHC Grant guidelines FY 2018/19 were disseminated and PHC grants release advice for release to LGs.
- A financial risk analysis and benefits incidence analysis for Uganda was undertaken and a report submitted to WHO. It was noted in the report that many of the vulnerable are being pushed into poverty because of high out of pocket spending on health.
- Health care services costing study was undertaken and report finalized.
- Uganda Health Public Expenditure Review 2013/14 – 2016/17 undertaken with support from USAID – Nathan Associates. Final report to be disseminated in FY 2018/19.
- Developed concept note for the Diagnostic Related Groups and Ambulatory Patient Group Based Payment Mechanism for the proposed NHIS in Uganda. Consultancy firm procured with support from the Belgo-Uganda Study fund.
- Participated in the study to determine equity of health transfers to LGs in Uganda conducted by MoFPED, ODI & DFID.
- The World Health Day and 70th WHO Anniversary was successfully commemorated in Luwero District. The theme was “Universal Health Coverage: everyone, everywhere”.

- Developed and reviewed a number of policies, bills, regulations and MoUs.
- MoUs signed between MoH and the following; We Care Solar, Bushenyi Integrated, Good Care International, Access Bio, Rushere Community Hospital, Sino Africa, China International, Uganda Red Cross Society, Common Wealth Center for Digital Health Collaboratives, Sutchi & PACE. The following are pending clearance from Solicitor General; BHL health care, Nurture Africa and Miracle Feet.
- Cabinet information papers developed e.g. Health effects of asbestos, Appointment of 2 Board Members of NDA, Hosting Cordex Committee, Establishment of Naguru, Kawempe and Kiruddu Referral Hospitals, Upgrading of 331 HC IIs to IIIs under the IGFTR Program – Health Development Grant.

TABLE 62: STATUS OF NEW POLICIES, BILLS AND REGULATIONS FY 2017/18

	Name	**Status**
1.	National Health Insurance Bill	Cabinet memo submitted
2.	Indigenous and Complementary Medicine Bill	Draft Bill at Cabinet
3.	Mental Health Bill	Presented to Parliament and stakeholder consultations are ongoing
4.	National Food and Drug Authority Bill	Stakeholder Consultations ongoing before submission to Cabinet
5.	Public Health Act Amendment	Presented to SMC awaiting presentation to Top Management
6.	Health Tertiary Institutions Bill	Principles yet to be submitted to Cabinet
7.	Human Organ and Tissue Transplant Bill	Reviewed by First Parliamentary Counsel and to be resubmitted after revision
8.	Assisted Reproductive Technology Bill	Consultation on going before principles are submitted for approval
9.	Uganda Health Services Management Institute Bill	Pending approval of principles by Top Management
10.	Pharmacy Bill	Consultations for revised bill are Ongoing before resubmission to Cabinet
11.	National Health Laboratories Services Bill	Draft Principles made by the 1st Parliamentary Counsel. Yet to be submitted to Cabinet
12.	Mulago Specialized Hospital Bill	Regulatory Impact Assessment ongoing before submission to Cabinet
13.	Immunization Act	Passed
14.	Immunization Act Regulations	Regulations to be developed before submission to Cabinet
15.	Tobacco Control Act Regulations	Regulations to be developed before submission to Cabinet
16.	HIV Trust Fund Regulations	To be finalized
17.	Review of Standing orders for Public Service	Stakeholder engagement to be undertaken and recommendations submitted to Ministry of Public Service for submission to Cabinet
18.	Alcohol Control Policy	To be costed and obtain Certificate of Financial Implications before submission to Cabinet
19.	Palliative Care Policy	Awaiting Certificate of Financial Implications before submission to Cabinet
20.	E- Health Policy	Awaiting Certificate of Financial Implications before submission to Cabinet
21.	Community Health Extension Workers Policy	Obtained Certificate of Financial Implications and Cabinet Memo to be submitted
22.	Nurses and Midwifery policy	Presented to MoH Top Management
23.	Mulago Specialized Hospital Bill	Draft Bill developed to be presented to Top Management

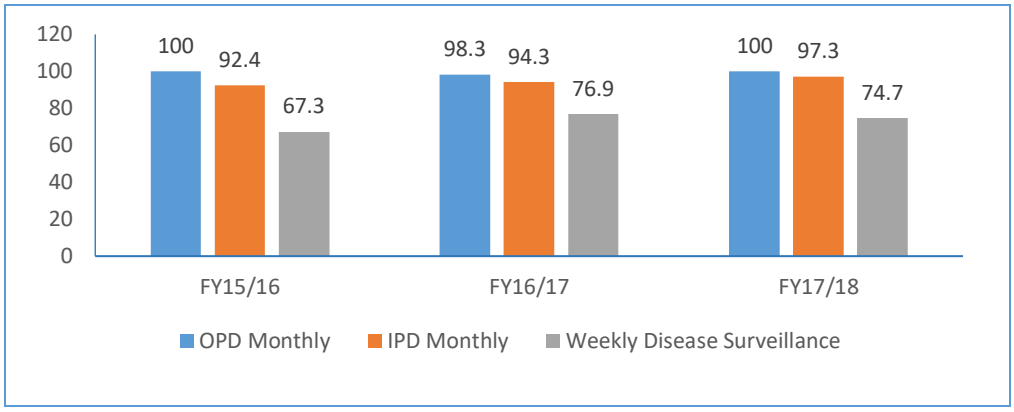
3.2.3 Health Information and Management

The MoH vision is to create a one-stop centre of excellence for management of health and health-related data / information in the health sector for utilization in the betterment of health of the population of Uganda.

Achievements

In FY 2017/18, all health facilities (100%) currently registered in the HMIS submitted their monthly OPD reports. This was up from 98% in the FY 2016/17. In the same period IPD monthly reporting rate was 97% up from 94% in the previous FY, a slight drop in the level of weekly surveillance reporting was observed in the same period with weekly surveillance reporting rate dropping from 77% in FY 2016/17 to 75% in FY 2017/18.

FIGURE 72: TRENDS IN REPORTING RATES FOR IP, OPD AND WEEKLY DISEASE SURVEILLANCE



- Finalised and disseminated an e-Health Policy, Strategy and Implementation Plan in April, 2018.
- The governance structures for coordinating e-Health have been strengthened through monthly e-Health TWG meetings, and establishment of an e-Health Steering Committee that is chaired by the Permanent Secretary.
- Maintained operation of the two major systems, the District Health Information System (DHIS2), and the Mobile/Medicine Tracking system (mTRAC) used as a channel fo reporting the data for the weekly surveillence report of the HMIS. All reporting health facilities submit their data electronically using these two systems on a weekly, monthly, quarterly and annual basis. Access is regulated and granted to stakeholders upon request and depending on the role one plays as far as data management is concerned.
- Developed standards for Electronic Medical Records, as well as Logistics Management Information Systems (LMIS), which forms a basis for guiding development of systems in these areas.
- Assessed four Electronic Medical Record Systems (EMR), and these include the Uganda EMR (Open MRS) – Implementation by PEPFAR, Integrated Clinic Enterprise Application (ICEA) - implemented by Infectious Diseases Institute – Makerere University, An excel based EMR implemented by Butabika Hospital, and Clinic Master System – Implemented by Walter Reed Project. There is need to ensure that all these systems are aligned to the developed standards for an EMR suitable for implementation in the Ugandan health sector in a sustainable manner.
- A total of four systems/applications under the category of LMIS were assessed, and these included; The RX Solution – Implemented by MoH Pharmacy Division in partnership with USAID-Uganda Health Supply Chain Program, the RASS system implemented by MoH Pharmacy Division in partnership with CDC-METS Project, the Integrated Computer System (IICS) - implemented by Office of the Prime Minister, and the ART Weekly reporting system implemented by Uganda Health Supply Chain Program.
- An MoH-LEADD Program has been developed with an aim to fastrack the implementation of the ehealth Strategy. This is comprised of members of the ehealth TWG includign Partners like WHO, CDC, USAID, Makerere University, among others. The tasks being implemented include fastracking the development of the enterprise architecture, the facility registry, the health worker registry, among others.

- The Health Facility Master List 2018 was updated and this shall form the basis for development of the Facility Registry.
- An online registration platform for registration of electronic systems (both new and existing) has been developed, and can be accessed by the public via ***http://154.72.198.133/register/***. This is aimed at facilitating the development of a database of electronic applications within the health sector.
- Conducted an HIS Interoperability Assessment in partnership with stakeholders including Measure Evaluation, and partners like WHO, USAID, CDC, UNICEF, UBOS, NITA-U, and Ministry of ICT. Gaps were identified as far as establishing standards and a basis for interoperability of the systems is concerned, and these are being addressed.
- Monthly Health Information Systems / Data Management Thematic TWG meetings were held.
- Quantified the HMIS tools needs for the various health facilities, developed a tool to aide districts in quantifying their HMIS tools needs, estimate costs for these tools, and then advise partners and national NMS on which tools should be printed and for which health facilities.
- Held quarterly regional & National data review and cleaning meetings: These are supported by our Partners including UNICEF, PEPFAR, Walterreed, Uganda Aids Commission, Uganda Bureau of Statistics, MAPD/Malaria Consortium, TASO – to which we are very grateful.
- Built capacity of various officers at various levels in HMIS, DHIS2, Mtrac, among other data management activities e.g. trainings in Nutrition HMIS for West Nile & Northern District, a total of 32 distrcts trained, capacity building for staff from all RRHs (an average of 6 people per RRH), orientation on the RMNCAH score card for Karamoja district leaders, among others.
- Review of the HMIS tools was done with support from UNICEF, PEPFAR, WFP, WHO, METS, SITES, and Wateraid. The 2018 HMIS review has seen revisions made to the tools to cater for disaagregations by level of health service delivery (reports to be by either at referral/General hospital level or lower levels), data to be dissaggregated by either refugee or national, Private sector, Armed forces and Civil Society needs taken care of.
- Data Quality Assessment exercises have been done in 80% of the districts with support from both Government and partnes. The technical areas that have continued to have issues of data quality include Malaria, Family Planning, HIV Counseling & Testing, and Safe Male Circumsciusion, among others. The problems largely come from lack of clarity in data recording and aggregation. This has however been addressed through development of Standard Operating Procedures (SOPs) for each section of all routine HMIS reports, clearing guiding how the various data elements are aggregated for appropriate filling in the registers and reports.
- 150 publications were uploaded on the MoH Knowledge management portal to increase awareness and access to MoH publications, 70 New publications were received, processed and added to MoH library collections, All library newspapers were bound for easy archiving and retrieval, as well as daily sharing of key health messages to emails of all MOH staff.
- The official MoH mail info.health.go.ug was well managed with and all public inquiries addressed.
- Continued to play a collaboration role with other agencies involved in data management e.g. the Uganda Bureau fo Statistics to implement the Plan for National Statistical Development (PNSD), the analysis for surveys done, collaboration with the National Identification & Registration Authority (NIRA) in the area of development of specifications for unique identification, registration of Births & Deaths in the health facilities and communities, also collaborating with the National IT Authority & Ministry of ICT who provide guidance on national data warehousing, harmonisation of IT systems implemented in the government MDAs, among others.
- Supported other technical departments in data review exercises for example, spearheading the EPI desk review of the development of the multi year data plan, supporting the MoH Mid term review of the HSDP analysis, supporting the Data Improvement Team Strategy under UNEPI, supporting the development and immplementation of the RMNCAH Score card component, day to day data requests and demands of the health sector and stakeholders like OPM, Ministry of Finance, among others.

3.2.3.1 MoH Call Center

The MoH Call Center was revamped in in September 2017.

Call Center Functionality: The call center acquired 2 call agents, a supervisor and manager and the total current number of staff is eight. During this reporting period, the call center also acquired 4 new computer sets. Working days have extended from 5 working days to 7 working days. Working hours have also

increased from 8 hours in August 2017 to 13 hours a day currently. A draft strategic plan has been submitted to the office of the permanent secretary for review.

Call Center Performance: A total of 8,513 have been received of which 80% were successful calls and 7% were mTRAC tickets. Of these successful tickets, 94% were successfully closed and clients rate the call center service at 82%. Our ticket closure rate improved from 76% in September 2017 to 98% in June 2018. On average 851 tickets are received by the call center per month. Tickets were received from 122 districts of the country (99% of all districts) and on average 101 districts contributed tickets per month. Central region accounts for 52% of tickets with Kampala contributing 20% of all tickets. The Call Center supported operations of other departments; including the UNEPI, malaria control program, Data unit, AIDS control program, EMS, EOC and office of the permanent secretary.

Over all, the Central region contributed the highest number of tickets (3,328). The other regions reported tickets as: Western (1,261), East (1,147) and North (698). For some tickets, a region was not indicated (713). This distribution is consistent with phone coverage in the country.

TABLE 63: TICKET DISTRIBUTION BY REGION

Region	Jun 18	May 18	Apr 18	Mar 18	Feb 18	Jan 18	Dec 17	Nov 17	Oct 17	Sept 17	Total
Central	308	224	329	336	363	1113	191	252	166	46	**3,328**
Western	96	117	168	165	154	209	96	177	67	12	**1,261**
East	119	97	142	83	109	174	118	224	79	2	**1,147**
Northern	79	63	98	54	95	117	61	98	28	5	**698**
Not specified	38	136		25					340	174	**713**

Number of Tickets per District: On average, each district contributed 54 tickets the entire period. This illustrates that the toll free number has not yet been highly publicized. Expectedly, Kampala contributed almost 20% of the tickets for which a district was indicated. The top 10 districts are Kampala, Wakiso, Masaka, Lwengo, Gomba, Mbale, Bukomansimbi, Kween, Mbarara and Kapchorwa. These contributed 47.68% of the total tickets.

TABLE 64: NUMBER OF DISTRICTS CONTRIBUTING TICKETS PER MONTH

Month	*Oct'17*	*Nov*	*Dec*	*Jan'18*	*Feb*	*Mar*	*Apr*	*May*	*Jun*
Number of Districts	*82*	*105*	*97*	*101*	*111*	*100*	*107*	*96*	*109*
% of total Number of districts	*66.67*	*85.37*	*78.86*	*82.11*	*90.24*	*81.3*	*86.99*	*78.05*	*88.62*

Ticket Content (Client Complaints): In this period, mosquito nets (ITNs) dominated tickets (987 tickets) followed by personal health related inquiries (935) and drugs & supplies stocks (640). The latter two were consistent throughout the reporting period while a spike in the concerns related to ITNs occurred in January and February owing to TV adverts that featured the toll free number.

FIGURE 73: LINE GRAPH SHOWING TREND OF TICKET VOLUME

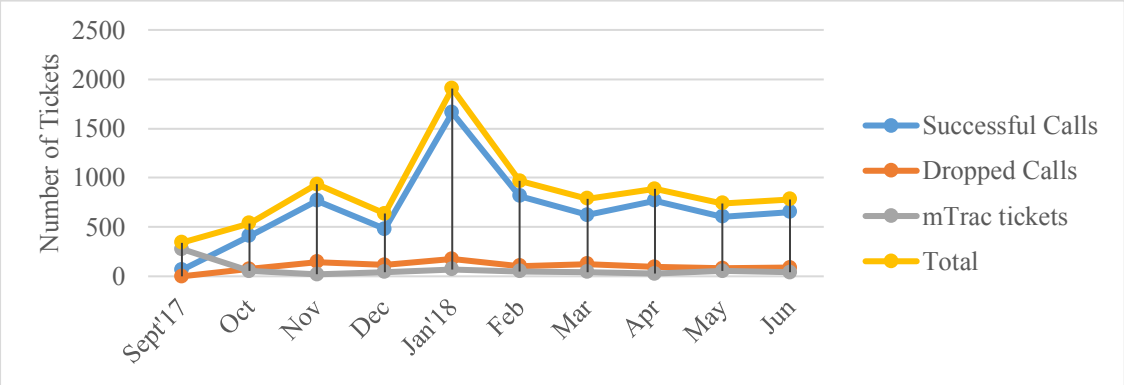


TABLE 65: TICKET VOLUME PER MONTH AND MAJOR ISSUES IN THE HEALTH SECTOR

Month	Successful Calls	Dropped Calls	mTRAC tickets	Total	Major Events in the sector
June 2018	651	89	40	**780**	Rota virus vaccine roll out
May	606	79	54	**739**	New salary structure, Stock out of Septrin
Apr	766	95	26	**887**	Child health days
Mar	621	125	42	**788**	Fake Hepatitis B vaccines on Market
Feb	814	103	50	**967**	Net Distribution, health worker transfers
Jan	1,660	176	69	**1,905**	Mosquito net distribution in central region, stock outs of ARVs and TB drugs
Dec 2017	479	115	42	**636**	Mosquito net registration, Marburg surveillance
Nov	766	146	20	**932**	mTRAC malfunction, Marburg, rift valley fever, industrial action by doctors
Oct	410	74	53	**537**	Marburg Outbreak
Sept	65	0	277	**342**	Yellow fever vaccination drive
Total	**6,838**	**1,002**	**673**	**8,513**	

Staff Development

- All staff underwent a one-week customer service and call center management training in September 2017.
- Held an orientation week for new staff in September that was described as "successful, beneficial and it will add value to (one's) performance".
- Staff growth has been facilitated by monthly career talks dubbed "power moments" by 7 guest speakers and weekly quizzes (28 "Teasers" in total) that constituted the frequently asked questions (FAQs).

Staff Performance

- Developed a performance metric based on number of tickets handled, proportion of tickets closed successfully, score on weekly teasers and client rating.
- On average each call center agent handled 1,252 tickets that translates to 125 tickets per month. This implies that agents are underutilized and necessitates measures to increase ticket volume.

Call Center Promotion

- Utilized the mTRAC platform to send weekly messages to all people on the platform to promote the toll free line.
- Acquired 400 posters and 400 flyers that have been distributed to selected health facilitates and district offices.
- Two full page adverts of the call center appeared in the health sector newsletter.
- Utilized Facebook to promote MoH campaigns and programs.
- When compared to August 2017, Facebook page likes as of June 30th were 5,897 from 327 (an increase of 1,703%).

Recommendations

- Setting up a patient information website in lay language to provide information on common ailments to meet the high demand for personal health related information.
- Strengthening drug supply chain management to prevent drug and supplies stock outs.
- Acquisition of a customer relationship management software and a short code (instead of the 10 digit toll free hot line) will improve ticket volume, closure and enable generation of real time reports.
- Promotion of call center hot line using television, Facebook and sms media has proved effective and should be maximized in the future. A low cost alternative is incorporating the call center toll free hotline in all communications, IEC materials and adverts of MoH (and partners) campaigns.

3.2.4 Sector Monitoring and Quality Assurance

Mandate

To ensure that health services provided are within acceptable standards for the entire sector, both public and private health services.

Achievements

- 11 out of 12 SMC meetings were conducted. New MoH Policy related issues were developed & forwarded to HPAC and Top Management.
- 4 performance review meetings of implementation of the MoH work-plan for 2017/18 conducted.
- 8 out of 12 SMEAR TWG meetings were held. 9 policy related issues were forwarded to SMC.
- National Service Delivery Standards and Service delivery standards disseminated to 110 districts.
- Health Sector Quality Improvement Framework and Strategic plan disseminated to 80 districts.
- 2 Quarterly Area Team support supervision visits conducted to 127 districts and 14 RRHs.
- Quality Improvement support supervision visits conducted to 60 districts.
- 13 Districts were supported to train HFQAP District Supervisors and undertake facility assessments. Gaps identified and Quality improvement approaches used to improve on service delivery. Supported by RITES-E, RITES-N, RITES EC, UMRCHIP project, UNICEF.
- Enable supported QAID to train 147 district leaders in supportive supervision from Rwenzori region (Kasese, Bundibugyo, Kabarole, Ntoroko, Kyegegwa, Kamwenge, Bunyangabo and Kamwenge). The 5-day training included members of the DHT, health facility In-charges and members of the HUMCs.
- Service Availability and Readiness Assessment & Data Quality Assessment (SARA/ DQA) Survey 2017/18 conducted. Pending reporting writing. Supported by Global Fund.
- Draft copy of the MoH Client Charter and Generic version of the RRH Client Charter developed with support from Intrahealth.
- Developed proposal for Patient Safety assessment and survey was initiated with support from the Belgo-Uganda Study fund. To be finalized in FY 2018/19.
- Developed proposal for development of a tool and conducting the Client Satisfaction survey. Consultancy firm procured with support from the Belgo-Uganda Study fund.

3.2.5 Health Infrastructure Development and Maintenance

In the FY 2017/18, the following were the accomplishments;

- Medical equipment and solar spare parts needs were determined.

- Procurement process to purchase solar batteries, inverters, charge regulator and solar panels commenced.
- Held meeting to review National oxygen supply and use scale up plan and strategy.
- New members of NACME were appointed.
- Drafted guidelines for operation and management of oxygen plants in RRHs. Draft Oxygen scale up plan and strategy was reviewed and approved by HPAC and MoH STMC. Final plan is expected to be signed by the end of July 2018.
- Held meeting to review Concept Note on Equipment Leasing and Rental. Draft concept note on Medical Equipment Leasing and rental was prepared, reviewed and approved by HITWG and MoH SMC.
- Developed draft project profile for the proposed DRIVE Project for Medical Equipment upgrade and enhancement of specialized healthcare services in RRHs. Project was prepared and submitted to Planning Department for presentation to HSBWG and MoFPED.
- Held meetings to finalize the scope, design and equipment for the JICA Grant Aid Project for Rehabilitation and Equipping of RRHs in Northern Uganda for Arua, Gulu and Lira RRHs. Equipment and scope of works for Arua, Gulu and Lira RRH were agreed up on and Grant Agreement for funding the project signed on 26th April 2018.
- Held meetings to review and verify equipment donated by BOU to Aiivuni HC III (Arua), Omel HC III (Gulu), Nakaloke HC III (Mbale) and Bwizibwera HC IV (Mbarara). BOU donated medical MCH equipment e.g. Ultrasound scanner, delivery beds.
- Reviewed proposal for solar powered oxygen concentrators supported by CHAI – solar system sizing, oxygen concentrator specifications. Proposal was approved by HITWG and CHAI requested to submit revised project proposal with funding mechanism.
- Carried out 3 technical support supervision and mentorship visits to 12 regional medical equipment maintenance workshops – i.e. Arua, Gulu, Hoima, Soroti, Lira, Moroto, Mbale, Mubende, Kabale, Jinja, Fort Portal & central workshop Wabigalo.
- Supervised and monitored construction and installation of 13 medical oxygen plants in Naguru. Arua, Gulu, Hoima, Soroti, Lira, Moroto, Mbale, Mubende, Kabale, Jinja, Fort Portal & Masaka RRHs. Installation of 13 medical oxygen plants completed and access to high quality medical oxygen enhanced in all RRHs.
- Assessed power backups and air conditioning systems for laboratories in Anaka, Aber, Kitgum, Kalongo & Apac GHs; and Atiak, Lalogi, Madi Opei, Pajule, Alebtong, Dokolo and Amolatar HC IVs. Power supply reliability for running ART clinic/Records data management computers enhanced in 149 health facilities countrywide. Power supply in 36 health facilities in 8 Districts in Western Uganda improved and capacity to operate idle electrical medical and Audio-visual equipment enhanced.
- Collected inventory of x-ray machines & ultrasound scanners in public hospitals and HC IVs; and monitored the maintenance of 42 Philips x-ray machine, 49 ultrasound scanners, 31 manual darkroom film processor equipment and 6 automatic x-ray film printers in 11 RRHs, 23 GHs & 28 HC IVs by M/s Dash-S Technologies Inc.
- Carried out technical support supervision and monitoring of health infrastructure development and maintenance in the following hospitals & HCIVs: All 14 RRHs, Nakaseke, Kayunga, Lyantonde, Moyo, Adjumani, Atutur, Bwera, Kambuga & Kapchorwa GHs; and Atiak Madi Opei, Pakwach, Kilembe Mines, Budaka, Nanukora, Tokora, Nabilatuk & Karenga HC IVs.
- Monitored and verified supply and installation of solar power backup systems for ART/Records data management computers in 149 health facilities under GF; and installation of centralized solar power min-grid systems for powering medical buildings and staff houses in 36 HCs in Kamwenge, Mitooma, Bushenyi, Kyegegwa, Ibanda, Sheema, Kyenjojo & Kabarole Districts.
- Held 3 Regional Medical equipment maintenance workshops' performance review meetings in Mubende, Masaka & Lira RRH. Supported by JICA, IDI and the SUSTAIN Project.4
- Maintenance of solar systems was carried out in 634 / 665 HCs in Mbale, Sironko, Amuria, Katakwi, Mayuge, Bukwo, Bundibugyo, Ntoroko, Bulambuli, Buliisa, Bududa, Masindi, Kitgum, Lamwo, Moroto, Nakapiripirit, Kiryandongo, Agago, Pader, Gulu, Nwoya, Amuru, Adjumani, Moyo, Apac, Kole, Kaberamaido, Dokolo, Soroti, Serere, Napak, Amudat, Mityana, Mubende, Kabale, Rukungiri, Kanungu, Luwero & Nakaseke Districts. 240 batteries, 14 inverters, 10 solar panels and 5 charge regulators were replaced. Of the 1,167 solar packages maintained the 24 Districts with ongoing maintenance contracts; 80.7% were functional after 4 to 5 years of operation, 14.5% of the functional solar systems need replacement of failing (weak) batteries & 6.3% of the solar systems were not functional after 4 to 5 years of operation.

- 686 Medical Equipment were maintained in 2 RRHs, 8 GHs, 40 HC IVs and 15 HC IIIs in central region – e.g. GeneXpert, Slit lamp, Refrigerators, Centrifuges, Generators, Shakers, Water Bath, Ophthalmoscope, Patient Monitor, Weighing Scales, BP Machines, Microscopes, Autoclaves, delivery beds, oxygen concentrators, anesthesia unit, suction machine & hot air oven. Serviced and certified 36 Biological safety cabinets in 8 RRH, 3 GH & 4 HC IVs. 58 BSC were decontaminated, serviced, tested and certified in 11 RRHs, 10 GHs & 8 HC IVs. The BSC for Kabarole COU was maintained but it was declared unrepairable & needs replacement. 36 BCS were tested, verified and certified saving Approx. Ug. Shs. 200 million in labour fees if a private firm was to be contracted to provide the service. Some of laboratory equipment maintenance was funded by AIHA and IDI.
- Assorted medical equipment spare parts and accessories were delivered and taken on charge in Wabigalo stores.
- Maintenance was carried out on 42 Phillips x-ray machines, 6 automatic printers and 49 Phillips ultrasound scanners in 10 RRH, 23 GHs & 28 HC IVs. 22 out 36 x-ray machines maintained are functional. 45 out of 47 Ultrasound scanners maintained are in functional condition. 2 out of 6 automatic printers are functional.
- 22 Biomedical/ Engineering Technicians trained in maintenance of Genexpert machines, 4 Biomedical/ Engineering Technicians completed training in decontamination, testing and certification of BSCs, 12 Technicians and 9 Regional User Trainers trained in Operation and Basic Maintenance of Anaesthesia Machine, Ventilator, ECG & Patient Monitors, 22 Engineers/ Technicians trained in leadership and 5S CQI-TQM management principles, and 22 Technicians trained in maintenance of laundry equipment and SSD Autoclaves.

Challenges

- Solar spare parts were not purchased due to lack of funds.
- Payment of service providers was not fully done. Unpaid invoices total UGX454,866,753/=

Staff Houses under construction at Lokitelaebu HC III, Kotido District

TABLE 66: INFRASTRUCTURE DEVELOPMENT PROJECTS STATUS

Project Name	Specific objective	Progress	Challenges	Way Forward
Rehabilitation of Kayunga and Yumbe Hospitals with support from Saudi Fund/OFID and BADEA	To contribute to overall HSDP sector objective of enhancing health sector competitiveness in the region and globally by constructing and maintaining functional, efficient, safe and environmentally friendly infrastructure for effective service delivery through renovation and consolidating existing health infrastructure.	The project cost is estimated at USD41.05 million. SFD is expected to fund 15.00M USD and has so far disbursed USD 250,915.53. BADEA is expected to fund 7.00M USD and has so far disbursed USD 526,088.27. OFID is expected to fund 15.00M USD. GoU is expected to fund 4.05M USD and has so far disbursed USD 4,050,000 The contract for Civil works for the rehabilitation and expansion of Kayunga Hospitals was signed on 5th January 2018 for contract sum of USD16,670,711.22. The works commenced on 8th Feb. 2018 following the handover of site to the contractor on 8th Jan. 2018. Three monthly site and several technical meetings were held. Work progressed to about 15%. The major activities carried out are: Foundation works for the new hospital buildings and staff houses, completion of the demolition works and commencement of the remodelling works of the existing buildings. The contract for Civil works for the rehabilitation and expansion of Kayunga Hospitals was signed on 5th January 2018 for contract sum of USD18,601,958.21. The works commenced on 10th February 2018 following the handover of site to the contractor on 10th January 2018 and the one month of mobilization. Held three site and several technical meetings. The overall progress achieved by the end of the FY 2017/18 was about 7%. The major activities carried out are: Foundation works for the new hospital buildings and staff houses, completion of the demolition works and commencement of the remodelling works of the existing buildings.	Delayed release of funds Lengthy and complex process of determining appropriate equipment specifications Slow start up of work due to delayed payment of advance. There were several initial issues to sorted out in the disbursement procedures	Timely understanding key disbursement / project management procedures of funding agencies should be taken serious to avoid undue delays.
Development of a	Contribute to improvement of	Construction of 450 Bed specialised Maternal & Neonatal hospital is on	Delay in release of GoU Counter -	MoH to budget for funds to pay

Project Name	Specific objective	Progress	Challenges	Way Forward
Specialised Maternal and Neonatal Healthcare unit in Mulago National referral Hospital (Mulago III Project)	access to specialized maternal and neonatal morbidity and mortality through construction of a 450-bed Hospital facility and equipping with state of art medical equipment and furniture and improvement of Services Quality through conducting specialized trainings of health workers as well as developing relevant hospital management protocols.	course and is expected to be completed in October 2017. Civil works is 100% complete. Good quality of works has been achieved.	part funding to the project. - Delay in release of VAT refund to contractor and consultant may attract interest at some stage if not addressed now.	for Counterpart funding and VAT to avoid huge interests charged by the respective service providers, which may if not addressed in time, can escalate project costs.
Support to Mulago Hospital Rehabilitation	Improve delivery of quality services, decongest, strengthen medical education and research capacity	The total value of the loan is US$ 78m out of which US$ 64.08m has been disbursed Construction of the Kawempe and Kiruddu Hospital ongoing. For Kawempe Hospital the overall progress of work is at 98%. The hospital is presently being used by Mulago hospital. For Kiruddu Hospital the overall progress of work is at 98%. The hospital is presently being used by Mulago Hospital. The Rehabilitation work for lower Mulago Hospital is ongoing and the current progress of work is at 91%. Procurement of medical equipment and furniture for Kawempe and Kiruddu hospitals is on-going. Procurement of the main medical equipment and furniture for Mulago hospital on-going. Contracts were signed and delivery and installation is expected during the period January to June 2018. The bulk of the funds here is from the donor component which is off budget. The Shs. 10 million was mainly used for site supervision and monitoring purposes.		
GAVI Vaccines and Health Systems Strengthening	To strengthen health systems& ensure universal access to the UNMHCP in order	• 26 staff houses that accommodate 2 staffs each (semidetached) were completed and handed over in 15 districts (Bundibugyo- 2, Kasese-2, Kanungu-2, Kisoro-2, Kakumiro-		

Project Name	Specific objective	Progress	Challenges	Way Forward
	to reduce morbidity and mortality.	1, Kagadi-1, Mukono-2, Wakiso-1, Namayingo-2, Mayuge-2, Bugiri-2, Kalangala- 2, Buvuma-2, Namutumba- 1 and Bulambuli-2) • 19 Medicine stores were completed and handed over: Ntoroko, Zombo, Nakaseke, Buikwe, Luuka, Pallisa, Serere, Napak, Nakapiripirit, Bukwo, Alebtong, Agago, Lwengo, Lyantonde, Isingiro, Buwheju, Sheema, Rubirizi and Bullisa.		
Italian support to the HSSP and PRDP: Karamoja staff housing	Construction of 68 (34 2-in-1 staff housing units) staff houses at selected health facilities (Health Centre IIIs) in Kaabong (4), Kotido (16), Abim (12), Moroto (6), Napak (14), Amudat (8) and Nakapiripirit (8) Districts.	The total grant value of the project is USHs 5.62bn of which USHs 5.62bn was released. Of the released amount, USHs 2.61 has been utilized representing 46% but with a pending certificate of payment amounting to US $ 259,000. On the side of government funding, Ushs 0.3bn was approved of which Ushs 0.28bn was released and utilized. 75% of construction of 68 staff houses completed. Construction of Kaabong, Kotido, and Abim is at 85%. Construction of Napak and Moroto is at 40% and Construction of Amudat and Nakapiripirit is at 15%.		
The Global Fund Grants to fight HIV/AID, Malaria and Tuberculosis	Scaling up prevention, Care, Treatment and Health System Strengthening. Support for the introduction of highly Effective Artemisinin-Based Combination Therapy Treatment.	Construction of new ware house for NMS at Kajjansi commenced	Procurement took a long time as it involved design and build by the same contractor and so needed clearance from PPDA, Solicitor General and GF	
Spanish Debt Swap for renovation of Kawolo and Busolwe Hospitals	Improve effective delivery of an integrated UNMHCP	Project financing is from the Kingdom of Spain under the debt-Swap program between the Kingdom of Spain and the Republic of Uganda. Total grant value is Ushs 18.98bn, out of which 4.02bn was disbursed and Ushs 3.46bn has so far been utilized. On the side of government funding, Ushs 0.45bn was approved of which Ushs 0.12bn was released. Ushs 0.09bn has so far been utilized. In Busolwe GH, The Consultant submitted the Site survey report on the	Delayed Payments to Contractors and Consultants	

Project Name	Specific objective	Progress	Challenges	Way Forward
		12th December 2017. Approval was given on the 30th January 2018. In Kawolo GH Civil works. The following progress has been registered on site: New OPD is at 70%, new casualty at 51%, new theatre at 60%, New Mortuary at 61%, Refurbishment of Maternity Ward at 17%, New Antenatal at 69%. New Placenta, Pit completed, New Medical Waste Pit at 99%, New Attendants Kitchen at 60%, New Attendants Laundry at 63%, Refurbishment of Service Block at 22%, New Staff Houses Block at 69%, Refurbishment of Male Existing Ward at 29%, Installation of the Labour Suite in the existing Maternity Block - complete, Redesign of hospital sewage and water supply system (Works) is at 30%.		
Infrastructure development under PHC	Improved infrastructure development in LGs	28 LGs received Ug. Shs, 9.622bn to expand and renovate the following hospitals and HC IVs; Apac GH, Atutur GH, Bududa GH, Bundibugyo GH, Entebbe Grade A, Gombe GH Kabarole GH, Kagadi GH, Kalisizo GH, Kambuga GH, Katakwi GH, Kiboga GH, Kyenjojo GH, Lyantonte GH, Masindi GH, Pallisa GH & Tororo GH. Anyeke HC IV, Ishongorero HC IV, Kakomo HC IV, Kasana HC IV, Kibale HC IV, Maracha HC IV, Mpigi HC IV, Mukono HC IV, Rukunyu HC IV and Zombo HC IV. Construction of Kibuku District Medicines Store	Inadequate funds for monitoring works and completion of projects that have been going on for some years	Completion of some of the long standing projects e.g. upgrading of Rukunyu HC IV and Maracha HC IV and functionalising them as hospitals in FY 2019/20.
Construction and Equipping of the International Specialised Hospital of Uganda	Construction & Equipping of a 240 bed hospital Procurement of Specialised medical equipment Financing by the M/S Finasi/Roko SPV in final stages	Preliminary works ongoing	Insufficient GoU allocations on the project that requires counterpart funding to the tune of UGX 54.4 billion	
East Africa Public Health Laboratory Networking Project	Improve training, Regional diagnostics & Surveillance. Build capacity for operational	Contracts signed for Mbale and Mbarara. Lacor cleared by Solicitor General. Arua- bidding advertised		

Project Name	Specific objective	Progress	Challenges	Way Forward
	research, and Knowledge Sharing	Process of procurement of consultant for VHF isolation centre at Mulago and remodelling of Entebbe on going ESIA Consultant engaged for construction of MDR TB treatment centre at Moroto		
Regional Hospital for Paediatric Surgery	To contribute to the development of Health systems in Africa through the establishment in Uganda of a Teaching Hospital for Paediatric surgery with a regional prospective.	A GoU provision of Ug. Shs 9.62bn was earmarked for the project for FY 2017/18 and USHs 9.62bn has been utilized so far. Construction of the hospital supervised; 1 site meeting held. Since February, a Project Manager has joined the team in the construction site. Supervised the installation of the electrical system of the construction site for the installation of the steel structure.		
Uganda Reproductive Maternal and Child Health Services Improvement Project	Improve utilization of essential health services with a focus on reproductive, maternal, newborn, child and adolescent health services in target districts. Strengthen Birth and Death Registration	The Total funding for FY 2017/18 is Ug. Shs 41.19bn out of which Ug. Shs. 13.75bn has been disbursed. Ug. Shs.4.03bn has so far been utilized. Engaged a consultant to carry out an assessment of Health Facilities to be renovated. 82 Lower level health facilities have been selected for rehabilitation (41 HC IIs to be upgraded to HC IIIs& 41 HC IIIs to be renovated & functionalized) Procured and distributed 15 Motors Vehicles for DHTs to support Supervision in Hard to reach and disadvantaged districts and 3 National Identification and Registration Authority (NIRA). The Districts that benefited included Butaleja, Butebo, Masaka, Kyotera, Buliisa, Kaberamaido, Bukedea, Abim, Nakasongola, Kaabong, Kakumiro, Kagadi, Buvuma, Sembabule & Amuru. Procured Medical Equipment and Furniture that include Bowl stands (503), Cupboard & Instruments (137), Examination Couch Gynecology (38), Instrument Trolley (361), Patient screen (513), Patient Trolley (300), Filing Cabinets (321), Cupboards steel Lockable (240), Patient Beds		

Project Name	Specific objective	Progress	Challenges	Way Forward
		Adult & Mattresses (1027), Delivery Beds (232), Delivery Beds Disabled (232) and Operating Tables (67). The Medical Equipment and furniture was distributed to Hospitals and HC IVs. Issued Bidding documents for the supply of assorted ICT Equipment including 23 Laptops, 250 Desktops and 125 Printers, 125 Servers and 125 Server UPS, Photocopiers and LCD/DLP Projectors for NIRA to be used in the regional offices.		

3.2.6 Uganda National Health Research Organisation (UNHRO)

UNHRO is mandated to regulate and coordinate health research: alignment and harmonization, set the health research agenda, share information and promote dialogue with stakeholders.

Achievements

- Held the Annual National Research Conference (9th ANREC) 10 - 12th July 2017. Participants: 500 from regulators, academia, IRC, civil society. Theme: - Research: Promoting mutual and equitable partnerships.
- Held a joint workshop and launched the EDCTP supported CREDU proposal. Report and Framework for effective partnerships developed to strengthen the capacities of the national regulatory agencies (UNCST, UNHRO, NDA, MakSPH, referral hospitals).
- Held one national Grants writing skills workshop for 30 participants. Objective - Entice young scientists to develop proposals that attract grants and career paths. Share /interact with experts in writing skills.
- Held a workshop to review the national research priorities in collaboration with University of California and Busitema University.
- Held a symposium with Parliamentarians and Stakeholders (UNAS, MaK, academia) on research and knowledge translation in collaboration with University of Reading, UK and Queen Victoria University.
- EA Health Research Council (EAHRC) reviewers meeting held in Entebbe on 30.10.2017- Composed of teams from partner states and National focal persons for EAHRC.
- Results of a cohort study shows declining trends of new infections since 2014.
- Initiative for On line e-platform (CRIMS) for harmonization of the management and the approval process ongoing for research protocols between the national regulatory agencies regulatory agencies, Academia, and RRH.
- CREDU Symposium held at Hotel Africana to disseminate CRIMS and the new framework.
- A National Health Symposium on Health was held to disseminate and discuss new research findings supported by UNHRO / EDCTP EAHRC / MAK / THETA / NDA.
- Workshop held to review following research findings: i) Family planning and Reproductive Health survey among HIV infected individuals in Uganda, determine unmet need; ii) Uptake of ART; and iii) Malaria in Northern Uganda. Disposal of old nets a problem, guidelines needed.
- Workshop held for dissemination of findings from the Rakai Health Research Project 1987 – 2017. Findings show declining trends in prevalence and incidence: 5% and 0.4% person years of observation.
- Hosted a regional EAC Digital conference for Health to develop a roadmap for digital data for health research. Roadmap for Regional Framework for digital Health developed. Conference opened by Hon MSH/General Duties. Venue Entebbe 6.09.2017
- A draft Strategic Plan for Regional Digital Data for health research developed at Regional meeting of Commissioners chaired by Uganda Venue Arusha, Karatu 10.10.2017 A second review by Expert from the region of the digital roadmap held on 3rd Nov 2017 at Entebbe.

- Held National Focal Persons meeting of stakeholders for the purpose of implementation of EAHRC strategies, web portal training, and enhancement of Good Practices; and also preparations for the 7th scientific symposium to be held in Dar es Salaam in 2019.
- Hosted a multidisciplinary (NFPs, HIMS) second meeting for the East African web portal for information sharing and management at national and regional levels. Started the process to establish a web based backbone for collecting research health data and information. Venue Entebbe 31.10.
- Held the Annual Traditional Medicine Conference (ANTRAMEC) and exhibition. 500 participants: scientists, traditional practitioners, HCWs, academia, policy makers. Theme: Harnessing the potential of traditional medicine to accelerate UHC. Exhibition: selected and potential traditional remedies Date: 6.09.2017. MoH/THETA Jointly supported by UNHRO/THETA/NCRI.

Challenges

- Implementation of the UNHRO Act 2011 remains unfunded priority with no vote to fully implement its mandates.

3.2.7 National Chemotherapeutics Research Institute (NCRI)

The mandate of NCRI is to conduct research on natural products and Traditional medicine systems for the treatment and management of Human diseases.

Achievements

- Held the Annual African Traditional Medicines conference (ANTRAMEC) at Hotel Africana from 29th – 30th August 2017 with the theme: "Harnessing the potential of Traditional medicine research to accelerate UHC".
- Developed a Herbal medicines laboratory catalogue of plants and formulations analyzed at the institute from 2013 to 2017 intended for researchers in the Traditional medicine sector.
- Safety evaluation of three herbal formulations (SD2018 formula, used for management of hypoglycemia, Nana Herbal antibacterial mouth wash and Maesa lanceolata, an antimalarial medicinal plant).
- Established and maintained Herbal medicines nursery and demonstration garden at the institute for training and conservation of medicinal plants.
- Disseminated information to the public on Nutrition, the role of Traditional medicine and practices in primary health care in Uganda through Radio and TV talk shows.
- Analyzed 132 herbal formulations for their phytochemical active ingredients to support notification of the products by NDA.
- Trained 70 youth from different districts of Uganda on standardization and manufacturing of herbal medicines in collaboration with private sector foundation (SDF) program for skilling the youth.
- Undertook training of 36 student interns from Makerere, Mbarara, Kyambogo, KIU and Gulu Universities on scientific methods in Traditional medicines research.

Impact of work done at NCRI

Work done at the institution has resulted in a marked rise in the safe utilization of herbal medicines on the Ugandan market as a result of the trainings and sensitization activities carried out by the institution through various media outlets.

There is also increased interest in traditional medicines research by various institutions of higher learning resulting from the trainings conducted at the NCRI for students and researchers.

There is increased interest from herbal medicines manufactures for the registration of their herbal medicine products manufactured locally with the NDA. This will register a marked improvement in the quality of

medicines produced and will also provide information to the public of the types of herbal interventions available in the market for health care needs.

NCRI coordinated the evaluation of larvicides as an intervention for the control of malaria. Both small scale and large scale field evaluations were conducted in Wakiso District for the small scale evaluation and in Nakasongola district for the large scale evaluation of SAFE larvicide. Both reports are available. It is expected that up to 3 publications from the study will be published.

It is also expected following the large scale evaluation of SAFE larvicide in Nakasongola that larviciding will be rolled out as an IVM intervention to augment current interventions in the control of malaria in Uganda.

Efforts by Ministry of Health through NCRI and InraD, the Egyptian government organization that produces SAFE will embark on local production of SAFE larvicide at pilot level. This will ensure availability of SAFE at affordable costs to support larviciding.

Challenges

- NCRI as part of its research activities conducts a lot of field research. This requires suitable vehicles for field work. Currently, the institution's two pick-up vehicles are old and run down. This has greatly affected field work. There is therefore need for purchase of new vehicles to address this gap.
- The funds availed for Health Research limit the scope of research that can be conducted by NCRI.
- There is need to give NCRI vote status to enable the institutional conduct research more effectively.

3.2.8 Uganda Nurses and Midwives' Council (UNMC)

The Uganda Nurses and Midwives Council (UNMC) is a Government Health Regulatory and Supervisory body, established by the Uganda Nurses and Midwives Act, 1996. It is mandated to set and regulate standards of training and practice for nursing and midwifery professions and provide professional guidance on the two professions for public safety.

In the FY 2017/18, the Council had the following strategic objectives derived from its strategic plan 2017/18 – 2012/22:

- Promoting standards and ensuring compliance by nurses and midwives.
- Strengthening regulation of education, training of nurses and midwifery professionals.
- Strengthening policy and regulatory framework.
- Strengthening and developing capacity of UNMC secretariat for effectiveness.

Achievements

- 2 supervisory visits of: A total of 17 districts, 44 health facilities and 12 clinics were supervised.

Bunyoro	Greater Masaka	Ankole	Kigezi
1. Hoima	1. Masaka	1. Mbarara	1. Kabale
2. Kibaale	2. Sembabule	2. Ntungamo	2. Kisoro
3. Kagadi	3. Kalungu	3. Ibanda	3. Rubanda
4. Kakumiro	4. Bukomansimbi	4. Bushenyi	4. Rukungiri
			5. Kanungu

A total of 44 Health facilities were supervised, 12 in Bunyoro; 11 in Greater Masaka; 12 in Kigezi; and 9 in Ankole sub regions respectively.

Bunyoro	Greater Masaka	Ankole	Kigezi

1. Hoima RRH 2. Kagadi Hospital 3. St. Ambrose Charity HC IV 4. Kibaale HC IV 5. Mugarama HC III 6. Kyebando HC III 7. Nyamarwa HC III 8. Kakumiro HC IV 9. St Andrea Kaahwa Kooki Community Hospital 10. Azur Christian HC IV 11. Bujumbura HC III 12. Kigorobya HC IV	1. Masaka RRH 2. Villa Maria Hospital 3. Bukulula HC IV 4. Kalungu HC III 5. Butenga HC IV 6. Buyoga HC III 7. Makukuulu HC III 8. Bugasa HC III 9. Bamu Hospital 10. Sembabule HC IV 11. Ntuusi HC IV	1. Rubaare HC IV 2. Mayanja Memorial Hospital 3. Mbarara RRH 4. Ishongororo HC IV 5. Ishaka Adventist Hospital 6. Uganda Martyrs Hospital – Ibanda 7. St Daniel Comboni Hospital 8. Rushere Community Hospital 9. Itojo Hospital	1. Kabale R. R. hospital 2. Rugarama Hospital 3. Karoli Lwanga Hospital - Nyakibale 4. Kisoro General Hospital 5. St. Francis Mutolere Hospital 6. Bwindi Community Hospital 7. Chahafi HC IV 8. Buhunga HC IV 9. Kebisoni HC IV 10. Muko HC IV 11. Kamukira HC IV 12. Rubanda PHC HC III

A total of 12 clinics were supervised, 7 in Bunyoro & 5 in Greater Masaka sub region

1. Akweheire Domiciliary Clinic
2. Abesiga Mukama Domiciliary Clinic
3. Buyanja Domiciliary Home
4. Jovilex Nursing clinic
5. Kagame Maternity Clinic
6. Mary Maternity Clinic
7. Peric Maternity Home
8. Kutesa Domiciliary Clinic
9. St Gertrude Domiciliary clinic
10. Liz maternity centre
11. Teguzibirwa Kubo Domiciliary clinic
12. Mukwano Medical Services Ltd

- 2 supervisory visits to Health Training Institutions were held in 2 sub regions of Kigezi and Ankole

- 13 Nursing and Midwifery training institutions were visited as indicated below:

Kigezi Sub region	**Ankole Sub region**
1. Rugarama school of nursing and midwifery 2. Mutolere School of Nursing 3. Kabale comprehensive School of Nursing 4. Kabale Institute of Health sciences 5. St. Karoli Lwanga School of Nursing and Midwifery 6. Uganda School of Nursing Bwindi	1. Mayanja Memorial Health Training Institute 2. Mbarara University of Science and Technology 3. Ntungamo Health training institute 4. Kampala International University 5. Ibanda School of Midwifery 6. Bishop Stuart University 7. Ishaka Adventist Nurses Training School

- A total of 27 facility based sensitizations of nurses and midwives and the public on Professional code of conduct and ethics were conducted.

- Four regional radio talk shows were held in the respective regions
    - Kanungu broadcasting services (KBS), 95.4FM for Kigezi Sub region
    - Vision Radio, 89.1 FM, Mbarara for Ankole Sub region
    - Buddu, 98.8 FM, Masaka for Greater Masaka Sub region
    - Spice, 89.9 FM, Hoima for Bunyoro Sub region
- Three CPD providers were accredited, that is Infectious Disease Institute, Global Health eLearning Centre (GHeL), and AMREF.
- Two disciplinary hearings were held and eighteen cases appeared. Of the eighteen cases, thirteen cases were concluded.
- Eighty-eight cases were investigated and three cases followed up. Most of the investigations were related to verification of authenticity of the academic documents.
- One stakeholder meeting was conducted for amendment of the Nurses and Midwives Act, 1996. A current draft exists, to be forwarded to the Minister.
- By end of June 2018, there were 65,866 nurses and midwives, 47,445 had valid practicing licenses. 72% was compliance rate to renewal. Gazetting is still in the process. List of names to be gazzetted (46,881 nurses and midwives) is with the Uganda Printing and Publishing Corporation.
- Online registration for nurses and midwives was piloted in 5 nursing and midwifery training institutions with support from ACHEST. The feedback indicated that the system was functional and welcomed. The digitized printer was purchased with support from UNFPA. Rollout of the online registration is still in the process; the platform was developed without the processes of registration. Completion of this process is to be done with support from world bank after Permanent secretary, MoH approval. The school that participated in the pilot are indicated below:

    1. Nsambya Sch. of Nursing and Midwifery
    2. Mbale Sch. of Nursing and Midwifery
    3. Arua sch. of comprehensive nursing
    4. Public Health Nurses College
    5. Lira Sch. of comprehensive nursing

- SMS system for reminders for renewal of practicing license for nurses and midwives was installed. Automatic practicing license is still in process. The script for the practicing license is being generated with support from Intra-health.
- GIS system for mapping nurses and midwives was developed and piloted in the districts of Lamwo, Gulu and Kitgum as planned. Visualized maps for the 3 districts were also developed. This was done with support from UNFPA. Reporting dashboard will be fully functional by August, 2018 with support from UNFPA.
- Nurses and midwives in 15 hard to reach districts were validated as indicated below. Kiryandongo district was not validated. The activity was conducted with support from UNFPA

Region	**Districts**	**Total Number Validated**
West Nile	Yumbe, Moyo, Adjumani	772
Northern	Gulu, Lamwo, Kitgum, Apac, Amuru	876
Karamoja	Kaabong, Kotido, Napak, Abim, Amudat, Moroto, Nakapiripirit	623

A total of 19 refugee settlement areas were visited, 14 in Northern and 5 in western. Northern: Rhino, Imvepi, Lobule, Bidibidi, Parolinya, Alere 2, Maaji, Boroli, Ayilo 1 & 2, Pagrinya, Nyumanzi, Baratuku, Palabek and Kiryandongo. Western: Kyaka II Refugee Settlement in Kyegegwa District, Nakivale refugee settlement in Isingiro District, Rwamwanja Refugee Settlement in Kamwenge District, Nyakabande refugee transit centre in Kisoro and Matanda refugee transit centre in Kanungu.

A total of 160 Nurses and midwives were verified, of these 150 were authentic while 10 were not authentic as shown by the details below:

District	**Settlement area**	**Total number verified**	**Authentic**	**Non Authentic**
1. Kamwenge	Rwamwanja	42	41	1

2. Kyegegwa	Kyaka II	38	35	3
3. Isingiro	Nakivale	73	68	5
4. Kisoro	Nyakabande	5	4	1
5. Kanungu	Matanda	2	2	0

- 13 regional satellite centers supervised (Hoima, Lira, Gulu, Arua, Moroto, Soroti, Mbale, Jinja, Masaka, Mbarara, Kabale, Fort portal, Mubende) with support from UNFPA. 12 centers were found functional, 1 centre (Mubende) not functional.
- 8040 new qualified nurses and midwives were registered and enrolled. 12 of these were foreign trained.
- 11,941 nurses and midwives registrations were renewed.
- A total of 70 clinics were registered, 40 nursing clinics and 30 maternity clinics.
- A total of 614 clinics were renewed, 151 nursing clinics and 463 maternity clinics.
- 13 curricular were reviewed, of which only 6 were approved

Name of University	**Name of Program**	**Recommendation**
FINS Medical University	Bachelor of Midwifery Science	Not approved
Mbarara University of Science and Technology	Bachelor of Nursing Science (Direct)	Not approved
Victoria University	Bachelor of Nursing Sciences	Not approved
Islamic University in Uganda (IUIU)	Bachelor of Science in Nursing	Approved
Mulago	Diploma in Palliative care Nursing	Not approved
MoES (BTVET)	Certificate in Nursing	Approved
	Higher Diploma in Public health	Approved
Uganda Christian University (UCU)	Master of Nursing Science – Nurse Education	Approved
Kabale University	Bachelor of Nursing Science	Approved
International Health Sciences University	Bachelor of Science in Midwifery (Completion Program)	Approved
Mountains of the Moon University	Bachelor of Science in Midwifery (Extension Program)	Not approved
Aga Khan University	Advanced Diploma in Oncology Nursing	Not approved
	Advanced Diploma in Critical Care Nursing	Not approved

- 35 health training institutions and universities were inspected for various reasons as elaborated below:

Institution	**Reason for visit**	**Recommendation**
Dokolo School of Nursing and Midwifery	To assess suitability to commence nursing and midwifery programs	Approved
Evelyn School of Nursing & Midwifery		Not Approved
FINS Medical University		Not Approved
Life Spring School of Nursing & Health Sciences		Approved
Mbarara Medical International Institute		Not Approved
Mt. Elgon School of Nursing & Midwifery		Approved
Mubende Answered Prayers School of Nursing & Midwifery		Approved
Nightingale Institute-Nkozi		Not approved
NESDA School of Nursing & Midwifery		Not approved

Nkumba University School of Nursing & Midwifery		Approved
Nsaka University – Jinja		Not approved
Sebei School of Nursing and Midwifery		Approved
Soroti University		Not approved
Sembabule School of Nursing and Midwifery		Not approved
NESDA		Not approved
Mbarara International Medical Institute		Not approved
Bugongi College of Nursing and Midwifery		Approved
Central school of Nursing and Midwifery		Not approved
Sebei School of nursing		Approved
Dokolo School of Nursing and Midwifery		Approved
Kumi proposed School of Nursing and Midwifery		Approved
Bweyale School of Nursing & Midwifery	To assess suitability for full registration	Not approved
St. Johns School of Nursing & Midwifery		Approved
Rwenzori School of Nursing and Midwifery		Not approved
Indian Institute of Health & Allied Sciences	To assess suitability to start new programs	Approved for certificate programs
Kisiizi School of Nursing & Midwifery		Approved for diploma programs
Mayanja Memorial Medical Training Institute		Approved for diploma programs
Mityana Institute of Nursing and Midwifery		Not approved
Rakai Community School of Nursing & Midwifery		Approved for diploma programs
Victoria University		Not approved
Mayanja Memorial		Not approved
Mayanja Memorial Medical training institute		Approved for Diploma programs
Access School of Nursing and Midwifery		Not approved
Masaka School of Health sciences	To ascertain compliance to standards	Were found compliant with minor gaps in staffing

- 4 meetings were held in the planned regions for 30 + 24 districts, 12 Teso region & 12 greater Mbale region. This was done with support from Intrahealth The districts included: **Greater Mbale**: Butaleja, Kibuku, Budaka, Tororo, Sironko, Bududa, Manafwa, Bukwo, Kween, Kapchorwa, Bulambuli. **Teso**: Soroti, Kaberamaido, Katakwi, Amuria, Serere, Kumi, Ngora, Bukedea, Pallisa, Butebo. **Central**: Nakasongola, Kyotera, Kalungu, Lwengo, Mukono, Buvuma, Wakiso, Gomba, Mpigi, Bukomansimbi, Masaka, Mityana, Kalangala, Lyantonde, Mubende, Sembabule, Rakai, Butambala, Kayunga, and Luwero. **Busoga**: Kamuli, Jinja, Namutumba, Iganga, Mayuge, Luuka, Kaliro, Bugiri and Buyende.

- 19 meetings were held, 16 for the committees and 3 for the full council. Committees in the council include: Disciplinary, Education, Training and Registration, Inspectorate and Quality Assurance and Finance, Administration and Planning.

Lessons Learned/Best Practices

During the entire FY, the Council has had the following lessons to learn:

Enhancement of professionalism and adherence to standards requires a collective effort of all relevant stakeholders. We have noted that the current situations/conditions on ground in various health facilities undermine the enforcement efforts of the council. There is need for an effective monitoring and evaluation system to be in place if adequate evaluation of performance is to be done.

Recommendations/Proposed reforms to improve Performance

In regard to the challenges and lessons learnt during this FY, the Council has the following recommendations to make:

There is therefore need to re-strategize involving all key stakeholders – politicians, development partners, policy makers, employers etc. to combine efforts.

- Strengthen the district health supervisory authorities and the regional satellite centers to enhance supervision at the grassroots.
- Strengthen collaboration with police and other security agencies in the investigation process.
- Strengthen the internal audit function of the Council.
- Develop and implement monitoring and evaluation systems for the Council.

3.2.9 Pharmacy Board

The Pharmacy Board is established by the Pharmacy and Drugs Act Chapter 280, Laws of Uganda 2000 edition to protect the society from substandard and unethical pharmaceutical practices by ensuring practicing pharmacists are duly registered and adhere to National, Regional and International pharmacy practice standards at all times, and to discipline the errant pharmacists.

Achievements

- The Pharmacy Profession and Pharmacy Practice Bill review report discussed at Senior management, HPAC and Senior Top management committees. The final report is due to be presented to First Parliamentary Counsel for inclusion in the Bill.
- Electronic database of registered pharmacists created with support from Intra health SHRS. Reliable data on the numbers of Pharmacists registered by gender, District of origin etc. can be produced/accessed any time.
- Two batches of newly qualified Pharmacists were registered. A few more Ugandans accessed services from registered Pharmacists and hence possible minimization of prescription error, wastages and improved quality of Pharmaceutical care where they are offering services to the population.
- Four board meetings and three committee meetings held.
- Names of Registered Pharmacists gazette. It is easy access to gazetted list of registered Pharmacists.

Challenges

i. Delays in enacting the Pharmacy Bill, stalling the development and the effective management of the pharmaceutical sub-sector.
ii. Inadequate finances, resulted into some planned activities such as review of the Pharmacy Board business plan and development of the Plot in Butabika into Offices not being done.
iii. Inadequate Human resources for the secretariat.

3.2.10 Allied Health Professional Councils (AHPC)

The Allied Health Professionals Council (AHPC) is a body corporate established by the Allied Health Professionals Act Cap. 268 to regulate, supervise and control the training and practice of the allied health professionals in Uganda.

Achievements

- 18/2,925 applicants assessed for professional competencies and skills before registration
- 2,938 / 2,590 newly qualified AHPs registered. Medical Clinical Officers, Health Assistants and Laboratory Assistants are in excess supply.
- 16,299 / 9,824 Annual practicing Licenses issued.
- 2,458 / 1,328 private health facilities registered and licensed.
- 753 / 555 Medical Laboratories registered and licensed.
- 8,423 / 7,500 health facilities inspected to ensure compliance with established standards. There is improved quality of services and staffing within inspected health facilities. All licensed health facilities found under un qualified personnel must be closed operating license revoked and supervisor referred to disciplinary committee for appropriate action
- Published Gazette (Vol. CXI No. 27 of June 8th 2018 in which 10,244 professionals were published.
- 26/48 allied health training institutions to ensure compliance with established standards. Most health training institutions are ill equipped as compared to available resources thus affecting quality of learning in the long run.
- Conducted 83 / 60 sensitizations for employers and allied health professionals in upcountry districts. Some district service commissions have limited capacity to assess eligibility of applicants documents.
- Conducted 34 / 30 support supervision visits to established supervisory authorities.
- 10 / 20 cases were investigated.
- 106 / 1,500 illegal practitioners were handled.
- 272 / 1,000 non-compliant practitioners were suspended from practice.
- Participated in regional and international conferences or meetings.
- 7 / 24C Council meetings were held. Delayed appointment of governing council left many activities not implemented.
- 8 / 24 Advisory Board meetings were held. Delayed appointment of governing council left many activities not implemented.
- 48 staff paid salaries and allowances.
- 18 performance review meetings were held.
- 2 pick-ups were procured for the regional offices.
- Undertook renovation of the board room with an office at AHPC
- A bi annual newsletter was published containing key information about AHPC.
- UGX 3,181,844,494 / 2,473,790,000/- was raised from fees charged to professionals and clients for services offered by the AHPC.
- Received UGX 78,155,506/- out of the planned UGX 75,000,000/- as release from MoH for FY 2017/18.

Recommendations

- Preregistration assessment statutory instruments should be expedited by the Council with support from the MoH.
- There is need to refocus on training of cadres in short supply like Anaesthetic Officers, Dispensers and Radiographers.
- All employers of health professionals must delete non-qualified staff.
- All employers must always liaise with professional council during recruitment and selection processes.
- There is need for better means of transport and spacious offices for regional officers.
- All employers must desist from retaining suspended professionals in their employment.

3.2.11 Uganda Medical and Dental Practitioners Council

The mandate of the UMDPC is to regulate the medical and dental practitioners in Uganda.

Achievements

- Inspected Kabale and Busitema Universities in collaboration with National Council for Higher Education (NCHE).
- Inspected internships sites.
- Updated the list of qualified graduates. A list 0f 611 graduates submitted from 4 Universities.
- Ethical sensitization done in Makerere.
- Reviewed 3 curricula from Gulu and UCU. Funded by NCHE
- Facilitated 5 professional associations to conduct CPD activities
- MLEB Exam conducted in March/April 2018.
- 4 Peer review meetings for foreign trained doctors
- Held 2 Regional ethical sensitization workshops in Kigezi and Bunyoro.
- Inspected 416 H/U in Wakiso/Mukono and 1,800 health units upcountry by the Regional Inspectors.
- Inspected all refugee settlements.
- 353 / 550 Provisional Licenses issued to the Medical & Dental Practitioners.
- 581 / 500 Full Registration Licenses issued to the Medical & Dental Practitioners.
- 4,563 / 4,000 Annual Practicing Licenses issued to the Medical & Dental Practitioners.
- 188 / 1,120 Specialist Certificates issued to the Medical & Dental Practitioners.
- 664 / 400 temporary Licenses issued to foreign trained Medical & Dental Practitioners.
- 209 / 150 certificate of good standing awarded to the Medical & Dental Practitioners.
- 2,148 / 2,000 Operating Licenses issued to existing health facilities.
- Drafts for statutory instrument for Collegiate training completed.
- Fast tracked the Assisted Reproductive Technology & Joint Health Professionals Council Bill principles.
- Reviewed MLEB & CPD guidelines.
- UMDPC revised Act still in progress.
- Application forms updated for effective registration and licensure.
- Inaugural & 3rd Quarterly Council meeting held.
- Research on quality of services in private clinics done together with MUSPH.
- Attended AMCOA meeting held in South Africa and protocols on IT, Ethics, workforce migration were launched.
- Worked with IFC and ACHEST to implement the web based registration platform.
- The Butabika land was surveyed. Parties seeking for funding acquiring Joint HPA Council premises; transport facilities and equipping Council offices for efficient and effective operations.

Challenges

- Weak and conflicting provision of the acts. The UMDP Act does not empower the inspecting officer to close a facility or effect arrest, even if the health unit does not meet the minimum standard of practice.
- Bottlenecks still exist in human resource and infrastructures in both public and private medical and dental schools.
- Gaps in internship sites range from overcrowding of interns, inadequate number of supervisors, and shortage of equipment, supplies and lack of accommodation**.**
- Slow speed in processing cases due to delays from our stakeholders notably the Police, Judiciary and the complainants.
- Inspection of health facilities recorded practice beyond scope, many clinics do not meet the required standards, absentee supervising doctors, idle equipment, laboratory fridges are used to keep food stuffs and other drinks, delay by the Waste collection companies and inadequate staff.
- Quacks are many but apprehending them is difficult because community support them, unregulated traditional herbalist and inadequate follow-up of closed health units.
- Resistance of some clinics to be inspected coupled with foreigners practicing without work permits & questionable academic qualifications

- District Health Supervisory Authorities (DHSA) are inactive due to financial constraints.
- Inadequate staffing at the secretariat resulting to inadequate visibility
- Professionals who upgrade to MO but maintain their registration with their former parent Council is challenging to regulate.

Recommendations

- MoH should plan for the number of graduates and how to handle them and revamps the internship sites to enable them produce competent and committed professionals.
- Council should request all medical and dental schools to provide the number of students admitted each year and those at all stages of training to able Council track the intake, progress and outputs of each University.
- There should be a joint Councils' inspection to ensure standards and UMDPC should sensitize the owners of facilities on the minimum required standards for the clinics it licenses e.g. equipment, furniture, buildings, room space.

3.2.12 Uganda Virus Research Institute (UVRI)

- Renovation of 3 staff houses and the office premises.
- With support from Rakai Health services, the institute got an extra piece of land that has been designated as staff parking.
- With support from the United States Government through DRA, the laboratory has been set up at the Arua station and it is in its final stages of completion.
- 2 research groups supported for field work.
- Mosquito Surveillance in Lira and Kitgum carried out.
- Surveillance of Rift Valley Fever in Kiboga, Mityana and Kiruhura carried out. Continued with Diagnostic activities at the Institute to confirm outbreaks of CCF.
- Acute Febrile illness studies carried out in Arua and Kasese Districts. samples tested for different Arboviruses.
- Technical audits carried out on the field sites of Kyamuribwa and Masaka.
- Tested 9361 AFP samples.
- Confirmed and supported the response to the measles outbreak.
- Received 36 to be tested for Drug resistance.
- Carried out LQMS training for 78 officers drawn from various hospital labs.
- Carried out insecticide resistance profiles in the cattle corridor.
- Continued with Mapping zika vector profiles around Entebbe.
- Epidemiological research in Rakai and Masaka districts carried out.

3.2.13 Joint Clinical Research Centre (JCRC)

Key functions include;

a) Provision of a scientific solution to the HIV/AIDS epidemic through Internationally accepted research.
b) Provision of state of the art treatment and care for HIV/AIDS in Uganda and the world.
c) Provision of infrastructure for collaborative research from National and International researchers/institutions.

Achievements

- Scale up generation of Research
    - 5 publications from secondary data
    - 20 research publications
    - 10 conference presentations
- Enhance delivery of Clinical Services
    - Improve patient Turn Around time from 45 minutes to 30 minutes

- Maintain at least 80% in care.
- 100% availability of x-ray, ultrasound and ECG consumables
- Trained all Clinic staff in new ART guidelines
- Maintained 100% availability of stock of drugs
- At least 90% of patients with unsuppressed Viral loads
- Strengthened 3rd line drug supply chain
- Paid for doctors practicing licenses

- Improve efficiency of laboratory services
  - Attained CAP accreditation of the laboratory
  - Improved results TAT to an average 45 minutes.
  - 95% LIMS operationalization
  - Conducted an internal laboratory audit
  - Paid for all laboratory staff practicing licenses

3.2.14 UGANDA MUSLIM MEDICAL BUREAU (UMMB)

UMMB is a national organization established by the Uganda Muslim Supreme Council (UMSC) in 1999 to coordinate activities of Muslim non-profit health facilities. The Bureau is the main link between these facilities, the government and other stakeholders.

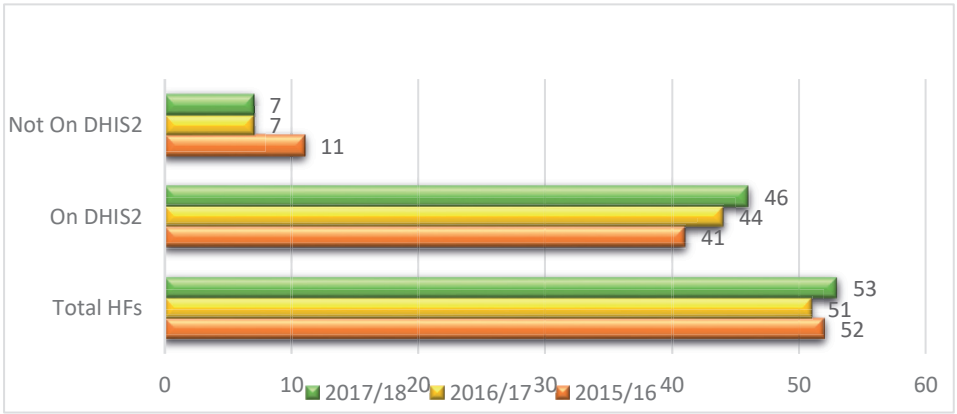
By the end of the FY 2017/18 the membership of the bureau consisted of 52 health facilities, one Nurses and Midwifery training institution and one Medical Laboratory training institution. Construction of another health training institution in Yumbe District is underway.

3.2.14.1 UMMB Performance during the FY 2017/18

1. EHMIS/DHIS 2 coverage in UMMB for 2017-2018 FY

The UMMB network has a total of 52 health facilities with 5 hospitals, 2 HC IVs, 25 HC IIIs and 20 HC IIs. UMMB health facility network has been reporting directly to the districts. Some facilities enter their data directly into the DHIS2. Facilities' reporting on the DHIS2 and to the district has been progressively improving since 2015/16 FY. By June 2017/18, 90% of the UMMB health facilities were on the DHIS2 and are reporting with the districts and UMMB has rights to the DHIS2 to review and analyze the data.

FIGURE 74: DHIS2 PRESENCE BY FACILITY SINCE 2015/16 TO 2017/18



2. HRH levels in the UMMB network

UMMB improved its HRH levels in the last FY with an increase from 567 to 669 health workers with an increase of 17% of staffing levels. Only 2% (8 workers) are seconded, supported by the districts, 9% (63 health workers) supported by partners i.e. SUSTAIN, Mildmay and Masaka IBC - Rakai health sciences project and 89% of the health workforce are supported by the user fees.

TABLE 67: STAFF AT UMMB HEALTH FACILITIES BY JUNE 2018

Cadre	Number
Senior Consultant	2
Consultant	4
Senior Medical Officer	4
Medical Officer	12
Clinical Officer	58
Enrolled Nurse/Midwife	161
Registered Nurse/Midwife	39
Laboratory Technologist	3
Laboratory Technician	28
Laboratory Assistant	40
Radiographers	6
Dental Officers/Assistants	3
Anesthetic officers/Assistants	2
Pharmacists	4
Dispensers	2
N/As	87
Other support staff	244

Source- iHRIS

3. OPD utilization

The UMMB network continued providing OPD services and there has been a steady improvement across financial years. This has been partly attributed to improved records management and reporting both to the secretariat and districts. Malaria still dominates the OPD as a case/diagnosis managed across all UMMB facilities established 31% in this FY.

TABLE 68: OPD ATTENDANCES IN UMMB HEALTH FACILITIES

	2013/14	2014/15	2015/16	2016/17	2017/18
Hospitals	56,880	65,982	77,441	89,057	89,099
LLUs	209,922	210,954	213,235	207,856	210,655
Total	**266,802**	**276,936**	**290,676**	**296,913**	**299,754**

4. Deliveries in the UMMB network

There has been a consistent improvement/increase in the maternal services utilization and deliveries since 2015/16 FY. This could be attributed to presence of qualified midwives at the health facilities, improved infrastructure for maternal services and increases community mobilization by health facilities through outreaches. There was a 25% increase in total deliveries in 2017/18 FY compared to 2016/17 FY.

All HC IIIs and above are accredited to provider eMTCT services (option B+). Some HC IIs (8 HFs) also provide maternity services and are accredited for option B+. The presence of qualified Midwives and Enrolled Comprehensive Nurses have been instrumental in improving maternity departments in terms of management and equipment.

The HIV+ exposed infant rate was at 2.9% in 2017-18 FY compared to 3.8% of 2016-17 FY, 100% (i.e. 2.9% of total deliveries) of HIV+ exposed infants were initiated in the exposed Infant diagnosis care for monitoring of all babies for HIV/AIDs. 8% of infants monitored were initiated on ART treatment (turned positive).

There has been a significant improvement in postnatal services in the network attributable to voucher projects run across the network facilities. There was an increase of 108% and 39% in 2016/17 FY and 2017/18 FY respectively for mothers attending postnatal services.

TABLE 69: NUMBER OF DELIVERIES IN UMMB NETWORK FACILITIES

Level	2015/2016	2016/2017	2017/2018	Level	2015/2016	2016/2017
	Deliveries	HIV+ Deliveries	Deliveries		Deliveries	HIV+ Deliveries
Hospitals	3,973	102	4,569	Hospitals	3,973	102
LLUs	2,826	100	3,250	LLUs	2,826	100
Total	**6,799**	**202**	**7,819**	**Total**	**6,799**	**202**

5. ANC AND FAMILY PLANNING SERVICES

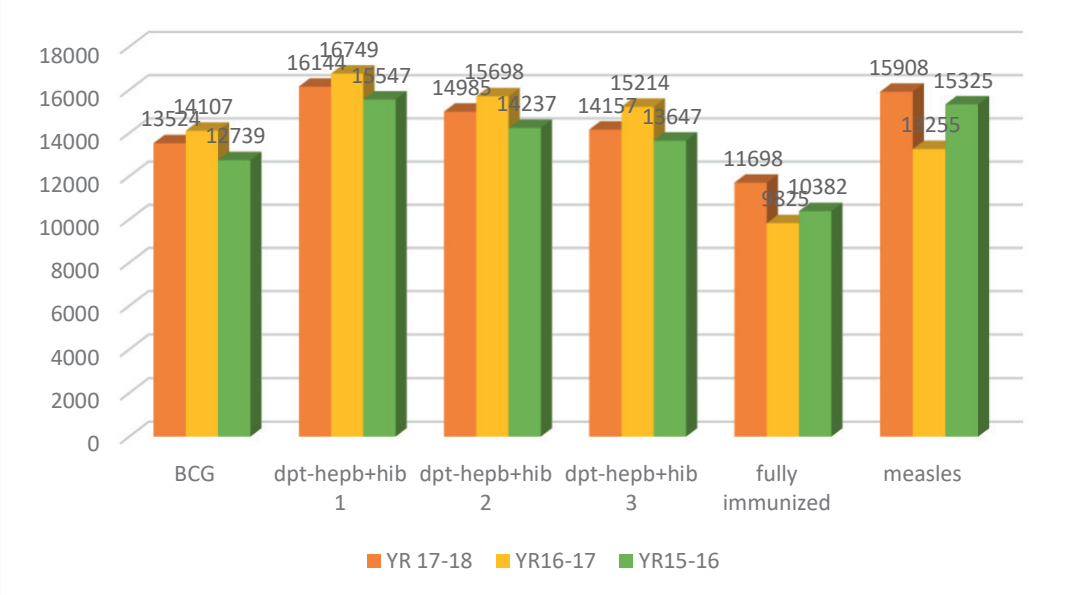
Generally, ANC improvements have been realized since 2015-16 across all facilities. There was a significant increase in HIV+ mothers identified and enrolled in care for eMTCT throughout the three years period. In 2017-18 an increase of 188% of mothers initiated in care compared to 2016-17 and this could be attributed to the availability of qualified staff (both Midwives and Nurses) and the intensified community engagement by the network facilities through outreaches on immunization & malaria treatment using the ICCM mechanism. The ANC prevalence rate moved up to 2.3 in 2017/18 from 0.9% in 2016/17. This could be attributable to increasing number of mothers attending ANC services with increased community mobilization for ANC testing by health workers and VHTs in the communities.

UMMB provides all FP methods except for permanent methods like Tubal ligation and vasectomy. When compared to 2015/16, FP services utilization increased by 134% and this could be attributed Partnerships with implementing partners like UHMG to scale up FP services in the network which improved access to FP services through community outreaches.

6. Immunization

Compared to 2015/16 FY, there is an increase in immunization for all doses. DPT2 & DPT3 dropout rate was 5% and 6% for 2016/17 FY and 2017/18 FY respectively. Measles immunization increased in 2017/18 FY compared to 2015/16 FY with an increase of 4%. The immunization completion rate (fully immunized) for 2017/18 FY was established at 86%.

FIGURE 75: IMMUNIZATION TRENDS IN UMMB FACILITIES



7. Community Sanitation Management (CSM)

This is a new component that UMMB has added on the monitored indicators to ensure that the living conditions of the community improve in the UMMB network. Sanitation management and monitoring

ensures high levels of hygiene and community well- being to be effective at preventing the spread of diseases in the community and control the expenditure on the health. In UMMB network HFs. 0nly 10 facilities reported on Community sanitation through VHTs and community extension workers. This represents 19% of the total network reporting for CSM in 2017/18 FY.

8. HIV/AIDs Care and Treatment

UMMB continued to provide HIV/AIDS care and management through its 16 ART sites. The ART sites also adopted the Test and Treat approach in this current FY 2017/18 as implemented by MoH. By end of June 2018, a total of 5,446 clients were active on ART.

TABLE 70: NUMBER ON ART IN UMMB HEALTH FACILITIES

HF Name	No on ART (ACTIVE)
Kibuli Muslim Hospital	446
Old Kampala HC IV	51
Lugazi Muslim HC	55
Kibibi Nursing Home	126
Nakatonya HC III	35
Mbirizi UMSC HC III	58
Lyantonde Muslim HC III	1,187
Mityana UMSC HC III	161
Saidina Abubakar Islamic Hospital	1,198
Taqwa HC III	226
Bweyogerere Hassan Tourabi HC III	92
Iganga Islamic Medical Centre III	1,171
Buwenge NGO Hospital	218
Jinja Islamic Health Centre	23
Oriajini Hospital	117
Katadooba UMSC HC III	282
Total on ART by June 2018	**5,446**

9. Infrastructure

In order to increase on the available services, the following health facilities have embarked on constructing additional structures:

- Lugazi Muslim Health Centre – constructing a two storeyed building to upgrade to HC IV
- Iganga Islamic Medical Centre – constructing new building for maternity
- Bushenyi UMSC Health Centre – A new building to incorporate a maternity ward is being constructed
- Al-Noor Health Centre – Maternity ward being constructed
- Al-Hijra Health Centre – construction of theatre underway
- Katadooba Health Centre – construction of maternity ward underway

3.2.15 Uganda Protestant Medical Bureau (UPMB) Performance 2017/18

The UPMB is a National umbrella organization, for Health Facilities affiliated to Protestant Churches in Uganda. It was established in 1957 by the Church of the Province of Uganda and the Seventh Day Adventist Uganda Union (SDAUU) as a Charitable and Technical Legal entity to serve as a liaison between Government of Uganda, Donors and Member health facilities.

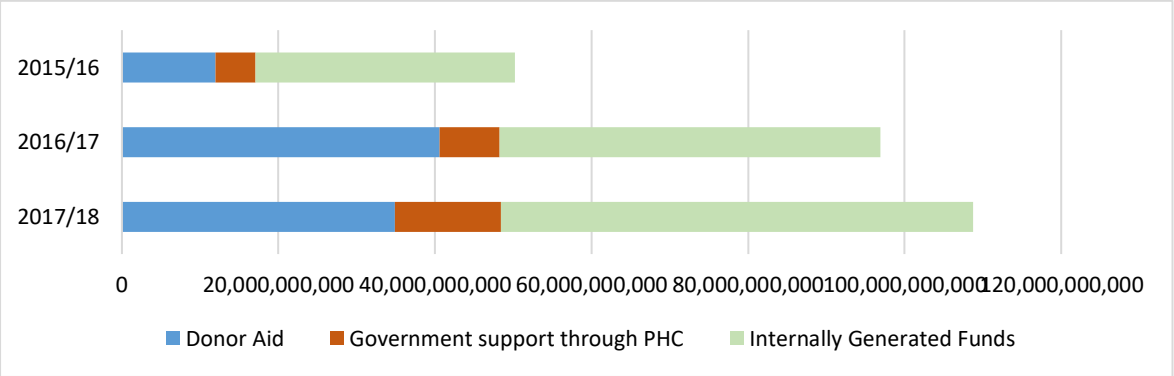
UPMB currently has a Network of 292 faith based PNFP health facilities (including Hospitals, Health Facilities and Health Training Institutions). Accessibility to drugs and medical supplies for member Facilities is ensured through the Joint Medical Store (JMS), founded and owned jointly by UPMB and Uganda Catholic Medical Bureau (UCMB).

UPMB's core function of Strengthening Health systems is achieved through four strategic objectives; Institutional Capacity Development with a focus on strengthening the Leadership and Governance, Support to Heath Service Delivery which aims at providing an enabling environment for health facilities to deliver a wide range of high quality health services, Patient Safety and Quality Health Services that supports health service delivery standards and monitoring compliance and Research, Advocacy and Networking.

3.2.15.1 Health financing in the UPMB network in the FY 2017/18

During the FY 2017/18, UPMB Member Health Facilities realized a total of UGX 108,760,115,691 accounting for a 12.3% increase in financial collections from the previous year. Internally generated revenues through user fees, tuition fees from Health Training Institutions and Community Health Insurance (CHI) contributed the highest source of income to the facilities of unto 56% while Government support and Donor funding contributed 12% and 32% respectively. For the last three years, there is a gradual increase in Health Facility incomes. Remarkable increments have been noted with internally generated funds while there was a drop in external donor funding to the facilities.

FIGURE 76: UPMB INCOME BY SOURCE OVER THE LAST 3 YEARS



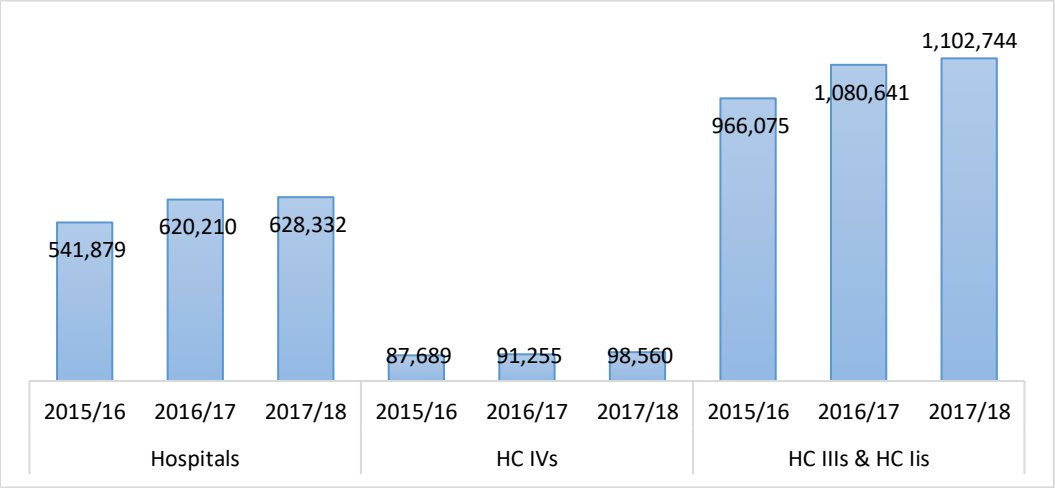
3.2.15.2 UPMB contribution to the HSDP outputs

The outputs highlight UPMB contribution towards the HSDP for the FY 2017/18 based on Key Interventional areas.

Out Patient Diagnosis (OPD) out puts

A total of 1,621,704 OPD attendances were registered at the UPMB member facilities with 1,316,472 (81%) new attendances and 305,232 (19%) re-attendances.

FIGURE 77: OPD CONTACTS IN UPMB HEALTH FACILITIES BY LEVEL

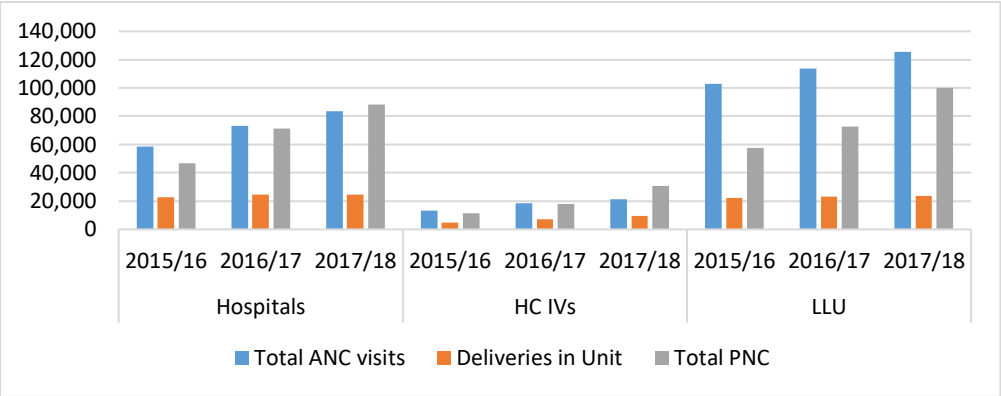


Maternal and Child Health

In general, there was an improvement in performance for MCH indicators compared to the previous year with ANC attendances improving by 11%, supervised deliveries improving by 4% and PNC attendances improving by 26%.

The improvement has been attributed to improved HMIS Reporting by the Facilities through DHIS2, improvement in Human Resources for Health even at the lower level units, Technical Mentorships to support MCH service delivery, the roll of Regional Partners, Individuals donations and other partners like ENABLE and the Voucher Projects which directly remunerated the facilities through various mechanisms to support MCH service delivery. The supported facilities registered a total 230,288 ANC attendances, 57,566 supervised deliveries within the facilities and 218,966 ANC attendances.

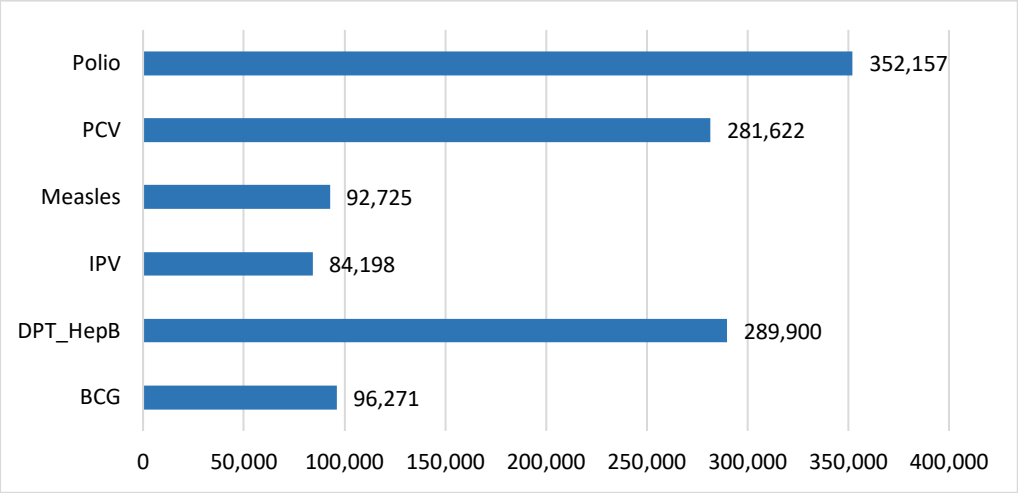
FIGURE 78: PERFORMANCE UNDER MATERNAL AND CHILD HEALTH



Immunizations

A total of 92,725 infants were fully immunized by 9 months. Figure 79 presents doses by vaccines administered across the supported facilities.

FIGURE 79: NUMBER OF DOSES BY VACCINES



Admissions

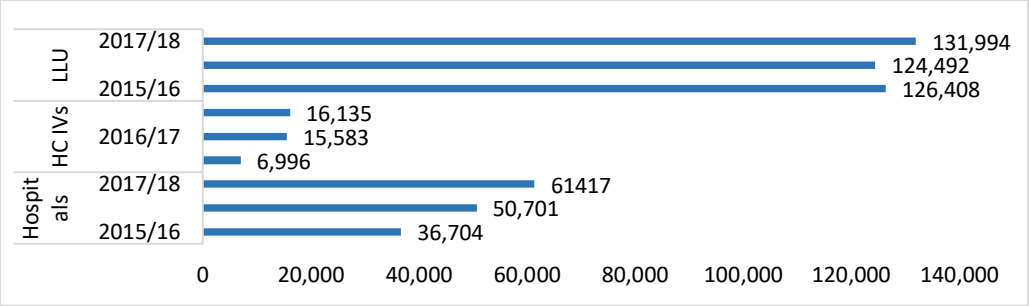
The total Facility admissions increased by 7% from 255,574 in FY16/17 to 275,050 in FY 17/18 with hospitals contributing the highest proportions. The increase in Hospital beds was also followed by increase in admissions as the facilities had improve capacity to provide In-patient Services.

Family Planning

A total of 209,546 FP users were registered at the UPMB supported facilities. The performance presented 9% improvement from the previous year.

UPMB has been central in strengthening and supporting the scale up of FP utilization within its member facilities through; expanding method mix through inclusion of Fertility Awareness Methods for FP, building the capacity of the VHTs to provide FP services including Depo and Sayana Press, supporting the supply chain for FP Methods, supported integrated outreaches for FP and intensifying awareness raising by the religious leaders collaboratively with the VHTs.

FIGURE 80: TOTAL FAMILY PLANNING USERS



Infrastructural Support

During the FY, UPMB conducted a number of structural improvements for facilities that enabled Health Service Delivery. A total of 15 health facilities received infrastructural support.

With support from PEPFAR through Centers for Disease Control and Prevention Uganda (CDC), UPMB constructed the Hub in Kagando to support Viral Load Monitoring for Patients in the Kasese Region.

FIGURE 81: REAR VIEW OF THE KAGANDO HUB WHICH WAS CONSTRUCTED WITH SUPPORT FROM PEPFAR THROUGH CDC-UGANDA

FIGURE 82: INSIDE THE HUB WAITING AREA UNDER CONSTRUCTION

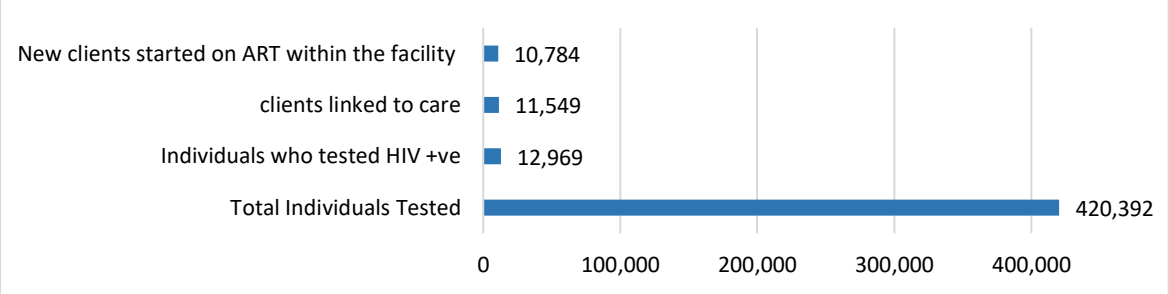
3.2.15.3 UPMB Contribution to the National HIV Response

HIV Testing Services (HTS)

UPMB facilities have increased accessibility to HTS through innovative strategies like; integrating PICT at all service delivery points, conducting targeted outreaches to key and priority populations, Contact tracing and testing using Index clients, Assisted Partner Notification (APN) and supporting community structures like supporting linkage facilitators at the facilities to enhance linkages and referrals.

UPMB Health facilities reached a total of 430,267 Individuals with HTS. 12,969 (3.1%) HIV positive individuals were newly identified, 11,549 (89.1%) newly diagnosed HIV positive individuals linked to care while 10,784 (93.4% of the HIV Positive individuals linked to care) were newly started on ART within UPMB member facilities.

FIGURE 83: INDIVIDUALS REACHED WITH HTS

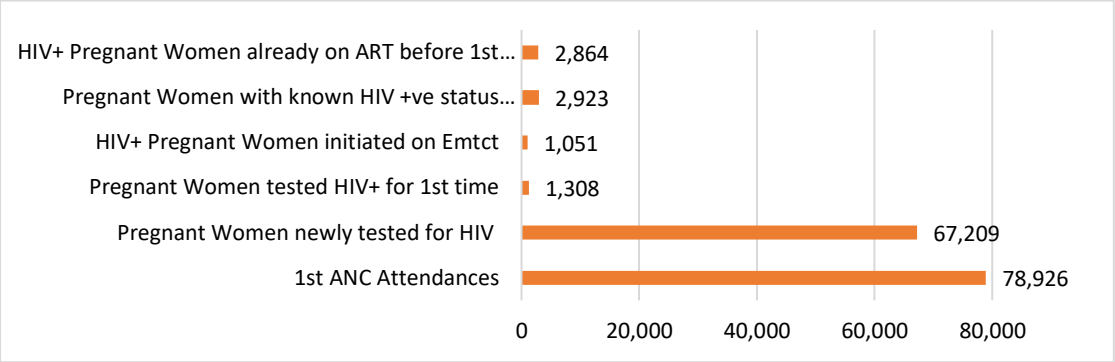


Elimination of Mother to Child Transmission (eMTCT)

A total of 78,926 1st ANC attendances were reported across all the UPMB member facilities. 67,209 (85.2%) of these were tested at 1st ANC. 4,231 HIV Positive pregnant women were identified with 1,308 (40%) newly identified HIV positive Pregnant women while 2,923 were known HIV Positive pregnant women.

A total of 3,915 (92.5%) of the identified HIV Positive pregnant women received ART with 1,051 (26.8%) newly initiated on ART for eMTCT while 2,864 (73.2%) continued on ART.

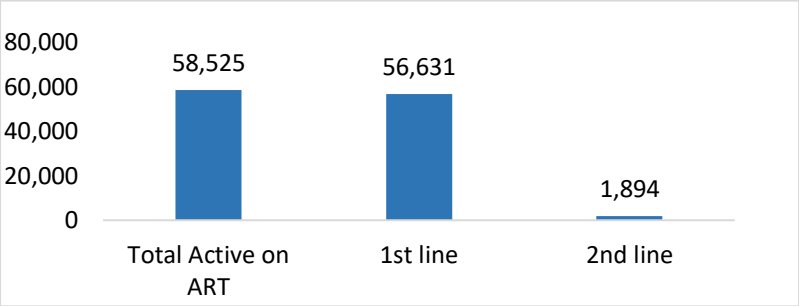
FIGURE 84: PERFORMANCE UNDER EMTCT



Antiretroviral Therapy (ART)

A total of 58,525 clients received ART at UPMB member facilities. 56,631 (96.7%) of these were on 1st line ART Regimens while 1,894 (3.3%) of these were on 2nd line ART Regimens.

FIGURE 85: INDIVIDUALS SUPPORTED ON ART



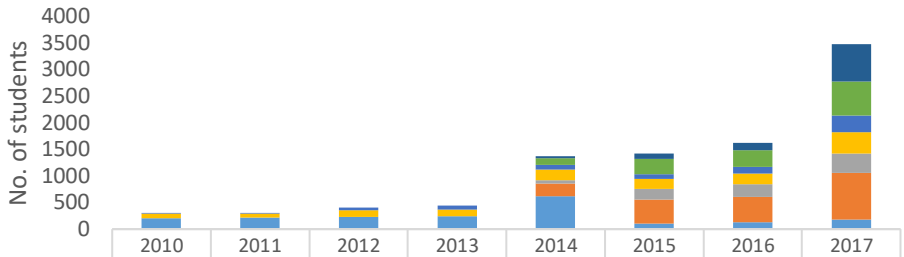
3.2.15.4 Status of Human Resource for Health in UPMB MHF 2017/18

During the FY 2017/18, the health workforce in UPMB facilities grew to 6,327 (3.9% growth compared to FY 2016/17) with 17.6% of the total HRH government seconded health workers. The growth in the health workforce was attributed to the number of Government seconded staff, increased HRH support by regional implementing mechanisms, contribution of direct HRH projects such as SUSTAIN as well as increased retention of critical cadres.

3.2.15.5 UPMB Health Training Institutions (HTIs)

UPMB has a current membership of 15 health training institutions affiliated to 15 MHFs (hospitals). The average success rate for the HTIs stood at 89%. Although during the year, Enrolled Nurses were produced most in the member HTIs, significance improvement in output was realized for critical cadres in midwifery, laboratory and other allied cadres. This is in-line with Government of Uganda health workforce master plan to increase outputs for critical cadres.

FIGURE 86: TRENDS OF HTI STUDENT OUTPUTS BY COURSE 2010 - 2017



	2010	2011	2012	2013	2014	2015	2016	2017
Registered Midwives	0	0	0	0	32	110	140	709
Enrolled Midwives	0	0	0	0	134	280	310	630
Lab technicians	11	21	40	68	76	96	126	320
Lab assistants	80	73	125	124	204	180	192	400
Registered Nurses	0	0	0	0	68	210	240	368
Enrolled Nurses	0	0	0	0	235	450	480	873
Enrolled Comprehensive Nurses	211	214	236	245	619	100	130	180

3.2.16 Uganda Catholic Medical Bureau (UCMB) Performance 2017/18 FY

The UCMB is the health department of the Catholic Church in Uganda responsible for coordination, advocacy and lobby, mentorship & technical support and supervision of accredited Catholic health services. The Bureau further provides national and regional representation and regulation of catholic health services in Uganda—which, collectively have the overall aim of building and strengthening national health systems within the framework of complementarity.

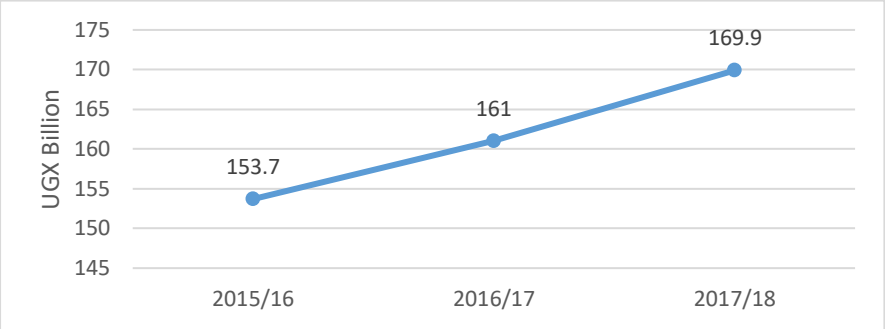
The Bureau coordinates, represents and supports 295 registered health facilities and 15 health training institutions. The health facilities comprise of 32 hospitals, 7 HC IVs, 180 HC IIIs and 75 HC IIs.

3.2.16.1 Health Financing in UCMB Network in FY 2017/2018.

The Catholic Health Network represents the largest faith-based PNFP and collects user-fees to complement service delivery. In the FY 2017/18, UGX. 169.9 Billion shillings was collected by the facilities in the UCMB network. There was an increase in user fees collections by 5.5%. User fees account for averagely 40 – 70% of the health facilities' total income—moreover in large hospitals it accounts for 80 – 95%.

The other financing sources for UCMB facilities are Donor Funding, Government subsidies mainly in form of the PHC Conditional Grant and to a limited extent Internally-Generated Income (e.g. Non-patient fees).

FIGURE 87: USER FEES COLLECTIONS IN THE UCMB NETWORK IN 3 YEARS



Source: UCMB Database

Government subsidy (PHC-CG) contribution to UCMB health services decreased slightly in absolute terms from 10.6Bn in FY 2016/2017 to 9.6Bn in the FY 2017/2018. Hospitals in the network in the FY under review received PHC-CG worth UGX 7.3Bn while Lower Level Units (LLUs) received UGX. 2.3Bn and the proportionate contribution to the total health facility income has progressively decreased—which is adversely affecting easy accessibility to quality services due to the rising cost of care.

The decline in PHC funding to the network is also partly due to accredited facilities whose PHC grants were withheld/suspended in the process of general cleaning up the non-state facility lists receiving PHC by the MoH.

Additional government support to the sector would stem the rising over-reliance of the facilities on user-fees thereby resulting in affordable quality health services.

The external donation contributions to UCMB budget both in-kind and in-cash for recurrent operations slightly increased from 36.1% in FY 2016/17 to 39% in FY 2017/18 in hospitals and lower level facilities.

3.2.16.2 UCMB CONTRIBUTION TO THE HSDP OUTPUTS

- **Outpatient Services**: Total OPD attendances decreased by 19.2% from 3,553,895 in FY 2016/17 to 2,871,474 in 2017/18. The decrease in these services is partly attributed to increased community based health promotion and prevention services that facilities conduct in their catchment areas. These efforts—together with aggressive national efforts to promote health e.g. through ITN distribution and iCCM have had a positive impact on general OPD attendances
- **Maternity services**: Total number of deliveries increased by 8.2% from 106,283 in FY 2016/17 to 115,039 in FY 2017/18. Lower Level Units registered a higher increase in deliveries than Hospitals, similar to what was observed last financial year. This is attributed to the increase in the number of LLU with capacity to deliver, as part of the UCMB long term strategy of strengthening a referral system through improved capacity of LLUs to conduct mainly normal deliveries and higher level facilities performing more complex deliveries.
- **Childcare:** The number of immunizations increased slightly by 6.6% from 2,143,544 doses in 2016/17 to 2,284,246 in FY 2017/18. There were some difficulties in accessing Rota Virus vaccine and BCG in our facilities and some babies missed these doses.
- **Inpatient services**: Total number of admissions decreased by 9.8% from 486,821 in FY 2016/17 to 438,929 in FY 2017/18.

TABLE 71: OUTPUTS IN THE SELECTED HSDP OUTPUTS IN THE UCMB NETWORK

	2014/15	2015/16	2016/17	2017/18	% Change in the Year
Total OPD attendances	3,212,863	2,911,231	3,553,895	2,871,374	-19.2%
Total ANC attendances	358,831	353,177	378,450	413,622	9.3%
Total Deliveries	94,356	99,818	106,283	115,039	8.2%
Total Immunization	2,105,887	2,147,856	2,143,544	2,284,246	6.6%
Total Admissions	460,006	494,096	486,821	438,929	-9.8%
Modern Natural FP Contacts		9,478	19,570	37,561	91.9%

SOURCE: UCMB DATABASE

The UCMB has been implementing a FP Project with support from partners—promoting WHO/USAID recognized modern methods of Fertility-Awareness Methods—namely SDM, TDM and LAM in some of its facilities but generally across the network—with activities including provider training, support to set up NFP clinics, supply of Cycle Beads, demand creation and routine technical support supervision. These activities over the last three and half years have significantly contributed to improved contacts for FP services in UCMB accredited facilities.

3.2.16.3 UCMB contribution to the National HIV response FY 2017/2018.

UCMB provides comprehensive HIV services throughout its network of facilities with support from donors, mainly PEPFAR funded implementing partners. Overall, during the year the following services were offered.

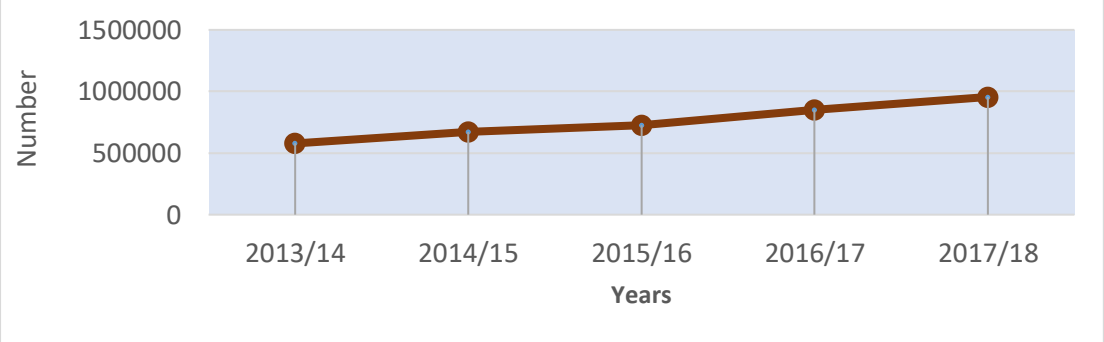
HTS & VMMC services: UCMB facilities counseled, tested and gave HIV results to a total of **955,262** individuals, representing 11% of the total country output for the year—and a **13%** increase from FY 2016/17; of these 48% were men, and 12% were under 15 years of age.

Overall, **27,325** individuals (3% positivity rate), were identified as HIV positive and 88% were documented as linked to care. A total of **3,204** (3%) were in discordant positive relationships. These were linked to appropriate services that would protect the negative partner, like initiating ART to the positive partner.

UCMB facilities circumcised a total of **41,667** men and only **212** (0.1%) experienced adverse events, which were all locally managed. This was a decrease by **8.2%** from the **45,521**, in FY 2016/17 while adverse events reduced in the period.

The graph below shows the trends of clients receiving HTS in the UCMB network—which has increased by 56% in the last 5 years—thereby contributing to increasing access to quality HIV services.

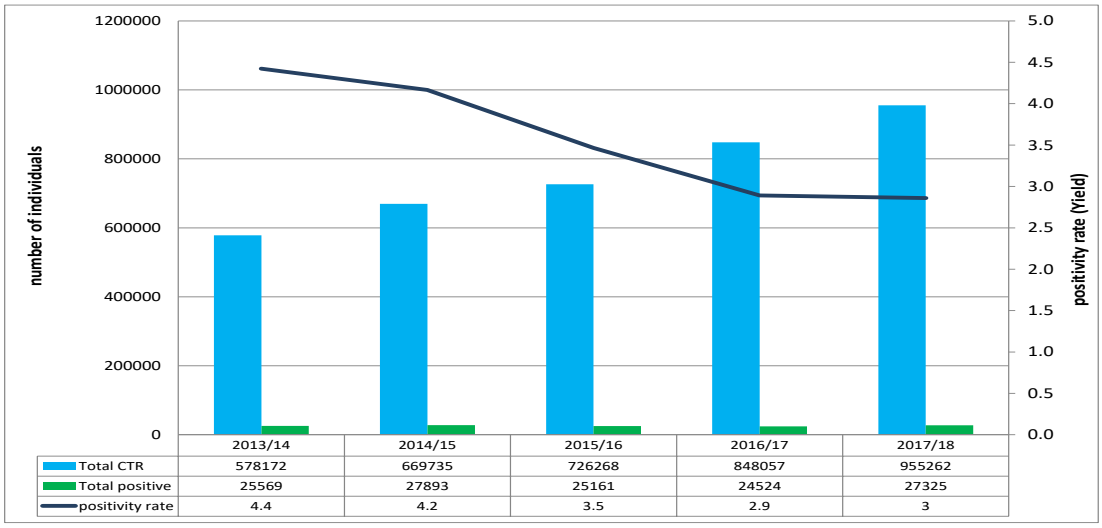
TABLE 72: NUMBER OF CLIENTS TESTED RECEIVING RESULTS



Source:DHIS2

In the same period, the average HIV Positivity Rate has reduced from 4.4% in FY 2013/14 to 3% in FY 2017/18 within the UCMB network health facilities, which is consistent with national trends of declining HIV prevalence rates.

FIGURE 88: HIV TESTING AND YIELD IN UCMB NETWORK OVER THE LAST 5 YEARS



	2013/14	2014/15	2015/16	2016/17	2017/18
Total CTR	578172	669735	726268	848057	955262
Total positive	25569	27893	25161	24524	27325
positivity rate	4.4	4.2	3.5	2.9	3

Source:DHIS2

PMTCT services: UCMB supported facilities implement interventions to eliminate mother to child transmission of HIV. These included: HIV counselling and testing, initiating positive pregnant and lactating women on ART, follow up of mothers in the community, and male involvement.

A total of 138,380 pregnant women attended 1st ANC. This represents 9.8% of the total national ANC output for FY 2017/18. And a 1% increase from 137,050 ANC1 reported in 2016/17 FY. 100% of the women who attended ANC1 were tested for HIV (includes those with known HIV results at entry in ANC); 5.9% (8249) were identified as HIV positive, and 94% (7718) were initiated on ART. Of the 8,249 positives, 2557 (31%) were new positives, while 69% were known positives at ANC1. Therefore, basing on the new positives the HIV incidence in ANC stood at 1.8% although prevalence was at 5.9% comparable with the national average of 6.3% in the same sub population.

The 6% (531) that were shown to have not started ART were actually initiated on ART but not well captured the records systems of the facilities. This gap is under follow-up through the continuous quality improvement efforts. A total of 51,782 men were tested and given results in PMTCT settings, out of whom 2% (1,030) were found HIV positive and enrolled into care. UCMB realized a 7% increase in male partner testing in PMTCT from the previous FY.

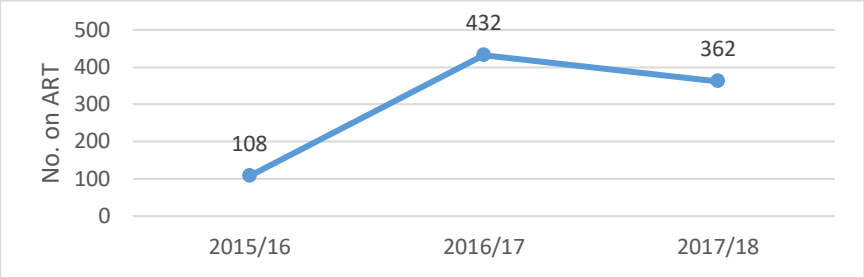
HIV/ART: UCMB facilities enrolled 19,534 new HIV positive individuals in chronic ART care, a 23% increase from the 15,887 enrolled in the 2016/17 FY. Of the new enrollees, 8% were children <15 years; 7,814(40%) were men.

Overall, a total of 109,484 clients were maintained on ART by end of the reporting period, 34% (32,358) being men. This represents a 15% increase from the 95,452 clients who were maintained on ART in the FY 2016/17. This contribution was achieved despite the decline in support to the PNFPs for HIV services. This translates into 10% of the total country ART caseload and a 1% increase in our contribution from, last FY.

The UCMB network posted a 35% growth in clients active on ART over the last three FYs—thereby significantly contributing to access to quality ART to the population.

UCMB also coordinates 2 PEPFAR funded projects as a sub partner in Kampala/Wakiso (IDI) and Masaka (with RHSP) regions were we offer direct service delivery to over 40,000 patients. These projects are run under the Inter-Bureau Coalition (recently formed special purpose vehicle) for all major bureaus in Uganda.

FIGURE 89: TREND OF ACTIVE CLIENTS ON ART FOR LAST 3 YEARS



Source:DHIS2

3.2.16.4 Status of HRH in the UCMB Network 2017/2018

The total health workforce in the UCMB network as at June 30th, 2018 was 9,774, a slight increase from 9,376 for 2016/2017.

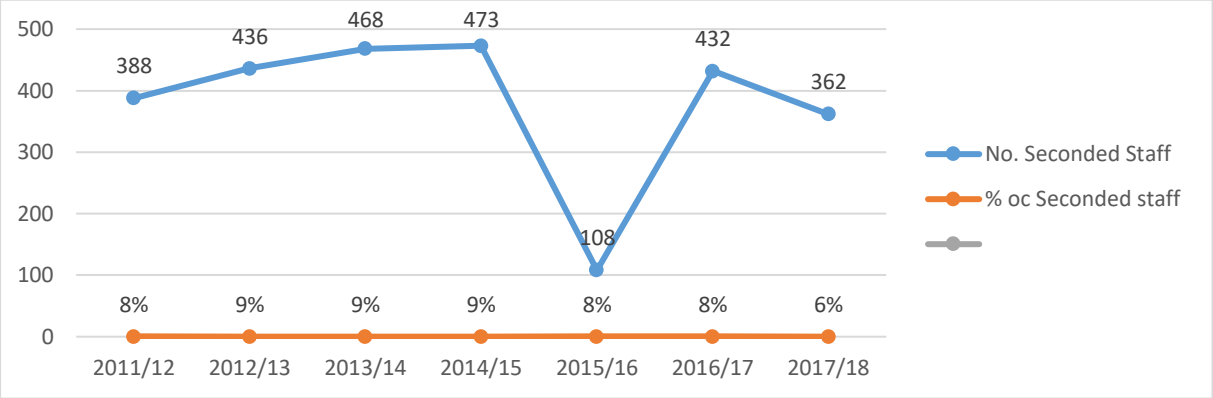
TABLE 73: TOTAL NUMBER STAFF IN UCMB HEALTH FACILITIES IN 8 YEARS

Years	2011/12	2012/13	2013/14	2014/15	2015/2016	2016/2017	2017/2018
Hospitals	5,355	5,435	5,502	5,618	5,753	5,974	6,250
LLUs	2,688	2,790	2,920	2,909	3,354	3,402	3,524
Total	**8,043**	**8,225**	**8,422**	**8,527**	**9,107**	**9,376**	**9,774**

Data Source: UCMB facility annual staffing report

However, the proportion of the clinically qualified workforce is at 57 percent and the administrative staff (non-clinical staff) remained the same. While for the support staff it has increased from 6 percent to 8 percent that represent the clinically non-qualified which are by majority the Nursing Assistants, Nursing Aide and Microscopist.

FIGURE 90: PROPORTION OF CLINICALLY QUALIFIED STAFF, AND OTHER CATEGORIES IN THE UCMB NETWORK OVER THE LAST 7 YEARS.



Source: UCMB facility Annual Staffing Report

The health facilities have endeavored to fill the staff gaps measurable to the institution output. Most UCMB health facilities utilize the workload indicators of staffing needs tool (WISN) method to define the staff establishment for especially the clinically qualified staff, to ensure the right mix and placement and recruitment of the staff to objectively fill the positions.

3.2.16.5 Health Worker Support in the Network

During the FY 2017/2018 the health facilities were able to privately employee 84 percent slightly higher by 2% from that of 2016/2017 of the total health workforce. Fourteen percent (16% compared to 17% in 2016/2017) of the human resource support was from GoU through secondment by LGs, and MoH, through

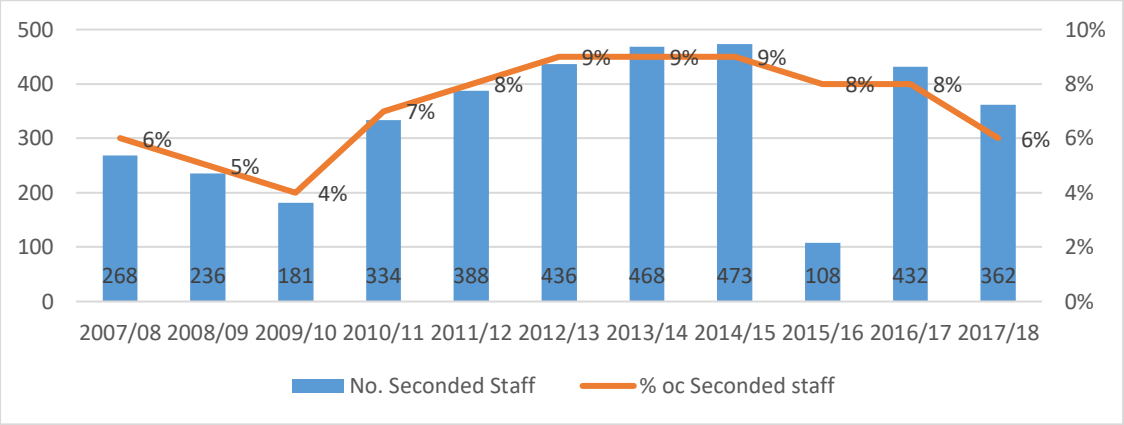
the internship system as well as religious institutions, agencies that offer support with expatriates and partners like SDS, SUSTAIN, Walter Reed, Rakai health sciences HIV/AID Project, IDI and Mildmay, MUWRP, RHITES-EC/SW. They facilitate and subsidized the cost associated with remuneration of staff. The PEPFAR HRH support to UCMB accounts for 33% of the partners' support to HRH in the network.

TABLE 74: HEALTH WORKFORCE SUPPORT FROM DIFFERENT PARTNERS IN HEALTH CARE DELIVERY

Health worker force contribution	2016/2017	2017/2018
PEPFAR HRH Support	348 (22%)	621 (41%)
GoU (MoH/Local Gov't)	432 (27%)	362 (24%)
Religious Institutions	694 (44%)	420 (28%)
Expatriate	99 (6%)	97 (6%)
Total	**1,573 (17%)**	**1,500 (16%)**

Kilembe Mines Hospital accounts for 57% of this kind of LG support, while the remainder is distributed across the country— Buluba, Kilembe Mines, Lacor, Maracha, Matany, Nyapea, Lubaga that have significant LG support.

FIGURE 91: NUMBER OF SECONDED STAFF BY MOH AND LGS TO UCMB FACILITIES 2007 - 2018



The attrition rates per the key clinical staff indicates that Nursing & Midwifery cadres are the highest and the Medical Officer attrition rate has steadily been increasing from 6% in 2015/2016 to 13 % in 2017/2018. There was a 13% reduction in the attrition of nurses, while midwifery as well as laboratory staff posted an insignificant reduction in the attrition rate for the year under review. In the year under review, majority (31%) of the staff departures were due to search for better paying jobs/terms of work, followed by others 20% to include issues related to transfers of seconded staff by Government, project closure, congregation; natural disaster, and retirement (20%). Contract termination due to various reasons including indiscipline increased in the FY 2016/17.

In FY 2016/17, there were 1,507 new staff arrivals accounting for 15% of the total staffing. Most of the new recruits were clinical personnel (77%) to replace departures during the year including nurses, midwives, Medical Officers, laboratory staff, clinical officers and other Allied Health Professionals.

The health facilities are not recruiting for 100 percent replacement due to the remuneration cost implication. The aim is to replace the key few cadres and pay them a salary which is close to that salary paid to the government health workers. However, this is at the expense of the health facilities output.

TABLE 75: NUMBER OF HEALTH WORKER RECRUITMENTS BY FY

	2011/12	2012/2013	2013/2014	2014/2015	2015/16	2016/17	2017/18
Total staff	8,043	8,225	8,406	8,566	9,091	9,376	9,774
Overall Recruits	1,729	1,755	1,626	1,029	1,565	1,572	1,507
Clinicians recruited	1,234	1,391	1,314	818	1,271	1,245	1,165
% of the clinicians recruited	71%	79%	81%	79%	81%	79%	77%

3.2.16.6 UCMB HTIs Contribution to Health Work Force Development

UCMB coordinates 15 HTIs, with the objective to train an optimal range of health care personnel of high moral and professional standards for PNFP health care facilities and national health care institutions. Certificate graduates (Nursing, Midwifery, and Laboratory) account for 80% of the total annual outputs from the UCMB Health Training Institutions. Efforts are underway to increase output for Diploma graduates consistent with international standards and trends.

TABLE 76: UCMB HTI PERFORMANCE BY PROGRAM IN 6 YEARS

Programs	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	Total	% share by Program
Certificate Nursing	148	176	230	349	354	327	1,584	29%
Certificate Midwife	137	250	292	401	435	443	1,958	36%
Certificate Comprehensive Nursing	145	131	33	39	0	0	348	6%
Certificate Clinical Laboratory	85	109	48	91	114	59	506	9%
Diploma Nursing	29	37	43	56	13	27	205	4%
Diploma Midwifery	0	0	0	0	0		0	0%
Diploma Nursing-Extension	39	67	55	50	48	83	342	6%
Diploma Midwifery-Extension	62	35	49	39	89	43	317	6%
Diploma Medical Clinical Laboratory	22	9	27	39	67	29	193	4%
E-Learning			14	0	0	0	14	0%
Total	**667**	**814**	**791**	**1,064**	**1,120**	**1,011**	**5,467**	

Source: UCMB HTI Database

3.3 Annex 3: Progress in Implementation of the 23rd RJM Aide Memoire

Milestone	Priority Actions / Recommendations	Progress as of 30th June 2018
1. Service Delivery		
1.1 Improve service delivery to citizens by addressing their key concerns	▪ Implement and monitor progress of the agreed actions in the Strategy for Health Services Improvement	Agreed actions incorporated in the annual work plans for the different Departments and implementation progress reviewed during the quarterly review meetings
	▪ Identify and redesign persistently poorly performing programs with the aim of improving targeting to reach the right people/beneficiaries.	Mid-term review of the HSDP interventions is ongoing. Report to be ready in August 2018 with recommendations

Milestone	Priority Actions / Recommendations	Progress as of 30th June 2018
1.2 Functionalize the Emergency Medical Services (EMS) and Critical Care services	▪ Finalize and roll-out EMS policy, guidelines, strategy and tools, including referral and ambulance guidelines	EMS policy has been developed awaiting approval by Top Management and Parliament. Draft EMS guidelines and manuals developed. Tools incorporated in the revised HMIS. To develop EMS Strategic plan in FY 2018/19. To cost the policy and undertake a Regulatory Impact Assessment. Referral guidelines developed and approved by Top Management. To be disseminated this FY
	▪ Training of frontline workers in emergency medicine and critical care	290 health workers from hospitals and HC IVs were trained supported by MKCCAP and KOFIH. Scholarships under URMCHIP advertised for 14 MMED EM and 15 Diploma in EM
	▪ Improve the specialized care, accident and emergencies units of hospitals	This is being undertaken by the Referral Hospitals. Kawolo hospital identified for expansion and renovation to cater for the accidents along the Kampala- Jinja Highway.
1.3 Improve coverage for indicators that have shown slow progress e.g. high malnutrition, low contraceptive use, high teenage pregnancies, high vaccination dropout rate for maternal and child health services e.g. ANC 4, IPT, high TB, malaria and HIV prevalence	▪ Finalize, disseminate and implement the communication strategy for Behaviour Change Communication to strengthen community mobilization, awareness and promote utilization of health services	Draft Communication Strategy developed and is yet to be presented for approval
	▪ Mobilize resources and implement the revised Sharpened Plan (Investment Case) for RMNCAH	Resources mobilized under the URMCHIP project (GFF, WB & SIDA = USD 165 Million), USAID Implementation Letter No.5, UNICEF, UNFPA, WHO. Resource mapping is ongoing to assess resource capacity and the report shall be presented during the RMNCAH Assembly
	▪ Disseminate the revised Maternal Perinatal Death Surveillance and Review (MPDSR) guidelines and forms and ensure mandatory MPDSR are conducted and use findings for improving maternal and neonatal care.	MPDSR Guidelines disseminated in Ankole Region, Busoga Region and Mbale Region through the RHITES Projects covering 72 districts. To cover the remaining districts under URMCHIP.
	▪ Scale up community family connect strategy & community mobilization on RMNCAH interventions	This has been successfully undertaken largely with support from UNICEF in 13 districts - Isingiro, Kabale, Rukiga, Kibale, Kasese, Oyam, Gulu, Kaabong, Kamuli, Iganga and Mayuge. This FY

Milestone	Priority Actions / Recommendations	Progress as of 30th June 2018
		2018/19 to scale up to Pakwach, Nebbi, Yumbe and Zombo.
	▪ Roll out Results Based Financing for RMNCAH services	National RBF Unit established under the Planning Department and 4 Officers recruited under URMCHIP and one financial specialist supported by Enabel. National stakeholders meeting held in February 2018 for awareness creation, and District Orientation meetings conducted in the 28 Phase 1 Districts in June 2018. Prequalification assessment and selection of HC IIIs and IVs to be undertaken in Q1 FY 2018/19.
	▪ Scale-up interventions in HIV/AIDS Control in areas of further reducing the prevalence	Critical HIV/AIDS prevention and treatment services being scaled up and he country is on the right course to meet the Fast Track targets for 2020. HIV incidence continues to fall as a result.
	▪ Strengthen TB CB DOTS	NTLP & LGs are working with the Community Health Workers, Subcounty health workers to support Community Based DOTS. Regional IPs have engaged CSOs to further engage communities in CB DOTS and TB management. The % of patients on CB DOTS is 80%.
	▪ Scale-up the Total Market Approach to increase access to priority health products and services e.g. condoms, FP commodities	Condom distribution framework developed and disseminated with emphasis on total market approach. Condom dispensers procured and distributed to all districts and placed in identified hot spots.
1.4 Improve TB Case detection	▪ Improve TB case finding (X-rays, Genexpert utilization, capacity building for health workers, contact tracing) ▪ Strengthen MDR TB surveillance and management	224 Genexpert machines are functional county wide. MDR TB treatment sites increased from 15 to 17 with addition of Jinja and Moroto RRHs. The treatment success rate for MDR TB patients was 70% for the 2015 cohort.
1.5 Improve health care waste management (HCWM)	▪ Strengthen the existing working committee on Health care Waste Management and engage other regulatory bodies to discuss HCWM e.g. NEMA, Ministry of Environment	MoH in consultation with NWSC has extensively discussed the issue of waste management for Kawempe and Kiruddu Hospitals. Kawempe to be connected to the major sewer line in the next FY and Kiruddu to use alternate system of lagoons.
	▪ Put in place a comprehensive multi-year health care waste management strategic plan	Not done MoH received a proposal from Green Label on a PPP arrangement for HCWM

Milestone	Priority Actions / Recommendations	Progress as of 30th June 2018
	and mobilize resources to support its implementation.	which was sound to be further discussed by Top Management.
	▪ Training of all health workers including waste handlers in HCWM	No report, however, on supervision practice of proper segregation and disposal is not adhered to.
	▪ Provision of color coded bins and bin liners and safety boxes	Bins available although the supply of bin liners is inadequate.
1.6 Improved supply of blood	▪ Establish system for accounting for blood at health facility level	Tools to be developed in the revised HMIS.
	▪ Generate a list of all potential institutions / organizations to help mobilize blood to expand catchment beyond schools	Done
	▪ Provide key facts (messages) for leaders and community to mobilize for blood	Members of Parliament mobilized and donated blood.
	▪ Increase resource allocation to Uganda Blood Transfusion Services	UBTS allocated an additional Ug. Shs. 10 billion from 9 bn allocated in 2017/18 and URCS allocated UG. Shs. One billion for mobilization activities
1.7 Improved availability of Oxygen at HC IVs	▪ RRHs to supply to General Hospitals and HC IVs ▪ Procure oxygen gas cylinders and accessories for GHs and HC IVs	Oxygen plants have been installed in all RRHs and supplies for lower level units are being supplied for those facilities who have cylinders Scale up of Medical Oxygen Implementation Plan 2016 – 2020 was approved by MoH Top Management in Jan 2018. Issue of financing the overhead costs for running the plants, cylinders, transport Hospitals still lack some accessories e.g. oxygen heads
1.8 Latrines built according to recommended standards	▪ Implementation of the Kampala Declaration on sanitation – Engagement of District leaders in monitoring and reporting; Display of shame lists at all levels of leadership ▪ Promote construction of latrines according to standards ▪ Strengthen enforcement of the Public Health Act	Ongoing under MKCCAP and USF in 55 LGs
1.9 Regulate rampant advertising by Traditional Complementary	▪ Establish a joint monitoring team for all regulators (UCC, Police, Regulators, MoH) to enforce regulations	Revised draft bills for the Professional Councils. Supported by ACHEST to develop a Draft Joint Professional Councils Bill

Milestone	Priority Actions / Recommendations	Progress as of 30th June 2018
Medicine Practitioners		
1.10 Improve community engagement for health	▪ Implementation of the CHEWs strategy ▪ Support training of the CHEWs (3,000) ▪ IP to utilize CHEWs and Village Health Teams instead of creating other structures	CHEWs Policy, strategy & training curriculum were finalized. GoU allocated UGX 3.2 billion for CHEW allowances in FY 2018/19 Selection of the CHEW trainees in the 13 pilot districts (Apac, Oyam, Kole, Lira, Dokolo, Amolatar, Alebtong, Otuke, Amuru, Gulu, Nwoya, Omoro and Mayuge) was conducted and training of the CHEWS shall commence in FY 2018/19 A CHW registry to monitor performance of CHW was developed being piloted in the 13 districts. Some HDPs e.g. USAID, UNICEF & WHO have committed to supporting the funding of the training, supplies and tools in the first year.
1.11 Increased focus on social determinants of health	▪ Advocacy for health-in-all-policies ▪ Active participation in the multi-sector engagements to ensure that policy decisions or other sector plans have neutral or beneficial impacts on the determinants of health.	
1.12 Institutionalization of planning and programming for refugee health	▪ Refugee health intervention plan drafted, marketed, resourced and implemented in a multi-sectoral manner	Draft Refugee Health and Nutrition Action Plan developed. To be costed and presented for approval to STM
2. Medicines and Health Supplies		
2.1. Improved capacity for procurement planning, quantification and ordering	▪ Continuous capacity building in procurement planning, quantification and ordering for all health facilities	Trainings on going with support of partners
2.2 Improved availability of medicines and supplies	▪ Strengthen the management and supervision of medicines at the districts ▪ Regular audit and reporting by the In-charges and DHT	Stock out reports prepared on quarterly basis and updates presented to HPAC on quarterly basis

Milestone	Priority Actions / Recommendations	Progress as of 30th June 2018
	▪ Continuous medical education on accountability of medicines	
2.3 Reduced stocks of expired drugs from facilities	▪ Develop guidelines / handbook for minimizing expiry of medicines ▪ Mobilize resources for disposal of expired medicines	MoH issued circular to LGs allowing NMS to collect the expired medicines which are to be destructed against the credit line budget for the facilities. Activity ongoing under NMS in collaboration with Pharmacy Division
2.4 Improve the Last Mile Delivery (LMD) of Medicines	▪ Enforce the MoU for LMD	MoUs being revised and other internal controls being enforced
2.5 ARVs supplied to all accredited facilities	▪ Continuous accreditation and updating list of all accredited facilities	Shortage of ARVs has significantly reduced this Calendar year. Some shortages of ARVs still prevail
	▪ Provision of ARVs to all accredited facilities	All accredited facilities provided with ARVs through the 3 warehouses (NMS, JMS & MAUL)
3. Human Resource for health		
3.1 Incentivize health workers for improved HRH attraction, performance and retention	▪ Provision of housing and social amenities for frontline health workers	Ongoing under different programs e.g. GAVI, Italian Support, RRHs
	▪ Absorb contract workers recruited for the sector on request by HDPs by aligning recruitment cycles to availability of recruitment resources to absorb contract staff	Ongoing in a few Local Governments due to PHC wage resource constraints
	▪ Progressively improve HW compensation	Salaries for FY 2018/19 have been enhanced for health workers
3.2 Improved staffing for critical Human Resource for Health (Anesthetic officers, psychiatrists, DHOs)	▪ Gaps driven Training/ capacity building ▪ Scholarships for critical cadres (Prioritize training anesthetic officers, Biomedical engineers, dispensers and health assistants)	182 Scholarships awarded in 2017/18 (including Bachelor in anesthesia, Diploma in Anaesthesia, Theatre Technics, Bachelor in Biomedical Engineering and other cadres. Advert for another 419 scholarships placed under the URMCHIP
	▪ Compile the list of double trained officers and present to an inter-ministerial forum HSC, MoLG, MoPS and MoFPED for special consideration in remuneration. Review the salary structure of all cadres in line with the job description	Not done
	▪ Establish mechanism for the center to take up critical staff on long term training and allow	Not done

Milestone	Priority Actions / Recommendations	Progress as of 30th June 2018
	LGs replace them so as not to disrupt service delivery	
	▪ Recruitment of substantive DHOs and ADHOs	Ongoing for LGs with wage so far 9 DHOs recruited this year.
	▪ Put in place mechanisms for making enforcing requirement of LGs to fill vacant positions in LGs	Circulars and communication circulated to Accounting Officer to prioritize recruitment of DHOs and officers on replacement
3.3 Improved Human Workforce recruitment and performance	▪ Fast-track recruitment of professional staff within the allocated available budget	Carried out by LGs within wage provision. 2,500 adverts made and by June 2018 1,200 health workers were recruited increasing staffing level from 73% to 74%.
	▪ Revise Staffing norms for RRHs and LGs	Work on revision of the staffing norms has started with the nursing cadre
	▪ Work with other stakeholders to complete revision of the Public Service Standing Orders 2010	MoPS is mobilizing resources to undertake the exercise
	▪ Introduce performance contracts for all staff with clear outputs and targets	Performance Agreements introduced for all officer from Principal Level upwards at MoH
	▪ Scale up attendance tracking with automated biometric attendance analysis routinely	With funding from DfID installed biometric scanners in 37 GHs & HC IVs, and 188 HC IIIs in 20 districts in eastern Uganda. Mobile Extended the use of the automated attendance analysis tool to 112 districts resulting into a national reduction in absenteeism without reason from 27% to 7% in a period of one year
3.4 Regular provision of Uniforms for health workers	▪ Timely procurement and distribution of uniforms in a phased manner beginning with the RRHs	Uniforms have been procured and distributed for all health workers in RRHs and General Hospitals. NMS shall commence distribution to HC IIIs and IVs in May 2018. Additional funding of Ug. Shs.1 bn has been provided in FY 2018/19 budget to make provision of Ug. Sh. 4 bn for uniforms.
4. Health infrastructure		
4.1 Establishment of HC IIIs in sub-counties without	▪ Progressively in a phased manner upgrade HC IIs to IIIs and construct HC IIIs in sub-counties without, considering the population	Funding (Ug. Shs. 200 bn) has been provided under IGFT program to upgrade 331 HC IIs to IIIs and under the URMCHIP project for upgrading 40 HC IIs and renovation of 40 HC IIIs. A total of 125 Subcounties / Division / Town Councils do not have any facility and a funding proposal has been developed to construct HC IIIs.

Milestone	Priority Actions / Recommendations	Progress as of 30th June 2018
4.2 Improved health infrastructure at HC IVs and IIIs	▪ Assessment of health facility infrastructure (HC IVs and IIIs) to guide construction and renovation ▪ Provide PHC Development Funds for completion of unfinished projects	Funding amounting to 9.4 bn Shs. has been provided in this year's budget for renovations and rehabilitations UGX 2.2 bn allocated in FY 2018/19 under the PHC Transitional Development Grant
4.3 Improved asset management in the sector	▪ Prepare, maintain and continuously update asset registers at all levels ▪ Establish fleet management system for sector fleets at all levels ▪ Budgetary allocations to LGs for asset operations and maintenance	Asset registers are updated annually and are submitted as part of the Ministerial Policy Statements. A vehicle servicing bay has been constructed for the MoH vehicles
4.4 Reliable Transport for coordination at the District Health Offices	▪ Provision of vehicles for coordination, monitoring and supervision at the District Health Offices within the available budget.	15 vehicles procured for the districts (Abim. Amuru. Bukedea, Buliisa, Butaleja, Butebo, Buvuma, Kaabong, Kaberamaido, Kagadi, Kakumiro, Kyotera, Masaka, Nakasongola and Sembabule) under URMCHIP
4.5 Equipment redistributed	▪ Take inventory of equipment, redistribute which is not in use and disposal of all old equipment	Equipment inventory undertaken in RRHs and GHs and the report is being used to plan for procurement of additional equipment with support from URMCHIP
4.6 Designs and BOQs for health structures harmonized	▪ Harmonize and disseminate the designs and BOQs for structures in the health sector	Technical Designs and BOQs for HC IIIs have been revised awaiting approval by Top Management
5. Governance and leadership		
5.1 Improved planning, including procurement planning and resource management in the sector	▪ Capacity building for evidence based planning, resource allocation, programming and procurement planning at all levels	Ongoing with support from ENABEL in West Nile & Rwenzori region; UNICEF through the Regional Planning meetings and USAID through the PBS program
	▪ Support individual programs to come up with a minimum number of high impact interventions, work out clear indicators & targets against which annual performance can be measured.	This is being carried using bottleneck analysis mechanism during the Regional Planning meetings in the LGs and during the Budget preparatory process using the PBB approach at MoH and Central level institutions
	▪ Participatory multi-sectoral and multi-stakeholder planning and	Carried out through Partner Meeting e.g. WHO, USAID, UNICEF

Milestone	Priority Actions / Recommendations	Progress as of 30th June 2018
	budgeting for health (including OAG)	Regional Budget meetings by MoFPED, Regional Planning meetings
	▪ Strengthen the health sector capacity to improve efficiency in procurement and projects execution, to reduce resource wastage	A Project Coordination Committee was established which compiles quarterly project performance reports for presentation to the HSBWG.
	▪ Enforce resource and financial management guidelines including value-for-money and mandatory timely accountability for all deployed sector resources at all levels	Ongoing and accountability for advances has greatly improved
	▪ Reduce leakage and wastage through eradication of theft / corruption (administrative measures, litigation)	Embracing internal controls and integrated support supervision by LGs and Ministers has minimized leakages and wastage
5.2 Strengthen the performance of the Hospital Boards and Health Unit Management Committees (HUMC)	▪ Induction of Hospital Boards and HUMCs	New Hospital Board members were inducted with support from Intrahealth
	▪ Finalize and disseminate the Hospital Board and HUMC guidelines	Guidelines finalized
5.3 Taxation of non-state actors harmonized	▪ Support / spearhead multi-sectoral dialogue on establishing mechanisms to harmonize taxation for non-state actors to avoid double taxation.	Not done
6. Health Information		
6.1 HMIS tools available in health facilities	▪ Printing and distribution of the HMIS tools on quarterly basis	UGX 2 billion allocated for procurement of HMIS tools by NMS HMIS tools have been procured and supplied by NMS to LLHUs
6.2 Improved quality of data	▪ Modify the DHIS2 to have DHOs validate the reports before submission to MoH	HMIS review conducted to be finalized in FY 2018/19
	▪ Revision of the HMIS for inclusion of National Identification Number (NIN) in the patient registration	Discussions are still ongoing with NIRA
	▪ Mentorship for Health Information Assistants	All health information assistants country wide have been mentored on HMIS
	▪ Review staffing norms and scheme of service to include cadre of Diploma level for Medical Record Management at all levels	To be included in the LG restructuring by MoPS

Milestone	Priority Actions / Recommendations	Progress as of 30th June 2018
6.3 All functional facilities reporting through the DHIS2	▪ Disseminate the current Master Facility List 2017	Health master facility list disseminated and are in process of updating the MFL 2018
	▪ Facilitate registration of all functional health facilities into DHIS2	To be undertaken after finalization of the MFL 2018.
6.4 eHMIS connectivity stabilized to enable timely reporting	▪ Upgrade capacity of the eHMIS – servers	Procured 4 new servers (supported by GFTAM, UNFPA, ASSIST) with high capacity – for MoH email, Health Observatory, New Instance for DHIS-2, Family Planning resource tracking, & the Knowledge Management Portal. UNICEF upgraded 2 servers for Family Connect. Established a power bank which supplies stabilized data to the data center and other Information systems e.g. IFMS, CCTV, access control, Biometric Attendance. Acquired a fire suppressing system for the Data Center.
	▪ Work with NITA-U for IT platform integration	NITA –U is represented on the E-Health TWG Internal assessment of the HIS is ongoing and developed a draft HIS exchange architecture to help in the integration of all HIS. Working on standards for all the HIS systems e.g. EMR, LMIS, CHIS in alignment with the e-health policy.
	▪ Disseminate and implement the five-year e-Health strategy	Awaiting policy approval by Parliament. Other activities are ongoing
7. Health financing		
7.1 Increased financing for the health sector	▪ Advocacy for improved domestic financing for the sector	Rationale and justification provided to Parliament for additional resources in the MPS
	▪ Prioritize deliberate capacity building, resourcing and support to the new districts	Not yet done
7.2 Health Financing reforms, including the NHIS and Results Based Financing implemented	▪ Fast track the legislation process for establishment of a NHIS	Regulatory Impact Assessment Report finalized and Cabinet Memo submitted to Cabinet
	▪ Incorporate all stakeholder inputs in formulation of the NHIS Bill.	Captured in the RIA report and Cabinet memo to be considered in the final Bill.
	▪ Scale up the RBF program	Scale up in 83 districts under the URMCHIP project has commenced.
8. Supervision, Monitoring and evaluation		

Milestone	Priority Actions / Recommendations	Progress as of 30th June 2018
8.1 Monitoring and support supervision	▪ Conduct periodic monitoring and supervision at all levels	Quarterly support supervision visits are being carried out to streamline health service delivery
	▪ Re-design and roll out a supervisee centered supportive supervision strategy	Supervision check list revised and circulated to LGs
	▪ Adopt the DHT cluster system of monitoring and supervision ▪ Scale up support supervision by sub county leadership	
	▪ Actively participate in the Community feedback system (Barazas) organized by the OPM	
	▪ Roll out the Regional Joint Review Missions	Regional JRM s carried out with support of ENABLE
	▪ Develop clear targets and performance assessment plan for all Hospital Directors, Medical Superintendents and DHOs	Performance assessment plans developed and targets set for RRHs and GHs.
8.2 Ranking of hospitals reviewed	▪ Review the formula used for ranking hospitals to take into account their core functions	Done. Replaced the PHC indicators i.e. ANC, immunizations, FP & Postnatal attendances with major surgery which includes Caesarean Sections.

3.4 Annex 4: RBF Payments to the PNFP Facilities in W. Nile and Rwenzori regions in 2017/18 FY

No.	Health facility	Level	District	Budget MOU FY 17/18	Total Payments	Execution Rate
1.	Moyo Mission	HC III	Moyo	48,433,600	**51,186,000**	106%
2.	Metu Negris Fr Bilbao	HC III		80,000,000	**74,614,000**	93%
3.	Angal St Luke	HOSP	Nebbi	709,968,000	**602,001,500**	85%
4.	Orussi	HC III		100,000,000	**90,048,000**	90%
5.	Goli	HC IV		331,920,000	**316,645,000**	95%
6.	St Joseph's Maracha Hospital	HOSP	Maracha	463,168,000	**477,671,000**	103%
7.	Yivu Abea	HC III		48,416,000	**52,205,000**	108%
8.	Pakele Maryland Kocoa	HC III	Adjumani	39,115,200	**49,195,000**	126%
9.	Adjumani Mission	HC III		90,000,000	**86,306,000**	96%
10.	Robidire	HC III		36,260,800	**40,888,000**	113%
11.	Kuluva	HOSP	Arua	620,000,000	**645,088,500**	104%
12.	Ocodri St Francis	HC III		48,814,400	**60,581,000**	124%
13.	Otumbari St Lawrence	HC III		100,000,000	**86,069,000**	86%
14.	St Luke Katiyi	HC III		42,984,000	**45,627,000**	106%
15.	Anyiribu	HC III		46,000,000	**18,574,000**	40%
16.	Ediofe	HC III		66,000,000	**27,881,000**	42%
17.	Adumi Ojee	HC III		80,000,000	**66,914,000**	84%
18.	Koboko Mission	HC III	Koboko	46,089,600	**43,911,000**	95%
19.	Lodonga	HC III	Yumbe	110,000,000	**87,148,000**	79%
20.	Kei	HC III		46,000,000	**22,571,000**	49%
21.	Agiermach	HC III	Zombo	60,417,600	**41,978,000**	69%
22.	Zumbo	HC III		57,972,000	**54,590,500**	94%
23.	Nyapea Hospital	HOSP		630,000,000	**611,857,000**	97%

No.	Health facility	Level	District	Budget MOU FY 17/18	Total Payments	Execution Rate
24.	Padre Pio	HC III	Kamwenge	87,046,400	**71,370,000**	82%
25.	Kyabenda	HC III		46,088,000	**43,120,000**	94%
26.	Kicwamba	HC III		69,315,200	**65,964,000**	95%
27.	Kyakatara	HC III	Kyenjojo	53,812,800	**42,181,000**	78%
28.	Kyembogo Holy Cross	HC III		56,000,000	**60,512,000**	108%
29.	Rwibale	HC III		80,000,000	**77,388,000**	97%
30.	Mabira St Martin	HC III		66,000,000	**58,336,000**	88%
31.	St. Adolf Butiti	HC III		56,000,000	**39,504,000**	71%
32.	Kaihura Villa Maria	HC III		40,000,000	**27,026,000**	68%
33.	St Joseph's Yerya	HC III	Kabarole	90,000,000	**79,077,000**	88%
34.	Mitandi	HC III		80,000,000	**71,981,500**	90%
35.	Nkuruba	HC III		60,651,200	**46,446,000**	77%
36.	Virika	HOSP		500,000,000	**444,151,000**	89%
37.	Kabarole hospital	HOSP		395,725,000	**255,270,000**	65%
38.	Busaru	HC IV	Bundibugyo	321,792,000	**157,244,000**	49%
39.	Kagando	HOSP	Kasese	948,992,000	**777,854,000**	82%
40.	Katadoba	HC III		57,076,000	**65,832,500**	115%
41.	Kyarumba	HC III		68,828,800	**81,630,000**	119%
42.	Kitabu St Francis	HC III		60,000,000	**63,131,000**	105%
43.	Kilembe Mines	HOSP		800,000,000	**748,935,500**	94%
44.	Nyabugando	HC III		41,780,000	**46,622,000**	112%
45.	Kasanga	HC III		76,408,000	**87,344,000**	114%
46.	Rwesande	HC IV		240,825,600	**157,339,000**	65%
47.	St Paul	HC IV		430,000,000	**414,697,500**	96%
48.	Stella Maris	HC III	Ntoroko	58,608,800	**59,445,500**	101%
49.	Wekomire St. Thereza	HC III	Kyegegwa	48,000,000	**41,970,000**	87%
	Total			**8,734,509,000**	**7,737,921,000**	**89%**

3.5 Annex 5: RBF Payments to the Public Facilities in W. Nile and Rwenzori regions in 2017/18 FY

No.	Health facility	Level	District	Medicines Donation	Budget FY 17/18	Total Payments	Execution Rate
1.	Ofua	HC III	Adjumani	10,000,000	52,300,500	64,419,750	123%
2.	Mungula	HC IV		28,000,000	364,762,500	164,679,500	45%
3.	Olujobu	HC III	Arua	20,000,000	123,040,000	132,143,250	107%
4.	Ntandi	HC III	Bundibugyo	10,500,000	97,770,000	-	0%
5.	Bundibugyo	GH		40,000,000	538,811,000	24,477,000	5%
6.	Bukuuku	HC IV	Kabarole	21,000,000	250,655,000	178,285,500	71%
7.	Kicheche	HC III	Kamwenge	4,000,000	70,101,500	51,937,000	74%
8.	Rukunyu	HC IV		26,000,000	289,999,000	257,438,500	89%
9.	Bugoye	HC III	Kasese	9,500,000	105,737,500	80,528,500	76%
10.	Kasese TC	HC III		14,500,000	130,412,500	120,658,000	93%
11.	Rukoki	HC III		8,000,000	84,462,500	70,942,000	84%
12.	Bwera	GH		55,000,000	640,695,000	404,761,750	63%
13.	Kakabara	HC III	Kyegegwa	10,500,000	103,704,500	78,613,750	76%
14.	Butiiti	HC III	Kyenjojo	9,000,000	99,217,000	77,411,500	78%
15.	Katooke	HC III		10,000,000	105,635,000	81,196,000	77%
16.	Kigaraale	HC III		10,000,000	90,390,000	69,076,000	76%
17.	Kisojo	HC III		7,500,000	88,445,000	73,980,250	84%
18.	Kyarusozi	HC IV		25,000,000	197,508,500	139,815,750	71%
19.	Oleba	HC III	Maracha	9,500,000	81,164,000	83,568,000	103%

No.	Health facility	Level	District	Medicines Donation	Budget FY 17/18	Total Payments	Execution Rate
20.	Besia	HC III	Moyo	2,500,000	56,180,000	54,039,500	96%
21.	Lefori	HC III		3,000,000	56,811,000	55,464,250	98%
22.	Logoba	HC III		7,500,000	61,645,000	57,452,500	93%
23.	Metu	HC III		10,500,000	81,756,500	56,815,250	69%
24.	Palorinya	HC III		7,500,000	62,792,500	51,292,250	82%
25.	Moyo	GH		50,000,000	375,712,500	309,848,500	82%
26.	Nebbi	GH	Nebbi	55,000,000	626,807,500	450,609,250	72%
27.	Paidha	HC III	Zombo	15,000,000	113,575,000	114,981,500	101%
28.	Warr	HC III		16,500,000	99,056,000	72,663,000	73%
29.	Zeu	HC III		14,500,000	115,851,500	85,773,450	74%
30.	Bubukwanga	HC III	Bundibugyo		37,802,500	-	0%
31.	Kisomoro	HC III	Bunyangabu		39,002,500	15,131,000	39%
32.	Bigodi	HC III	Kamwenge		40,214,875	11,007,500	27%
33.	Karambi	HC III	Kasese		38,817,500	10,722,000	28%
34.	Kyenjojo	GH	Kyenjojo		141,830,000	41,868,750	30%
35.	Nyamabuga	HC III			37,810,625	10,431,000	28%
	Total			**510,000,000**	**5,500,476,500**	**3,552,031,700**	**65%**

3.6 Annex 6: RBF Payments to Facilities under the USAID/Uganda Voucher Plus Project in 2017/18 FY

No.	Facility Name	Ownership	District	Expected Amount	Total Payments	Execution Rate
1.	Abalang Community HC III	PNFP	Kaberamaido	17,464,145	1,897,693	11%
2.	Agule Community H/C	PNFP	Pallisa	49,188,042	22,129,179	45%
3.	Ahamadiyya Muslim Medical Centre	PFP	Mbale	78,114,367	42,787,750	55%
4.	Amucu HC III	PNFP	Amuria	45,604,271	20,411,323	45%
5.	Asianut Medical Centre	PFP	Ngora	96,415,492	51,494,265	53%
6.	Atira Medical Centre	PFP	Serere	97,940,220	47,907,338	49%
7.	Beatrice Tierney HC II B	PNFP	Namisindwa	63,829,260	30,614,749	48%
8.	Bethesda Hospital	PFP	Soroti	246,699,513	161,986,530	66%
9.	Budadiri Mission HC	PNFP	Sironko	32,606,894	16,246,991	50%
10.	Buhugu HC III	PNFP	Sironko	3,713,850	110,535	3%
11.	Bukedea Mission HC II	PNFP	Bukedea	137,654,097	89,652,619	65%
12.	Busamaga HC III	PNFP	Mbale	12,166,734	503,500	4%
13.	Bushikori HC IV	PNFP	Mbale	167,643,902	86,184,537	51%
14.	Busolwe Community Clinic	PFP	Butaleja	60,317,386	34,295,798	57%
15.	Butiru Chrisco HCIII	PNFP	Manafwa	226,853,121	127,496,564	56%
16.	Butiru Holy Family Dispensary	PNFP	Manafwa	14,859,129	318,410	2%
17.	Buwasunguyi HC II	PNFP	Namisindwa	57,173,627	37,704,983	66%
18.	Community Care Medical Services	PFP	Ngora	43,060,949	13,214,672	31%
19.	Cross Emergency Medical Centre	PFP	Bukedea	71,836,310	38,193,989	53%
20.	Destiny Dormiciliary Clinic	PFP	Sironko	85,872,033	38,158,017	44%
21.	Divine Community Medical Centre	PFP	Sironko	153,461,115	79,123,558	52%
22.	Divine Medical Centre Bulambuli	PFP	Bulambuli	26,616,653	13,971,583	52%

No.	Facility Name	Ownership	District	Expected Amount	Total Payments	Execution Rate
23.	Doctor's Clinic Serere	PFP	Serere	57,132,793	25,534,049	45%
24.	Doctor's Plaza Ngora	PFP	Ngora	23,395,830	2,235,688	10%
25.	Dunamis Health Care	PFP	Bulambuli	5,895,150	1,384,150	23%
26.	Galimagi HC III	PNFP	Butebo	124,576,264	56,313,497	45%
27.	Grace Medical Centre Pallisa	PFP	Pallisa	58,592,655	6,444,166	11%
28.	Holy Innocent HC III	PNFP	Bukedea	90,592,645	49,043,817	54%
29.	Hope Medical Centre	PNFP	Mbale	163,274,210	92,743,593	57%
30.	Iki-iki Health Centre	PNFP	Budaka	119,037,130	44,672,897	38%
31.	Janju Family Health Care	PFP	Ngora	51,484,145	29,737,683	58%
32.	Jordan Medical Centre	PFP	Serere	14,529,227	8,007,373	55%
33.	Joy Medical Centre	PFP	Mbale	11,918,800	4,714,842	40%
34.	Kabasa Memorial Hospital	PNFP	Butaleja	164,058,608	85,241,566	52%
35.	Kaberamaido Catholic HC III	PNFP	Kaberamaido	58,444,147	27,850,929	48%
36.	Kalif Medical Centre	PFP	Butaleja	40,224,915	11,083,428	28%
37.	Kanginima Hospital	PNFP	Butebo	76,098,456	37,393,210	49%
38.	Kapuwai Pacodet HC III	PNFP	Kapchorwa	99,051,390	65,211,007	66%
39.	Kaserem Christian H/C	PNFP	Kapchorwa	14,168,757	4,494,971	32%
40.	Katakwi COU HC II	PNFP	Katakwi	24,385,501	1,012,582	4%
41.	Katakwi Joint Medical Centre	PFP	Katakwi	119,245,504	84,201,167	71%
42.	Kateta COU HC III	PNFP	Serere	18,505,152	6,104,061	33%
43.	Katine HC II	PNFP	Serere	24,802,100	-	0%
44.	Kidetok Mission HC III	PNFP	Serere	110,247,193	50,978,723	46%
45.	Kim-Tab Maternity Home	PFP	Manafwa	68,343,216	36,048,839	53%
46.	Kolonyi Hospital	PNFP	Mbale	441,244,524	252,359,684	57%
47.	Kona Clinic	PFP	Namisindwa	8,747,284	1,717,878	20%
48.	Kumi Hospital	PNFP	Kumi	292,453,393	170,607,916	58%
49.	Kyaterekera Domiciary Maternity Clinic	PFP	Serere	93,133,846	45,235,272	49%
50.	Kyere Mission HC III	PNFP	Serere	119,725,162	55,315,792	46%
51.	Lake Kyoga Falter Nursing home	PFP	Pallisa	44,442,911	19,935,878	45%
52.	Lucky Medical Centre	PFP	Kaberamaido	90,059,571	28,178,244	31%
53.	Lwala Hospital	PNFP	Kaberamaido	209,738,562	116,252,753	55%
54.	Madonna Domiciliary Clinic	PFP	Kapchorwa	141,020,390	76,351,155	54%
55.	Marah HC III		Budaka	19,452,852	1,596,587	8%
56.	Masha Clinic Kapchorwa	PFP	Sironko	71,783,136	38,979,677	54%
57.	Masiyompo HC III	PNFP	Sironko	43,827,621	21,269,155	49%
58.	Mbale People's Clinic & Maternity Home	PFP	Mbale	69,448,303	39,743,049	57%
59.	Michoes Medical Center	PFP	Kumi	255,911,834	136,940,148	54%
60.	Midas Touch Medical Services	PFP	Kumi	116,697,790	45,887,535	39%
61.	Molly Eriki Nursing Home	PFP	Amuria	86,133,812	49,016,448	57%
62.	Mukongoro Community Health Care Services	PFP	Kumi	127,409,481	59,890,130	47%
63.	Ngora Freda Carr Hospital	PNFP	Ngora	138,779,079	68,148,901	49%

No.	Facility Name	Ownership	District	Expected Amount	Total Payments	Execution Rate
64.	Obule Community Based HC II	PNFP	Mbale	50,119,415	31,356,376	63%
65.	Olimai Community HC III	PNFP	Soroti	76,863,662	36,253,341	47%
66.	Ongino General Hospital	PNFP	Kumi	35,871,200	7,399,399	21%
67.	Ongutoi H/C	PNFP	Amuria	2,169,218	1,387,850	64%
68.	Our Lady of Lourdes-Mulagi HC III	PNFP	Butaleja	67,013,330	40,692,648	61%
69.	Pakegido HC III	PFP	Kaberamaido	108,767,410	66,409,416	61%
70.	Pallisa General Hospital	Govt	Pallisa	7,670,851	-	0%
71.	Pallisa Kaucho Mission HC III	PNFP	Pallisa	74,640,744	36,659,121	49%
72.	Pallisa Medical Centre	PFP	Pallisa	106,855,374	43,441,759	41%
73.	Professor Wamukota Memorial Medical Centre	PNFP	Mbale	64,474,178	30,859,988	48%
74.	Rehema Medical Centre	PFP	Mbale	41,748,367	20,496,426	49%
75.	Reproductive Health Uganda-Kapchorwa	PNFP	Kapchorwa	5,476,600	35,550	1%
76.	RHU-Mbale Clinic	PNFP	Mbale	85,886,920	38,468,270	45%
77.	SESMART Foundation Medical Centre	PFP	Mbale	55,820,529	25,239,767	45%
78.	Seventh Day Adventist HC III	PNFP	Kapchorwa	74,671,208	37,296,559	50%
79.	Shared Blessings HC III	PFP	Sironko	30,217,002	12,119,249	40%
80.	Siloam Nursing Home	PFP	Soroti	20,962,883	13,273,782	63%
81.	Simu Corner Medical Centre	PFP	Bulambuli	14,178,000	-	0%
82.	Sipi Gamatui Mission HC II	PNFP	Kapchorwa	45,665,188	17,630,430	39%
83.	Soroti Medical Associates Nursing Home	PFP	Soroti	222,759,162	130,146,806	58%
84.	Soroti Medical Chambers	PFP	Soroti	72,583,675	34,913,439	48%
85.	Soroti RRH	Govt	Soroti	13,814,458	-	0%
86.	St. Mary's Salarila	PNFP	Katakwi	78,753,374	30,942,772	39%
87.	St. Anne Usuk HC III	PNFP	Ngora	79,342,948	46,386,499	58%
88.	St. Anthony HC II	PNFP	Amuria	28,712,078	15,608,899	54%
89.	St. Clare Orungo HC III	PNFP	Namisindwa	97,024,026	39,537,206	41%
90.	St. Elizabeth Magale HC IV	PNFP	Amuria	306,519,521	193,816,880	63%
91.	St. Francis Acumet HC III	PNFP	Katakwi	80,952,446	43,761,761	54%
92.	St. Francis Namengo HC III	PNFP	Budaka	54,317,876	26,067,594	48%
93.	St. Jude Clinic and Maternity Home	PFP	Bukedea	12,552,560	203,780	2%
94.	St. Kevin HC III Toroma	PNFP	Serere	66,321,540	38,613,909	58%
95.	St. Martha Maternity Home	PNFP	Sironko	153,521,212	92,557,628	60%
96.	St. Martin Amakio HC III	PNFP	Amuria	35,807,551	18,530,349	52%
97.	St. Micheal Health Care Foundation	PNFP	Pallisa	56,658,845	31,980,581	56%
98.	St. Richards Medcare Centre	PFP	Soroti	80,778,210	36,174,778	45%
99.	St. Thereza Nyondo HC III	PNFP	Manafwa	100,113,875	52,143,672	52%
100.	Teso Safe Motherhood HC III	PNFP	Namisindwa	77,564,522	42,917,249	55%
101.	Thornbury Bufumbo Mission HC II		Mbale	-	-	#DIV/0!
102.	Tropical Medical & Maternity Hospital		Arua	4,552,621	270,498	6%
103.	Tunyi Mission HC II		Bulambuli	463,600	-	0%
104.	Wa-Jo Memorial Medical Centre	PFP		67,938,557	39,210,747	58%

No.	Facility Name	Ownership	District	Expected Amount	Total Payments	Execution Rate
105.	Wango Domiciliary Home	PFP		45,947,169	23,833,942	52%
106.	Abedober HC III	HC III	Apac	126578519	71022757.99	56%
107.	Aber Hospital	Hospital	Oyam	145,346,304	100,860,410	69%
108.	Aboke Mission HC II	HC II	Kole	87,809,578	51,607,256	59%
109.	Adok Maternity Home (KENTH)	H/C II	Dokolo	13,252,129	5,099,790	38%
110.	Aduku Mission HC II	HC II	Apac	64,140,069	36,500,824	57%
111.	Adwoki Maternity Home	Nursing Home	Dokolo	60,312,590	51,752,452	86%
112.	Aero Medical Clinic	H/C III	Oyam	22,229,331	8,911,780	40%
113.	Akia Mission H/C	H/C III	Lira	13,260,450	6,065,014	46%
114.	Alanyi HC III	HC III	Alebtong	93,754,636	52,735,602	56%
115.	Alenga HC III	HC III	Apac	131,982,358	78,234,017	59%
116.	Alito Medical Centre	H/C III	Kole	30,536,245	4,742,288	16%
117.	Aliwang HC III	HC III	Otuke	175,796,072	90,595,461	52%
118.	Alleluyah Joint Maternity Clinic	HC II	Alebtong	200,982,914	119,420,496	59%
119.	Aloi Mission HC III	HC III	Alebtong	140,587,457	79,034,399	56%
120.	Amuca SDA HC III	HC III	Lira	247,200,537	148,927,186	60%
121.	Amuda HC II	HC II	Dokolo	48,835,630	28,112,306	58%
122.	Apac Medical Centre	HC IV	Apac	133,960,850	85,324,506	64%
123.	Apostolic Medical Centre	Medical Centre	Oyam	132,622,694	80,710,794	61%
124.	Aromo Clinic and Maternity Home	HC III	Lira	136,825,437	69,971,185	51%
125.	Bala MedicalL Centre	HC III	Kole	163,282,801	97,193,874	60%
126.	Bata Medical Centre	H/C III	Dokolo	16,594,129	11,219,552	68%
127.	Blessed Medical Centre	H/C III	Dokolo	25,718,675	12,097,285	47%
128.	Boroboro HC III	HC III	Lira	143,331,087	85,469,793	60%
129.	Charis HC III	HC III	Lira	79,925,200	45,190,661	57%
130.	David Fagerlee H/C	H/C III	Agago	33,560,693	14,802,920	44%
131.	Dokolo Maternity Home	Nursing Home	Dokolo	69,302,201	36,822,927	53%
132.	Dr. Ambrosoli Memorial Hospital Kalongo	PNFP	Omoro	99,544,417	56,116,865	56%
133.	Dream Centre(U) H/C III-ADAK	H/C III	Apac	11,261,288	6,221,111	55%
134.	Florence Nightingale Hospital	Hospital	Lira	67,409,962	32,404,506	48%
135.	Gift Life Medical Centre and Laboratory	Medical Centre	Nwoya	714,128,816	471,262,984	66%
136.	God's Mercy Clinic - Anaka	Clinic	Gulu	223,764,469	130,418,570	58%
137.	Good Hope Medical Services		Gulu	19,246,926	8,958,703	47%
138.	Gracious Clinic and Maternity	HC II	Lira	42,421,115	21,939,066	52%
139.	Heaven of Peace Medical Centre	H/C III	Kole	27,384,394	18,133,132	66%
140.	Hope Medical Clinic	H/C II	Oyam	17,211,734	6,725,789	39%
141.	Iceme HC III	HC III	Apac	177,358,265	104,939,604	59%
142.	Iwal Maternity Home	H/C III	Pader	36,728,921	9,700,192	26%
143.	Jafo Medical Centre	HC II	Pader	87,448,007	50,960,519	58%
144.	Jowa Medical Centre	Clinic	Agago	75,916,059	46,573,738	61%

No.	Facility Name	Ownership	District	Expected Amount	Total Payments	Execution Rate
145.	Kalongo Hospital	Hospital	Gulu	28,454,507	13,008,501	46%
146.	Karin Medical Centre	H/C III	Amuru	86,411,305	49,567,821	57%
147.	Keyo Medical Centre and Matenity H	HC III	Otuke	50,227,457	11,341,279	23%
148.	Kristina HC II	HC II	Dokolo	63,170,446	29,533,877	47%
149.	Kwera Community Maternity Home	Nursing Home	Amuru	89,413,298	61,430,230	69%
150.	Lacor HC III Amuru	HC III	Amuru	66,007,550	22,778,272	35%
151.	Lacor Health Centre III Opit	HC III	Amuru	87,776,219	51,104,229	58%
152.	Lacor HC III Pabo	HC III	Amuru	116,343,421	66,322,609	57%
153.	Lakang Community HC II	HC II	Gulu	75,807,971	42,671,941	56%
154.	Lira Medical Centre		Lira	23,706,070	967,463	4%
155.	Lukodi HC	Medical Centre	Gulu	39,763,245	21,240,195	53%
156.	Mary Queen of Peace H/C	H/C III	Oyam	4,059,647	1,932,777	48%
157.	Minakulu HC III	HC III	Omoro	63,969,669	25,041,340	39%
158.	Mother Angioletta Memorial Clinic	Medical Centre	Kitgum	129,991,914	74,844,169	58%
159.	Mother Health International HC III	HC III		51,908,347	43,429,929	84%
160.	Multi-Hope Clinic			28,298,247	7,396,047	26%
161.	New Life HC II	HC II	Lira	60,146,610	28,873,228	48%
162.	Ngetta HC III	HC III	Amuru	96,295,350	51,472,923	53%
163.	Oberabic HC II	HC II	Alebtong	33,175,199	19,221,742	58%
164.	Ocan Community Clinic	Medical Centre	Omoro	120,585,945	65,482,293	54%
165.	Pabbo Medical Centre & Maternity Home	Medical Centre	Pader	192,325,537	87,438,416	45%
166.	Pader Maternity Home	Nursing Home	Lamwo	95,021,332	54,877,716	58%
167.	PAG Health Unit Lira HC IV	HC IV	Lira	38,334,969	1,560,048	4%
168.	Pearl Medical Clinic	HC II	Oyam	196,288,055	123,275,609	63%
169.	PRAO Medicare	Clinic	Gulu	6,184,420	2,484,970	40%
170.	Reproductive Health Uganda-Gulu		Gulu	1,222,700	581,225	48%
171.	Shimone Maternity Centre			43,754,720	17,448,267	40%
172.	SOS Herman Gmeiner Medical Centre	HC II	Kitgum	31,033,246	17,143,245	55%
173.	St. Joseph's Community Medical Centre - Onywange			6,548,330	1,554,665	24%
174.	St. Joseph's Hospital Kitgum	Hospital	Gulu	519,603,178	286,744,985	55%
175.	St. Mary's Hospital Lacor	Hospital	Gulu	816,802,904	466,904,914	57%
176.	St. Mauritz HC II	HC II	Gulu	71,388,196	41,461,939	58%
177.	St. Monica Kanyagoga HC II	HC II	Lamwo	48,884,025	27,167,933	56%
178.	St. Peter & Paul HC III Padibe	HC III	Omoro	80,176,807	46,960,459	59%
179.	St. Peter's HC II Awere	HC II	Kole	38,583,818	27,114,724	70%
180.	Tikoling Mission	H/C II	Oyam	16,286,829	6,941,138	43%
181.	Timagi Community Medical Centre	HC III	Nwoya	198,794,948	92,297,373	46%
182.	Wii-Anaka HC II	HC II	Nwoya	38,024,012	19,073,711	50%
	Total			**16,295,499,756**	**8,754,394,461**	54%

3.7 Annex 7: District League Table FY 2016/17

District	PCV3		ANC4		IPTZ		Deliveries		HIV+ pregnant women initiated on ART		Latrine Coverage		Fresh Still Births per 1,000 Deliveries		Maternal Deaths Audited		TB Treatment Success Rate		Patients diagnosed with Malaria that are lab confirmed		Approved posts filled with qualified personnel in public health facilities		Monthly reports sent on time		Completeness monthly reports		Timeliness of Quarterly DBT reporting		% score (Total score /90)*100	National Ranking
	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score		
		10		5		5		10		5		10		5		5		5		5		10		5		5		5		
ADJUMANI	229,900	104.1	10.0	61.9	3.1	95.6	4.8	87.5	8.8	110.7	5.0	80.5	8.0	6.0	3.7	75.0	3.8	84.3	4.2	83.9	4.2	84.2	8.4	99.8	5.0	99.8	5.0	75	86.3	1
MOYO	147,900	116.2	10.0	72.7	3.6	123.8	5.0	97.6	9.8	79.9	4.0	91.2	9.1	6.4	3.6	50.0	2.5	79.1	4.0	73.1	3.7	82.1	8.2	97.2	4.9	100	5.0	75	85.6	2
BUSHENYI	240,600	90.4	9.0	64.1	3.2	65.4	3.3	86.0	8.6	102.6	5.0	97.0	9.7	5.9	3.7	92.9	4.6	71.6	3.6	94.3	4.7	77.8	7.8	89	4.5	97.3	4.9	50	83.4	3
GULU	298,200	112.5	10.0	42.5	2.1	82.5	4.1	98.2	9.8	94.9	4.7	77.6	7.8	9.9	2.8	80.0	4.0	58.8	2.9	70.5	3.5	98.4	9.8	95.7	4.8	97	4.9	50	82.1	4
KABAROLE	316,600	89.3	8.9	62.1	3.1	73.2	3.7	103.1	10.0	100.7	5.0	83.7	8.4	17.4	1.2	62.9	3.1	74.4	3.7	96.9	4.8	87.4	8.7	89.7	4.5	92.3	4.6	75	81.7	5
OYAM	415,500	84.2	8.4	42.7	2.1	84.2	4.2	71.4	7.1	86.6	4.3	82.4	8.2	7.1	3.4	100.0	5.0	78.8	3.9	78.3	3.9	100.3	10.0	92	4.6	97.2	4.9	50	80.8	6
KABALE	238,700	86.3	8.6	49.1	2.5	89.0	4.5	79.4	7.9	99.8	5.0	97.0	9.7	8.4	3.2	70.0	3.5	76.2	3.8	91.2	4.6	69.6	7.0	98.2	4.9	100	5.0	50	80.6	7
KAMWENGE	459,000	91.1	9.1	50.5	2.5	64.1	3.2	61.2	6.1	96.5	4.8	86.6	8.7	10.6	2.7	137.5	5.0	81.3	4.1	89.6	4.5	80.7	8.1	96.3	4.8	96.3	4.8	75	80.1	8
SHEEMA	213,300	75.8	7.6	49.9	2.5	56.8	2.8	70.6	7.1	96.3	4.8	96.9	9.7	6.2	3.6	---	5	91.7	4.6	100.0	5.0	55.9	5.6	100	5.0	100	5.0	75	80.0	9
JINJA	491,000	106.4	10.0	45.9	2.3	77.3	3.9	85.5	8.5	91.6	4.6	73.8	7.4	6.3	3.6	73.7	3.7	64.7	3.2	50.6	2.5	84.9	8.5	93.5	4.7	98.6	4.9	75	79.5	10
KYENJOJO	468,700	103.2	10.0	53.1	2.7	69.6	3.5	62.2	6.2	100.1	5.0	91.9	9.2	3.8	4.2	0.0	0.0	87.0	4.4	85.4	4.3	78.4	7.8	96.3	4.8	99.8	5.0	75	78.6	11
LUWERO	487,300	111.8	10.0	45.7	2.3	74.1	3.7	67.1	6.7	90.7	4.5	77.0	7.7	9.1	3.0	85.7	4.3	71.1	3.6	78.3	3.9	83.6	8.4	98.1	4.9	99.9	5.0	50	78.3	12
TORORO	553,600	92.6	9.3	52.4	2.6	84.8	4.2	71.9	7.2	97.9	4.9	83.0	8.3	5.1	3.9	60.0	3.0	68.9	3.4	85.4	4.3	55.3	5.5	99.7	5.0	100	5.0	75	78.2	13
RUBANDA	202,000	87.2	8.7	34.8	1.7	93.5	4.7	40.9	4.1	103.5	5.0	92.0	9.2	1.7	4.6	---	5	68.2	3.4	99.8	5.0	62.1	6.2	100	5.0	100	5.0	50	78.0	14
LAMWO	138,600	103.0	10.0	48.9	2.4	81.5	4.1	73.2	7.3	98.0	4.9	59.3	5.9	3.7	4.2	100.0	5.0	62.1	3.1	75.4	3.8	54.9	5.5	99.7	5.0	100	5.0	75	77.7	15
KIRUHURA	362,000	83.1	8.3	48.4	2.4	68.8	3.4	48.5	4.9	90.7	4.5	93.0	9.3	4.0	4.1	---	5	80.3	4.0	97.4	4.9	51.0	5.1	99.5	5.0	100	5.0	75	77.4	16
NEBBI	258,900	87.1	8.7	55.6	2.8	72.0	3.6	84.6	8.5	106.0	5.0	83.0	8.3	9.9	2.8	88.9	4.4	60.2	3.0	80.6	4.0	60.9	6.1	95.8	4.8	100	5.0	50	77.3	17
KOBOKO	229,600	90.6	9.1	53.2	2.7	48.3	2.4	61.9	6.2	94.0	4.7	80.3	8.0	7.7	3.3	100.0	5.0	76.2	3.8	94.4	4.7	80.2	8.0	88.9	4.4	88.9	4.4	50	77.0	18
BUHWEJU	131,300	121.4	10.0	57.9	2.9	89.9	4.5	33.1	3.3	74.2	3.7	88.0	8.8	4.3	4.1	---	5	82.6	4.1	98.2	4.9	55.7	5.6	97.4	4.9	97.4	4.9	50	76.8	19
DOKOLO	197,800	72.9	7.3	40.2	2.0	74.7	3.7	49.4	4.9	80.5	4.0	90.0	9.0	4.6	4.0	---	5	80.5	4.0	74.0	3.7	88.1	8.8	99.6	5.0	100	5.0	50	76.7	20
MASAKA	314,500	81.9	8.2	37.4	1.9	58.0	2.9	91.7	9.2	84.4	4.2	86.2	8.6	12.8	2.2	75.0	3.8	56.5	2.8	82.9	4.1	72.9	7.3	99.8	5.0	100	5.0	75	76.6	21

District	PCV3		ANC4		IPT2		Deliveries		HIV+ pregnant women initiated on ART		Latrine Coverage		Fresh Still Births per 1,000 Deliveries		Maternal Deaths Audited		TB Treatment Success Rate		Patients diagnosed with Malaria that are lab confirmed		Approved posts filled with qualified personnel in public health facilities		Monthly reports sent on time		Completeness monthly reports		Timeliness of Quarterly DBT reporting		% score (Total score /90)*100	National Ranking
	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score		
		10		5		5		10		5		10		5		5		5		5		10		5		5		5		
LYANTONDE	101,400	85.5	8.5	48.9	2.4	75.7	3.8	83.3	8.3	90.0	4.5	89.0	8.9	6.3	3.6		0.0	90.5	4.5	82.3	4.1	82.3	8.2	92.2	4.6	93.6	4.7	50	76.4	22
OMORO	176,900	103.6	10.0	36.8	1.8	72.5	3.6	53.2	5.3	95.4	4.8	71.0	7.1	5.5	3.8	100.0	5.0	67.1	3.4	75.0	3.7	82.0	8.2	88.4	4.4	100	5.0	50	76.3	23
KASESE	739,600	100.2	10.0	52.8	2.6	75.0	3.8	64.2	6.4	103.5	5.0	78.3	7.8	8.9	3.0	71.4	3.6	92.2	4.6	66.4	3.3	63.5	6.4	95.6	4.8	96.6	4.8	50	76.3	23
KIBAALE	166,000	126.1	10.0	29.2	1.5	63.6	3.2	45.4	4.5	92.2	4.6	86.3	8.6	10.9	2.6	100.0	5.0	72.6	3.6	81.2	4.1	85.8	8.6	96.4	4.8	99	5.0	50	76.2	25
NTUNGAMO	509,700	81.0	8.1	38.6	1.9	49.9	2.5	51.4	5.1	94.7	4.7	95.6	9.6	4.7	4.0	140.0	5.0	69.4	3.5	83.0	4.1	74.0	7.4	86.8	4.3	88.7	4.4	75	76.1	26
MPIGI	266,900	120.5	10.0	55.7	2.8	82.8	4.1	94.0	9.4	94.4	4.7	69.6	7.0	9.4	2.9	50.0	2.5	72.5	3.6	89.3	4.5	58.3	5.8	98.4	4.9	98.8	4.9	25	76.1	26
LIRA	440,000	95.6	9.6	32.8	1.6	71.4	3.6	66.5	6.6	82.3	4.1	80.0	8.0	9.8	2.8	55.6	2.8	62.7	3.1	54.8	2.7	100.3	10.0	94.4	4.7	96.9	4.8	75	75.9	28
ZOMBO	259,600	90.7	9.1	46.8	2.3	66.1	3.3	49.1	4.9	96.4	4.8	88.0	8.8	7.4	3.4	50.0	2.5	62.8	3.1	83.0	4.2	94.7	9.5	98.6	4.9	100	5.0	50	75.9	28
SOROTI	326,900	86.7	8.7	32.6	1.6	55.8	2.8	73.4	7.3	93.4	4.7	87.6	8.8	8.2	3.2	147.1	5.0	100.0	5.0	52.7	2.6	64.9	6.5	92.1	4.6	99.4	5.0	50	75.8	30
OTUKE	117,300	86.6	8.7	38.8	1.9	57.7	2.9	43.9	4.4	89.3	4.5	80.0	8.0	9.2	3.0	---	5	87.0	4.4	92.0	4.6	81.3	8.1	100	5.0	100	5.0	50	75.4	31
MARACHA	196,300	86.4	8.6	41.4	2.1	67.8	3.4	54.9	5.5	95.7	4.8	91.0	9.1	10.9	2.6	50.0	2.5	56.3	2.8	80.5	4.0	107.1	10.0	95.1	4.8	100	5.0	50	75.2	32
NGORA	152,800	90.8	9.1	31.7	1.6	59.4	3.0	58.7	5.9	85.5	4.3	87.0	8.7	3.7	4.2	---	5	94.7	4.7	63.1	3.2	60.4	6.0	89.6	4.5	99.3	5.0	50	75.1	33
MBALE	533,000	108.0	10.0	46.2	2.3	70.3	3.5	78.5	7.9	99.2	5.0	65.0	6.5	12.9	2.2	31.0	1.6	58.8	2.9	78.7	3.9	94.1	9.4	97.8	4.9	100	5.0	50	75.0	34
RUKUNGIRI	323,100	89.6	9.0	45.8	2.3	59.1	3.0	65.3	6.5	103.3	5.0	98.9	9.9	5.3	3.8	20.0	1.0	71.2	3.6	77.2	3.9	69.5	7.0	98.8	4.9	100	5.0	50	74.8	35
RUBIRIZI	136,000	77.9	7.8	52.0	2.6	74.4	3.7	54.2	5.4	90.4	4.5	94.1	9.4	5.9	3.7	---	5	35.1	1.8	100.3	5.0	57.8	5.8	99.7	5.0	100	5.0	50	74.6	36
KIBOGA	158,700	107.2	10.0	47.0	2.4	86.2	4.3	85.3	8.5	86.5	4.3	60.0	6.0	13.9	2.0	50.0	2.5	72.2	3.6	95.7	4.8	63.6	6.4	98.5	4.9	100	5.0	50	74.6	36
YUMBE	563,600	116.5	10.0	41.7	2.1	60.4	3.0	57.1	5.7	81.9	4.1	83.9	8.4	8.7	3.1	62.5	3.1	73.7	3.7	84.6	4.2	71.1	7.1	100	5.0	100	5.0	50	74.5	38
NAKASEKE	214,200	124.5	10.0	38.8	1.9	69.2	3.5	79.9	8.0	91.7	4.6	84.4	8.4	14.7	1.8	27.3	1.4	65.6	3.3	62.0	3.1	85.7	8.6	99.7	5.0	100.0	5.0	50	74.4	39
KAYUNGA	386,100	88.3	8.8	29.5	1.5	53.9	2.7	57.3	5.7	93.0	4.6	72.4	7.2	9.9	2.8	300.0	5.0	79.7	4.0	92.2	4.6	74.0	7.4	100	5.0	100	5.0	50	74.4	40
BUTAMBALA	104,000	90.4	9.0	28.2	1.4	61.1	3.1	118.9	10.0	95.8	4.8	67.0	6.7	9.8	2.8	71.4	3.6	52.2	2.6	84.4	4.2	60.8	6.1	100	5.0	100	5.0	50	74.2	41
ARUA	842,400	96.1	9.6	42.7	2.1	76.4	3.8	71.0	7.1	88.2	4.4	74.9	7.5	13.3	2.1	33.3	1.7	80.2	4.0	80.7	4.0	67.4	6.7	96.1	4.8	99.8	5.0	75	74.0	42
IBANDA	262,200	83.1	8.3	45.8	2.3	70.1	3.5	61.4	6.1	96.6	4.8	84.1	8.4	10.4	2.7	58.3	2.9	66.7	3.3	98.4	4.9	53.1	5.3	98.4	4.9	99.5	5.0	75	73.7	43

District	PCV3		ANC4		IPT2		Deliveries		HIV+ pregnant women initiated on ART		Latrine Coverage		Fresh Still Births per 1,000 Deliveries		Maternal Deaths Audited		TB Treatment Success Rate		Patients diagnosed with Malaria that are lab confirmed		Approved posts filled with qualified personnel in public health facilities		Monthly reports sent on time		Completeness monthly reports		Timeliness of Quarterly DBT reporting		% score (Total score /90)*100	National Ranking
	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score		
		10		5		5		10		5		10		5		5		5		5		10		5		5		5		
AGAGO	238,400	96.9	9.7	56.0	2.8	87.0	4.3	75.6	7.6	83.4	4.2	66.5	6.6	5.3	3.8	0.0	0.0	53.4	2.7	67.4	3.4	75.1	7.5	99.4	5.0	100	5.0	75	73.7	43
NAMUTUMBA	276,900	97.7	9.8	31.6	1.6	48.2	2.4	30.3	3.0	99.4	5.0	84.1	8.4	3.7	4.2	---	5	97.6	4.9	50.9	2.5	58.5	5.8	100	5.0	100	5.0	75	73.7	43
KISORO	297,000	90.7	9.1	34.1	1.7	69.4	3.5	66.4	6.6	85.1	4.3	76.6	7.7	4.2	4.1		0.0	69.5	3.5	95.4	4.8	75.7	7.6	98.2	4.9	99.2	5.0	75	73.7	43
RUKIGA	102,700	80.2	8.0	45.9	2.3	76.7	3.8	46.1	4.6	99.3	5.0	97.0	9.7	1.3	4.7	0.0	0.0	77.6	3.9	97.6	4.9	69.6	7.0	98.5	4.9	100	5.0	50	73.7	43
MUKONO	644,200	99.4	9.9	23.9	1.2	46.9	2.3	56.2	5.6	87.4	4.4	92.0	9.2	7.6	3.3	11.1	0.6	74.2	3.7	75.4	3.8	84.8	8.5	100	5.0	100	5.0	75	73.6	48
KAMPALA	1,585,800	103.2	10.0	52.6	2.6	56.0	2.8	121.1	10.0	95.6	4.8	98.0	9.8	10.0	2.8	27.8	1.4	80.2	4.0	31.5	1.6	88.5	8.9	72.8	3.6	75.4	3.8	0	73.4	49
KITGUM	212,900	81.3	8.1	45.5	2.3	66.4	3.3	72.4	7.2	101.5	5.0	60.3	6.0	9.1	3.0	60.0	3.0	63.6	3.2	66.5	3.3	79.7	8.0	96.5	4.8	98.2	4.9	75	73.3	50
KIRYANDONGO	287,700	106.8	10.0	35.5	1.8	62.6	3.1	62.4	6.2	90.1	4.5	75.4	7.5	10.9	2.6	66.7	3.3	82.1	4.1	80.4	4.0	61.4	6.1	100	5.0	100	5.0	50	73.2	51
AMURU	200,300	91.7	9.2	38.6	1.9	69.7	3.5	51.3	5.1	81.6	4.1	72.0	7.2	5.6	3.8	---	5	55.8	2.8	77.0	3.9	82.8	8.3	98.5	4.9	99.8	5.0	25	73.2	51
MITOOMA	188,300	72.6	7.3	37.3	1.9	56.9	2.8	38.5	3.8	85.7	4.3	93.9	9.4	1.7	4.6	---	5	84.7	4.2	65.4	3.3	71.4	7.1	91.7	4.6	99.1	5.0	50	73.1	53
PAKWACH	175,200	95.4	9.5	47.0	2.3	67.4	3.4	69.2	6.9	88.0	4.4	83.0	8.3	5.1	3.9	0.0	0.0	72.6	3.6	96.1	4.8	60.9	6.1	99.6	5.0	100	5.0	50	73.1	53
BUGIRI	426,700	123.6	10.0	30.3	1.5	62.2	3.1	51.9	5.2	86.1	4.3	81.7	8.2	11.7	2.4	114.3	5.0	79.6	4.0	81.2	4.1	54.9	5.5	99.4	5.0	99.8	5.0	50	73.0	55
MITYANA	344,200	107.2	10.0	40.5	2.0	67.4	3.4	65.4	6.5	98.1	4.9	88.7	8.9	11.7	2.4	57.1	2.9	48.2	2.4	86.2	4.3	62.3	6.2	91	4.6	92.2	4.6	50	72.9	56
LWENGO	281,900	88.4	8.8	31.7	1.6	56.4	2.8	35.0	3.5	98.5	4.9	76.0	7.6	3.8	4.2	---	5	72.8	3.6	81.3	4.1	58.2	5.8	98.1	4.9	98.8	4.9	75	72.9	56
KYOTERA	291,300	71.1	7.1	36.4	1.8	49.9	2.5	66.3	6.6	93.6	4.7	84.0	8.4	10.7	2.7	66.7	3.3	81.3	4.1	76.8	3.8	72.5	7.3	92.5	4.6	95.6	4.8	75	72.7	58
MBARARA	501,100	78.5	7.8	40.6	2.0	54.7	2.7	78.0	7.8	95.1	4.8	98.0	9.8	11.0	2.6	56.9	2.8	73.1	3.7	80.3	4.0	47.8	4.8	98.9	4.9	99.6	5.0	50	72.5	59
AMURIA	297,000	107.6	10.0	27.3	1.4	75.0	3.7	54.6	5.5	82.7	4.1	86.0	8.6	6.2	3.6	0.0	0.0	80.9	4.0	80.9	4.0	75.8	7.6	100	5.0	100	5.0	50	72.3	60
KOLE	259,700	84.2	8.4	22.7	1.1	56.5	2.8	35.4	3.5	75.6	3.8	79.1	7.9	8.7	3.1	200.0	5.0	89.9	4.5	92.6	4.6	90.7	9.1	98.7	4.9	100	5.0	25	72.3	60
IGANGA	545,000	76.9	7.7	32.8	1.6	58.3	2.9	61.7	6.2	90.5	4.5	78.9	7.9	11.0	2.6	100.0	5.0	72.9	3.6	80.4	4.0	79.3	7.9	95.9	4.8	97.1	4.9	25	72.1	62
KANUNGU	263,600	90.3	9.0	49.7	2.5	59.3	3.0	57.9	5.8	98.5	4.9	94.0	9.4	7.3	3.4	12.5	0.6	81.2	4.1	67.4	3.4	63.7	6.4	97.6	4.9	100	5.0	50	72.0	63
RAKAI	253,100	102.9	10.0	39.5	2.0	76.1	3.8	57.4	5.7	91.6	4.6	84.0	8.4	9.1	3.0	0.0	0.0	71.6	3.6	76.7	3.8	72.5	7.3	97.3	4.9	100	5.0	50	71.7	64
MASINDI	313,600	82.8	8.3	44.0	2.2	71.9	3.6	56.0	5.6	93.4	4.7	79.0	7.9	11.7	2.4	33.3	1.7	78.1	3.9	62.5	3.1	84.7	8.5	97	4.9	97.2	4.9	50	71.2	65

District	PCV3		ANC4		IPT2		Deliveries		HIV+ pregnant women initiated on ART		Latrine Coverage		Fresh Still Births per 1,000 Deliveries		Maternal Deaths Audited		TB Treatment Success Rate		Patients diagnosed with Malaria that are lab confirmed		Approved posts filled with qualified personnel in public health facilities		Monthly reports sent on time		Completeness monthly reports		Timeliness of Quarterly DBT reporting		% score (Total score /90)*100	National Ranking
	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score		
		10		5		5		10		5		10		5		5		5		5		10		5		5		5		
BUYENDE	364,000	82.6	8.3	36.1	1.8	47.3	2.4	36.1	3.6	88.7	4.4	86.0	8.6	5.2	3.9	700.0	5.0	76.7	3.8	71.0	3.5	64.1	6.4	95	4.8	98.8	4.9	50	71.0	66
BUNDIBUGYO	242,300	108.3	10.0	38.8	1.9	62.5	3.1	60.5	6.0	100.7	5.0	72.5	7.3	8.4	3.1	0.0	0.0	62.9	3.1	53.4	2.7	92.7	9.3	96.8	4.8	98.1	4.9	50	70.9	67
KAMULI	519,100	100.3	10.0	48.2	2.4	73.5	3.7	63.4	6.3	95.6	4.8	76.6	7.7	14.5	1.8	14.8	0.7	59.0	2.9	78.5	3.9	70.4	7.0	98.7	4.9	100	5.0	50	70.9	67
KUMI	259,800	83.7	8.4	43.0	2.2	74.6	3.7	64.7	6.5	123.8	5.0	88.1	8.8	9.3	2.9	14.3	0.7	65.4	3.3	64.7	3.2	54.2	5.4	95.6	4.8	100	5.0	75	70.7	69
NTOROKO	71,100	115.8	10.0	50.0	2.5	72.4	3.6	56.1	5.6	103.4	5.0	67.5	6.8	5.2	3.9	0.0	0.0	54.9	2.7	62.0	3.1	81.7	8.2	95.4	4.8	100	5.0	50	70.7	69
KAPCHORWA	113,700	92.1	9.2	38.1	1.9	77.8	3.9	69.0	6.9	76.5	3.8	85.0	8.5	15.8	1.5	12.5	0.6	74.3	3.7	60.7	3.0	87.0	8.7	92.3	4.6	92.3	4.6	50	70.6	71
KIBUKU	223,800	78.3	7.8	28.9	1.4	64.0	3.2	56.9	5.7	85.7	4.3	83.5	8.3	5.7	3.8	0.0	0.0	77.4	3.9	53.9	2.7	87.8	8.8	98.4	4.9	100	5.0	75	70.6	71
KWEEN	100,800	91.8	9.2	23.3	1.2	55.6	2.8	29.2	2.9	63.5	3.2	69.3	6.9	2.8	4.4	---	5	100.0	5.0	38.0	1.9	74.9	7.5	97.2	4.9	100	5.0	75	70.6	71
KALANGALA	60,100	93.5	9.4	33.8	1.7	69.4	3.5	38.0	3.8	96.0	4.8	69.0	6.9	11.7	2.4	60.0	3.0	100.0	5.0	60.8	3.0	82.2	8.2	91.7	4.6	95	4.8	50	70.6	71
KYEGEGWA	349,600	92.0	9.2	51.7	2.6	79.4	4.0	54.8	5.5	102.3	5.0	79.0	7.9	12.6	2.2	0.0	0.0	63.6	3.2	73.1	3.7	94.3	9.4	66.3	3.3	76	3.8	75	70.6	71
BUKEDEA	228,500	89.7	9.0	25.3	1.3	59.0	3.0	51.7	5.2	100.5	5.0	89.5	8.9	4.7	4.0	0.0	0.0	73.7	3.7	63.2	3.2	78.2	7.8	96.5	4.8	100	5.0	50	70.3	76
BUIKWE	446,100	95.2	9.5	34.4	1.7	60.1	3.0	52.4	5.2	93.4	4.7	68.8	6.9	13.0	2.1	59.1	3.0	71.2	3.6	68.6	3.4	69.9	7.0	89.9	4.5	94.9	4.7	75	70.1	77
SIRONKO	256,900	97.7	9.8	34.0	1.7	67.0	3.3	51.4	5.1	90.0	4.5	87.2	8.7	3.4	4.2	0.0	0.0	73.1	3.7	49.5	2.5	73.1	7.3	92.2	4.6	100	5.0	50	70.0	78
BUNYANGABU	181,500	88.7	8.9	45.7	2.3	56.0	2.8	51.7	5.2	98.8	4.9	83.7	8.4	3.7	4.2	0.0	0.0	74.8	3.7	69.3	3.5	87.4	8.7	76.7	3.8	81.4	4.1	50	70.0	78
ISINGIRO	535,900	88.6	8.9	39.1	2.0	68.1	3.4	52.0	5.2	93.3	4.7	93.8	9.4	6.1	3.7	0.0	0.0	87.4	4.4	69.3	3.5	54.5	5.5	96.5	4.8	100	5.0	50	69.7	80
NWOYA	175,700	80.3	8.0	29.9	1.5	61.2	3.1	43.8	4.4	89.0	4.5	80.0	8.0	4.0	4.1	66.7	3.3	75.3	3.8	85.5	4.3	52.3	5.2	100	5.0	100	5.0	50	69.6	81
BUSIA	351,000	83.3	8.3	37.4	1.9	63.7	3.2	63.7	6.4	90.1	4.5	84.5	8.4	11.5	2.5	8.3	0.4	73.6	3.7	85.8	4.3	52.5	5.2	99.8	5.0	100	5.0	75	69.5	82
ALEBTONG	245,000	80.8	8.1	29.7	1.5	55.9	2.8	43.5	4.3	54.9	2.7	86.0	8.6	7.0	3.5	---	5	75.5	3.8	64.0	3.2	65.6	6.6	99.2	5.0	100	5.0	50	69.5	82
KAGADI	386,800	97.0	9.7	28.9	1.4	57.5	2.9	51.2	5.1	95.5	4.8	68.9	6.9	17.3	1.2	50.0	2.5	73.2	3.7	76.9	3.8	66.2	6.6	99	5.0	99	5.0	75	69.2	84
BUTALEJA	269,500	79.7	8.0	53.3	2.7	94.8	4.7	69.9	7.0	85.4	4.3	63.2	6.3	7.4	3.4	0.0	0.0	86.7	4.3	36.9	1.8	61.1	6.1	98.3	4.9	99.3	5.0	75	69.2	84
KATAKWI	179,100	106.2	10.0	33.1	1.7	67.0	3.4	60.9	6.1	102.3	5.0	77.0	7.7	5.3	3.8	0.0	0.0	55.1	2.8	67.6	3.4	59.8	6.0	99.4	5.0	99.7	5.0	50	69.1	86
NAKASONGOLA	196,900	71.7	7.2	33.3	1.7	66.1	3.3	48.5	4.8	96.4	4.8	56.8	5.7	8.2	3.2	62.5	3.1	83.7	4.2	72.2	3.6	82.5	8.3	97.6	4.9	97.8	4.9	50	69.0	87

District	PCV3		ANC4		IPT2		Deliveries		HIV+ pregnant women initiated on ART		Latrine Coverage		Fresh Still Births per 1,000 Deliveries		Maternal Deaths Audited		TB Treatment Success Rate		Patients diagnosed with Malaria that are lab confirmed		Approved posts filled with qualified personnel in public health facilities		Monthly reports sent on time		Completeness monthly reports		Timeliness of Quarterly DBT reporting		% score (Total score /90)*100	National Ranking
	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score		
		10		5		5		10		5		10		5		5		5		5		10		5		5		5		
MANAFWA	140,800	109.0	10.0	20.9	1.0	52.4	2.6	44.5	4.4	102.7	5.0	83.2	8.3	9.6	2.9	0.0	0.0	95.2	4.8	53.3	2.7	78.8	7.9	98.5	4.9	100	5.0	50	69.0	87
KALUNGU	188,000	78.0	7.8	37.8	1.9	60.7	3.0	65.2	6.5	92.5	4.6	81.8	8.2	11.1	2.6	0.0	0.0	71.7	3.6	85.5	4.3	72.3	7.2	97.4	4.9	99.5	5.0	50	68.9	89
WAKISO	2,395,700	90.6	9.1	18.8	0.9	33.6	1.7	31.6	3.2	92.9	4.6	88.2	8.8	7.0	3.4	82.4	4.1	58.9	2.9	57.7	2.9	70.6	7.1	85.3	4.3	86.5	4.3	75	67.9	90
BULAMBULI	199,500	67.2	6.7	20.9	1.0	42.3	2.1	32.4	3.2	83.5	4.2	81.0	8.1	8.3	3.2	100.0	5.0	53.9	2.7	59.0	3.0	86.6	8.7	93.3	4.7	94.2	4.7	75	67.8	91
BUKOMANSIMBI	153,600	69.8	7.0	28.4	1.4	43.8	2.2	33.5	3.3	92.6	4.6	68.5	6.8	10.8	2.6	---	5	87.8	4.4	93.3	4.7	67.6	6.8	94.4	4.7	97.9	4.9	50	67.7	92
GOMBA	166,200	84.9	8.5	30.3	1.5	46.1	2.3	37.1	3.7	92.5	4.6	55.0	5.5	8.0	3.2	---	5	76.6	3.8	86.4	4.3	55.7	5.6	99.1	5.0	100	5.0	50	67.3	93
BUKWO	102,600	98.2	9.8	30.1	1.5	57.2	2.9	33.3	3.3	98.5	4.9	78.0	7.8	17.5	1.1	75.0	3.8	85.0	4.3	33.9	1.7	57.7	5.8	97.9	4.9	100	5.0	75	67.2	94
HOIMA	643,600	93.7	9.4	35.9	1.8	67.8	3.4	68.1	6.8	81.8	4.1	78.8	7.9	21.5	0.3	28.3	1.4	52.4	2.6	75.0	3.8	62.6	6.3	98.4	4.9	100	5.0	50	66.7	95
BUTEBO	160,100	74.9	7.5	22.7	1.1	65.1	3.3	47.8	4.8	90.6	4.5	83.2	8.3	2.7	4.4	0.0	0.0	57.1	2.9	59.6	3.0	77.4	7.7	97.4	4.9	100	5.0	50	66.5	96
KAABONG	179,700	124.1	10.0	52.0	2.6	62.9	3.1	68.1	6.8	61.9	3.1	31.1	3.1	6.7	3.5	116.7	5.0	44.7	2.2	59.7	3.0	60.7	6.1	75.8	3.8	97.2	4.9	50	66.4	97
APAC	402,300	70.3	7.0	31.1	1.6	58.1	2.9	45.2	4.5	80.2	4.0	86.0	8.6	7.8	3.3	0.0	0.0	78.1	3.9	58.5	2.9	84.3	8.4	99.5	5.0	100	5.0	50	66.3	98
NAMAYINGO	225,200	109.9	10.0	29.3	1.5	70.8	3.5	38.2	3.8	95.8	4.8	66.0	6.6	8.4	3.2	0.0	0.0	62.5	3.1	83.3	4.2	52.6	5.3	98	4.9	100	5.0	75	66.2	99
SERERE	318,900	79.7	8.0	21.6	1.1	60.4	3.0	51.5	5.1	93.0	4.7	88.5	8.9	8.4	3.1	0.0	0.0	93.5	4.7	34.9	1.7	66.4	6.6	100	5.0	100	5.0	50	66.0	100
KABERAMAIDO	240,400	80.3	8.0	24.0	1.2	51.3	2.6	51.5	5.2	93.2	4.7	90.7	9.1	11.3	2.5	0.0	0.0	63.6	3.2	38.0	1.9	84.6	8.5	100	5.0	100	5.0	50	65.8	101
KALIRO	259,800	79.3	7.9	30.3	1.5	61.4	3.1	31.7	3.2	82.1	4.1	74.2	7.4	7.8	3.3	0.0	0.0	73.3	3.7	75.2	3.8	90.0	9.0	97.8	4.9	97.8	4.9	50	65.8	102
PADER	186,700	85.1	8.5	41.8	2.1	66.7	3.3	51.1	5.1	98.6	4.9	51.0	5.1	9.3	3.0	0.0	0.0	64.2	3.2	73.7	3.7	74.3	7.4	97.1	4.9	100	5.0	50	65.2	103
PALLISA	264,400	75.9	7.6	28.2	1.4	67.4	3.4	58.8	5.9	101.5	5.0	83.2	8.3	9.2	3.0	0.0	0.0	66.1	3.3	34.9	1.7	77.4	7.7	99.6	5.0	100	5.0	25	65.1	104
KAKUMIRO	369,300	86.0	8.6	35.7	1.8	60.7	3.0	43.1	4.3	85.9	4.3	78.0	7.8	13.4	2.1	33.3	1.7	68.1	3.4	81.1	4.1	50.2	5.0	95.4	4.8	95.4	4.8	50	64.5	105
SEMBABULE	272,300	87.4	8.7	27.3	1.4	49.7	2.5	29.7	3.0	99.2	5.0	72.0	7.2	15.8	1.5	---	5	63.5	3.2	69.4	3.5	52.7	5.3	91.9	4.6	94.7	4.7	50	64.4	106
KYAKWANZI	244,900	87.4	8.7	29.3	1.5	62.0	3.1	29.0	2.9	91.0	4.6	59.0	5.9	6.1	3.7	0.0	0.0	74.0	3.7	85.9	4.3	58.6	5.9	100	5.0	100	5.0	75	64.3	107
NAPAK	149,500	115.3	10.0	50.8	2.5	72.6	3.6	65.4	6.5	57.7	2.9	33.5	3.4	8.2	3.2	0.0	0.0	46.8	2.3	60.4	3.0	81.6	8.2	69.6	3.5	100	5.0	75	64.3	107
BUDUDA	237,400	75.6	7.6	18.8	0.9	35.7	1.8	32.0	3.2	82.1	4.1	75.0	7.5	6.0	3.7	50.0	2.5	79.2	4.0	73.1	3.7	62.9	6.3	100	5.0	100	5.0	50	64.1	109

District	PCV3		ANC4		IPT2		Deliveries		HIV+ pregnant women initiated on ART		Latrine Coverage		Fresh Still Births per 1,000 Deliveries		Maternal Deaths Audited		TB Treatment Success Rate		Patients diagnosed with Malaria that are lab confirmed		Approved posts filled with qualified personnel in public health facilities		Monthly reports sent on time		Completeness monthly reports		Timeliness of Quarterly DBT reporting		% score (Total score /90)*100	National Ranking
	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score		
		10		5		5		10		5		10		5		5		5		5		10		5		5		5		
MUBENDE	763,100	101.6	10.0	30.9	1.5	52.5	2.6	44.7	4.5	96.0	4.8	83.5	8.3	22.7	0.0	52.8	2.6	67.8	3.4	77.5	3.9	49.2	4.9	96.4	4.8	99.9	5.0	25	64.1	109
BUVUMA	106,900	77.0	7.7	14.6	0.7	37.3	1.9	21.0	2.1	92.1	4.6	41.4	4.1	9.2	3.0	---	5	75.3	3.8	90.9	4.5	77.3	7.7	98.5	4.9	99.2	5.0	50	64.0	111
MAYUGE	514,800	74.0	7.4	30.0	1.5	71.9	3.6	43.9	4.4	76.8	3.8	67.4	6.7	7.3	3.4	0.0	0.0	69.9	3.5	62.8	3.1	74.5	7.4	96	4.8	99	5.0	50	63.5	112
KOTIDO	197,600	106.2	10.0	43.0	2.1	77.2	3.9	60.0	6.0	100.0	5.0	13.2	1.3	10.6	2.7	0.0	0.0	58.0	2.9	55.4	2.8	72.9	7.3	94.2	4.7	95.4	4.8	75	63.5	112
NAMISINDWA	237,700	106.6	10.0	17.4	0.9	46.7	2.3	38.1	3.8	48.4	2.4	83.2	8.3	8.2	3.2	0.0	0.0	76.9	3.8	52.6	2.6	78.8	7.9	81.1	4.1	93.9	4.7	50	62.8	114
MOROTO	110,300	82.7	8.3	40.3	2.0	69.7	3.5	39.1	3.9	92.0	4.6	10.3	1.0	10.0	2.8	100.0	5.0	80.7	4.0	73.9	3.7	53.8	5.4	89.9	4.5	99.1	5.0	50	62.4	115
BUDAKA	228,200	69.6	7.0	29.1	1.5	73.3	3.7	51.4	5.1	62.6	3.1	72.7	7.3	6.5	3.6	0.0	0.0	80.0	4.0	22.6	1.1	75.5	7.6	96.4	4.8	96.9	4.8	50	62.3	116
AMOLATAR	161,900	83.6	8.4	28.2	1.4	61.2	3.1	43.0	4.3	72.9	3.6	86.0	8.6	27.2	-1.0	0.0	0.0	51.5	2.6	75.5	3.8	81.8	8.2	97.4	4.9	98.1	4.9	50	61.3	117
BULIISA	129,200	80.9	8.1	30.7	1.5	69.3	3.5	41.9	4.2	97.9	4.9	62.0	6.2	11.0	2.6	0.0	0.0	73.6	3.7	65.4	3.3	49.6	5.0	100	5.0	100	5.0	25	60.1	118
ABIM	127,800	73.0	7.3	30.5	1.5	55.7	2.8	54.1	5.4	94.1	4.7	70.0	7.0	5.7	3.8	0.0	0.0	35.6	1.8	62.8	3.1	68.2	6.8	92.5	4.6	96.8	4.8	0	59.6	119
NAKAPIRIPIRIT	177,400	79.7	8.0	43.0	2.1	60.8	3.0	40.3	4.0	96.9	4.8	33.6	3.4	8.9	3.0	0.0	0.0	32.8	1.6	62.7	3.1	74.7	7.5	99	5.0	99.5	5.0	50	59.0	120
AMUDAT	118,800	70.2	7.0	21.0	1.0	41.8	2.1	34.3	3.4	110.7	5.0	26.3	2.6	8.1	3.2	---	5	50.0	2.5	79.0	3.9	38.5	3.9	99	5.0	100	5.0	50	58.0	121
LUUKA	251,200	88.6	8.9	22.3	1.1	47.9	2.4	27.1	2.7	46.1	2.3	65.6	6.6	6.7	3.5	0.0	0.0	72.8	3.6	76.7	3.8	58.0	5.8	73.6	3.7	75	3.8	50	56.3	122
NATIONAL	37,741,300	92.6	9.3	38.2	1.9	63.2	3.2	59.6	6.0	92.1	4.6	78.3	7.8	9.4	2.9	49.5	2.5	70.3	3.5	71.8	3.6	72.3	7.2	95.4	4.8	94.3	4.7	56	69.2	

3.8 Annex 8: Improvements in the DLT Scores 2017/18 FY

No.	District	DLT Score		% Change
		2016/17	2017/18	
1.	AMUDAT	46.8	58	24%
2.	KAABONG	54.6	66.4	22%
3.	BULAMBULI	55.7	67.8	22%
4.	BUVUMA	53.0	64	21%
5.	LAMWO	65.4	77.7	19%
6.	KIRUHURA	65.3	77.4	19%
7.	NTUNGAMO	65.0	76.1	17%
8.	SHEEMA	68.9	80	16%
9.	MOYO	73.7	85.6	16%
10.	OMORO	65.9	76.3	16%
11.	NEBBI	67.2	77.3	15%
12.	RUBANDA	67.8	78	15%
13.	LWENGO	63.6	72.9	15%
14.	IGANGA	63.0	72.1	14%
15.	KITGUM	64.2	73.3	14%
16.	JINJA	70.0	79.5	14%
17.	BUSHENYI	73.9	83.4	13%
18.	TORORO	69.5	78.2	12%
19.	RAKAI	63.9	71.7	12%
20.	MOROTO	56.0	62.4	11%
21.	BUIKWE	63.0	70.1	11%
22.	BUGIRI	65.6	73	11%
23.	ZOMBO	68.2	75.9	11%
24.	WAKISO	61.1	67.9	11%
25.	KIBAALE	68.6	76.2	11%
26.	MPIGI	68.6	76.1	11%
27.	KAGADI	62.5	69.2	11%
28.	BUTAMBALA	67.1	74.2	11%
29.	MASAKA	69.5	76.6	10%
30.	MANAFWA	62.6	69	10%
31.	SOROTI	68.8	75.8	10%
32.	KABAROLE	74.2	81.7	10%
33.	BUHWEJU	69.8	76.8	10%
34.	LUWERO	71.2	78.3	10%
35.	DOKOLO	69.8	76.7	10%
36.	KYENJOJO	71.7	78.6	10%
37.	KIRYANDONGO	67.0	73.2	9%
38.	KALANGALA	64.7	70.6	9%
39.	ARUA	67.9	74	9%
40.	OYAM	74.3	80.8	9%

No.	District	DLT Score		% Change
		2016/17	2017/18	
41.	YUMBE	68.6	74.5	9%
42.	ALEBTONG	64.1	69.5	8%
43.	IBANDA	68.2	73.7	8%
44.	KABALE	74.6	80.6	8%
45.	BUKEDEA	65.2	70.3	8%
46.	LIRA	70.4	75.9	8%
47.	AGAGO	68.5	73.7	8%
48.	MUKONO	68.5	73.6	7%
49.	MASINDI	66.3	71.2	7%
50.	NAKASONGOLA	64.4	69	7%
51.	KAYUNGA	69.6	74.4	7%
52.	KAKUMIRO	60.4	64.5	7%
53.	ADJUMANI	80.9	86.3	7%
54.	MBARARA	68.0	72.5	7%
55.	RUBIRIZI	70.1	74.6	6%
56.	NAPAK	60.5	64.3	6%
57.	KASESE	71.8	76.3	6%
58.	OTUKE	71.1	75.4	6%
59.	MITYANA	68.8	72.9	6%
60.	NAMAYINGO	62.5	66.2	6%
61.	NTOROKO	66.8	70.7	6%
62.	SIRONKO	66.3	70	6%
63.	LYANTONDE	72.5	76.4	5%
64.	KWEEN	67.2	70.6	5%
65.	BUDUDA	61.0	64.1	5%
66.	KOLE	68.9	72.3	5%
67.	BUNDIBUGYO	67.6	70.9	5%
68.	AMURU	69.9	73.2	5%
69.	KAMWENGE	76.6	80.1	5%
70.	GULU	78.5	82.1	5%
71.	NAMUTUMBA	70.8	73.7	4%
72.	KOBOKO	74.0	77	4%
73.	KALUNGU	66.3	68.9	4%
74.	MARACHA	72.4	75.2	4%
75.	BUYENDE	68.6	71	3%
76.	PADER	63.5	65.2	3%
77.	KANUNGU	70.3	72	2%
78.	NWOYA	67.9	69.6	2%
79.	RUKUNGIRI	73.1	74.8	2%
80.	APAC	64.8	66.3	2%
81.	KUMI	69.1	70.7	2%
82.	BUSIA	68.0	69.5	2%

No.	District	DLT Score		% Change
		2016/17	2017/18	
83.	BUDAKA	61.0	62.3	2%
84.	GOMBA	66.0	67.3	2%
85.	NGORA	73.6	75.1	2%
86.	BULIISA	59.0	60.1	2%
87.	KISORO	72.4	73.7	2%
88.	MITOOMA	71.8	73.1	2%
89.	AMURIA	71.1	72.3	2%
90.	ISINGIRO	68.6	69.7	2%
91.	BUTALEJA	68.3	69.2	1%
92.	KYAKWANZI	63.7	64.3	1%
93.	BUKOMANSIMBI	67.0	67.7	1%
94.	BUKWO	66.6	67.2	1%
95.	KAPCHORWA	70.0	70.6	1%
96.	KIBUKU	70.2	70.6	1%
97.	NAKASEKE	73.9	74.4	1%
98.	KALIRO	65.6	65.8	0%
99.	MAYUGE	63.8	63.5	0%
100.	HOIMA	67.1	66.7	-1%
101.	KYEGEGWA	71.7	70.6	-1%
102.	MUBENDE	65.2	64.1	-2%
103.	KAMULI	72.4	70.9	-2%
104.	MBALE	76.6	75	-2%
105.	KAMPALA	75.1	73.4	-2%
106.	KIBOGA	76.5	74.6	-2%
107.	SEMBABULE	66.0	64.4	-2%
108.	KOTIDO	65.2	63.5	-3%
109.	NAKAPIRIPIRIT	60.6	59	-3%
110.	AMOLATAR	63.0	61.3	-3%
111.	PALLISA	67.2	65.1	-3%
112.	KATAKWI	71.5	69.1	-3%
113.	KABERAMAIDO	71.3	65.8	-8%
114.	SERERE	72.5	66	-9%
115.	ABIM	67.6	59.6	-12%
116.	LUUKA	65.0	56.3	-13%
117.	BUNYANGABU		70	New
118.	BUTEBO		66.5	New
119.	KYOTERA		72.7	New
120.	NAMISINDWA		62.8	New
121.	PAKWACH		73.1	New
122.	RUKIGA		73.7	New

3.9 Annex 9: SUO for General Hospitals 2017/18 FY

No.	Hospital	OPD attendance	ANC Visits	PNC Visits	FP	Immunization	Deliveries	Admissions	Major Surgery	SUO 2017/18	SUO 2016/17	Change
1.	Iganga	128,814	13,348	7,143	2,784	34,201	6,326	19,146	2,871	***523,532***	580,406	10%
2.	Mityana	88,388	10,930	6,701	4,294	27,760	5,833	13,227	2,703	***386,533***	385,165	0%
3.	Kagando	26,410	6,493	3,173	2,868	17,575	2,771	17,388	2,411	***359,087***	315,977	-14%
4.	KIU Teaching	29,923	5,912	9,414	2,041	9,446	2,941	17,107	1,882	***349,446***	306,106	-14%
5.	Tororo	56,553	10,874	10,998	1,421	22,624	6,909	13,540	1,315	***336,669***	324,981	-4%
6.	Kawolo	79,193	10,647	5,405	4,982	24,651	3,966	11,619	1,347	***315,695***	314,053	-1%
7.	Entebbe	60,534	16,778	6,465	3,075	40,967	5,993	9,811	2,097	***300,956***	248,416	-21%
8.	Bwera	44,194	11,852	1,466	2,959	40,045	3,730	12,166	1,881	***299,102***	279,756	-7%
9.	Kagadi	21,976	9,810	8,624	1,325	26,055	4,669	13,182	1,720	***292,542***	284,216	-3%
10.	Kalongo Ambrosoli Memorial	26,891	6,045	1,905	2,379	15,263	3,547	13,460	1,150	***277,743***	362,714	23%
11.	Angal St. Luke	27,483	5,454	6,453	4,847	16,818	2,537	11,752	1,477	***257,729***	256,030	-1%
12.	Atutur	62,721	4,334	4,877	2,248	14,830	1,640	10,954	444	***252,807***	271,899	7%
13.	Busolwe	67,618	3,624	3,204	566	7,238	1,834	9,942	1,054	***252,143***	252,524	0%
14.	Adjumani	66,733	4,484	1,950	1,179	11,100	2,124	9,782	948	***249,070***	251,999	1%
15.	Masindi	42,209	9,416	6,431	2,023	31,089	4,094	9,836	1,048	***246,332***	223,420	-10%
16.	Gombe	42,114	6,094	1,552	1,610	13,847	3,602	9,929	1,301	***242,476***	231,517	-5%
17.	Kibuli	66,266	6,582	3,486	2,044	31,109	2,649	7,888	1,614	***242,389***	143,774	-69%
18.	Kitagata	53,906	4,613	4,768	1,442	10,227	2,975	9,129	1,437	***241,913***	252,327	4%
19.	Kitgum	61,606	3,875	6,596	2,063	11,847	2,038	9,604	867	***241,832***	390,879	38%
20.	Kiryandongo	36,808	8,561	2,507	2,045	21,278	2,771	10,528	1,033	***240,055***	260,964	8%
21.	Kamuli	57,703	7,947	7,980	3,616	20,220	2,082	8,882	825	***231,659***	324,911	29%
22.	Bundibugyo	47,681	3,442	766	1,018	17,501	2,113	9,686	996	***229,569***	176,929	-30%
23.	Kayunga	48,076	4,521	6,781	1,283	15,960	3,011	8,179	1,692	***229,141***	267,967	14%
24.	Kisoro	50,864	5,362	5,809	2,999	13,712	3,008	9,226	728	***228,681***	198,447	-15%
25.	Nakaseke	43,223	4,892	8,876	535	65,446	3,088	7,362	1,861	***226,554***	204,427	-11%
26.	Nebbi	40,798	7,774	3,556	1,472	27,744	2,246	9,666	774	***224,448***	243,392	8%
27.	Kisiizi	58,796	6,069	3,783	1,836	18,113	2,130	7,749	1,445	***224,048***	219,567	-2%
28.	Kalisizo	54,529	6,973	799	905	16,303	3,078	7,870	1,421	***223,988***	235,441	5%
29.	Katakwi	35,128	2,380	1,923	1,578	12,981	1,196	11,131	441	***222,430***	196,846	-13%
30.	Kaabong	33,792	2,695	2,098	612	27,820	904	11,006	285	***217,369***	184,358	-18%
31.	Bududa	50,570	3,359	2,276	2,692	11,685	1,236	9,778	285	***215,621***	268,490	20%
32.	Masafu	41,800	4,853	4,601	4,095	17,536	1,659	9,638	533	***215,607***	227,988	5%
33.	Apac	74,102	9,829	2,202	1,259	17,860	2,006	7,135	615	***213,674***	327,586	35%
34.	Kiwoko	29,930	6,584	6,142	1,095	19,370	2,710	8,555	1,484	***212,270***	167,019	-27%
35.	Matany	25,847	3,890	2,730	574	22,374	1,283	9,927	878	***206,799***	185,492	-11%
36.	Aber	39,242	5,933	3,462	1,437	15,474	2,187	8,442	989	***205,098***	241,223	15%
37.	Bombo Military	32,357	7,012	152	4,847	10,713	3,191	8,241	1,233	***204,735***	166,070	-23%
38.	Ibanda	14,554	4,073	1,785	26	9,413	2,259	9,644	1,319	***201,714***	219,274	8%
39.	Pallisa	38,528	5,282	5,939	4,222	15,164	2,895	8,428	405	***198,277***	236,492	16%
40.	Kiboga	34,127	7,888	7,347	358	11,071	3,259	8,127	695	***196,238***	221,217	11%
41.	Mutolere (St. Francis)	16,200	6,018	5,023	1,119	11,114	2,052	8,576	1,537	***194,143***	176,672	-10%
42.	Nakasero	66,010			159	14,065	1,481	5,032	2,058	***192,948***	85,101	-127%
43.	Moyo	43,544	1,500	1,674	826	6,200	1,435	7,668	1,083	***190,639***	142,205	-34%
44.	Itojo	32,042	2,449	2,700	1,160	7,208	1,761	8,586	647	***187,173***	231,536	19%
45.	Rakai	47,407	3,215	2,842	936	9,205	2,060	7,014	884	***185,935***	199,513	7%
46.	St. Joseph Kitovu	25,750	2,607	3,339	11	9,769	1,921	7,601	1,481	***183,922***	155,520	-18%
47.	St. Joseph's Kitgum	21,873	5,075	2,747	-	13,908	2,252	7,882	1,269	***183,436***	164,454	-12%
48.	Bugiri	34,454	8,133	4,873	2,189	17,449	2,574	6,385	1,422	***182,626***	149,358	-22%
49.	Kilembe	19,275	3,452	2,724	210	13,172	1,467	8,199	1,242	***180,262***	204,712	12%
50.	Kyenjojo	33,483	7,289	3,953	3,965	36,984	2,408	7,158	310	***174,093***	205,228	15%
51.	Koboko	25,153	9,653	5,903	2,144	29,751	2,665	7,041	547	***169,833***	161,495	-5%

No.	Hospital	OPD attendance	ANC Visits	PNC Visits	FP	Immunization	Deliveries	Admissions	Major Surgery	SUO 2017/18	SUO 2016/17	Change
52.	St. Karoli Lwanga Nyakibale	15,522	3,753	2,861	1,520	11,183	1,279	8,008	1,069	***169,721***	135,784	-25%
53.	Kamuli Mission	15,278	7,472	8,870	1,128	13,687	2,266	6,666	1,455	***167,170***	171,737	3%
54.	St. Francis Naggalama	47,608	5,575	4,358	-	17,121	1,687	5,278	1,137	***166,344***	127,238	-31%
55.	Bwindi Community	37,714	4,977	5,241	2,806	8,602	1,840	6,114	943	***165,716***	125,815	-32%
56.	Kumi	37,384	2,957	2,271	811	10,727	1,616	5,250	1,056	***150,499***	161,310	7%
57.	Virika	21,454	1,980	3,171	3,942	13,499	1,558	5,907	1,142	***147,935***	116,167	-27%
58.	Lyantonde	55,661	6,366	1,299	1,704	14,177	1,865	4,814	97	***146,656***	174,126	16%
59.	Kuluva	26,926	4,820	1,903	821	15,300	1,267	5,772	959	***145,853***	145,340	0%
60.	Kapchorwa	28,232	4,974	582	2,488	13,461	1,680	5,519	980	***145,731***	156,855	7%
61.	Abim	43,532	1,774	1,737	546	5,808	752	5,939	200	***143,567***	113,990	-26%
62.	Kisubi	39,810	6,046	3,391	647	36,991	1,464	4,021	1,100	***141,885***	122,167	-16%
63.	Anaka	29,205	3,009	3,019	1,035	15,274	955	5,895	161	***132,211***	148,054	11%
64.	Nkozi	19,076	3,732	5,433	1,096	11,543	1,661	4,924	870	***126,080***	113,919	-11%
65.	Nyapea	9,210	3,592	2,641	364	17,510	1,509	5,472	983	***125,296***	114,731	-9%
66.	Murchison Bay Main	81,487	4,904	2,065	651	6,810	1,066	2,040	30	***123,189***	130,827	6%
67.	Ruharo Mission	27,764	1,676	1,718	123	6,111	879	4,736	613	***118,440***	101,280	-17%
68.	Yumbe	23,510	3,295	591	1,019	32,642	1,145	4,506	601	***117,826***	249,207	53%
69.	Comboni	13,378	3,744	3,568	-	7,491	1,450	4,860	618	***111,042***	113,024	2%
70.	Rugarama	22,225	1,967	2,739	1,521	7,491	1,277	4,317	583	***109,637***	119,422	8%
71.	Bukwo General	37,374	2,787	1,289	882	9,630	488	3,980	79	***105,499***	102,654	-3%
72.	Kambuga	25,303	2,588	1,850	1,441	7,053	1,061	4,140	372	***104,498***	114,207	9%
73.	Maracha	12,569	2,035	1,844	-	8,118	1,052	4,260	890	***103,092***	108,241	5%
74.	Mayanja Memorial	13,835	2,156	4,926	323	8,507	2,097	3,061	1,217	***99,979***	72,359	-38%
75.	Buikwe St. Charles Lwanga	11,783	3,016	623	-	9,054	1,288	4,468	548	***99,833***	99,387	0%
76.	Ishaka Adventist	15,163	4,554	4,612	5,906	15,560	918	3,906	467	***98,331***	120,761	19%
77.	Buluba	19,812	2,183	709	56	7,305	1,311	3,416	705	***94,642***	90,154	-5%
78.	Kakira Worker's	45,886	1,699	1,082	2,290	7,390	385	2,661	70	***93,140***	94,055	1%
79.	Villa Maria	12,569	1,866	1,357	69	6,793	879	3,613	715	***88,464***	81,309	-9%
80.	Kabarole	11,200	1,709	3,978	680	12,131	800	3,762	534	***87,920***	85,521	-3%
81.	Mildmay Uganda	75,508	1,980	1,984	1,035	2,862	134	433	55	***86,845***	63,376	-37%
82.	Dabani	7,978	1,768	650	580	7,213	805	3,206	509	***73,215***	69,293	-6%
83.	Rushere Community	9,755	2,447	1,562	210	9,316	799	3,080	378	***71,483***	49,716	-44%
84.	Rubongi Military	29,495	2,462	1,580	1,172	8,340	920	2,100	-	***69,870***	59,248	-18%
85.	Lugazi Scoul	31,327	1,656	1,322	1,035	3,743	270	2,150	-	***67,682***	79,230	15%
86.	Lwala	6,064	2,477	2,633	141	7,732	956	2,801	447	***65,971***	81,879	19%
87.	Mukwaya	42,968	507	927	149	2,429	332	660	130	***58,405***	48,894	-19%
88.	Amudat	6,541	1,882	2,619	175	7,454	434	2,925	71	***57,835***	55,440	-4%
89.	Mount Elgon	33,191	460	551	167	1,771	175	1,036	216	***54,869***	52,913	-4%
90.	Ngora	8,791	534	464	91	6,388	312	2,498	243	***54,503***	83,853	35%
91.	Namungoona Orthodox	16,320	2,350	1,340	27	9,142	515	1,784	165	***52,642***		#DIV/0!
92.	International Hospital Kampala	19,415	1,700	1,138	41	2,287	449	1,429	344	***51,872***	178,194	71%
93.	Nkokonjeru	13,778	2,249	764	17	7,152	562	1,709	306	***51,288***	46,422	-10%

No.	Hospital	OPD attendance	ANC Visits	PNC Visits	FP	Immunization	Deliveries	Admissions	Major Surgery	SUO 2017/18	SUO 2016/17	Change
94.	Life Link	39,342	763	375	47	3,269	168	361	100	***48,843***		#DIV/0!
95.	St. Francis Nyenga	13,515	2,277	1,770	23	7,878	343	1,499	194	***45,206***	44,593	-1%
96.	St. Catherine	41,851	387	500	-	2,694	249		-	***44,078***	37,730	-17%
97.	Nakasongola Military	14,855	468	960	186	1,605	87	1,419	70	***39,103***	37,139	-5%
98.	St. Anthony's Tororo	6,635	1,420	533	1	2,994	174	1,716	183	***38,481***	48,268	20%
99.	Buwenge NGO	2,950	2,345	3,467	1,266	21,080	836	1,401	83	***37,560***	41,292	9%
100.	Buliisa	9,550	1,580	231	83	5,461	252	1,462	54	***35,859***	38,944	8%
101.	Ruth Gaylord	15,804	1,151	693	2	5,847	364	811	196	***35,801***	27,107	-32%
102.	Kida	3,665	1,566	1,144	1,211	5,539	369	1,625	83	***34,613***		#DIV/0!
103.	Bamu	4,605	223	301	619	-	497	1,400	237	***33,402***	30,241	-10%
104.	Amai Community	3,565	1,511	590	255	4,834	293	1,253	273	***31,430***	29,692	-6%
105.	Rhema	9,094	397		2	270	212	938	255	***29,578***		#DIV/0!
106.	UPDF 2nd Div.	14,245	1,431	132	4,943	3,214	89	584	14	***27,626***	25,633	-8%
107.	Pioneer	7,153	22		-	-	1	1,344	10	***27,529***		#DIV/0!
108.	Mbarara Community	1,358	674	1,748	307	2,840	849	817	372	***27,231***	16,659	-63%
109.	Gulu Military	9,927	590	203	229	1,100	43	934	39	***25,663***	35,143	27%
110.	Kanginima	1,045	1,541	345	1,254	9,556	353	1,076	115	***24,731***	55,988	56%
111.	Devine Mercy Clinic	15,278	454	1,487	392	4,447	694	120	102	***24,644***		#DIV/0!
112.	Oriajini	2,455	1,406	714	108	5,760	425	1,022	4	***22,256***	26,081	15%
113.	Kabasa Memorial	1,441	3,542	3,991	430	6,163	653	605	147	***21,935***	15,399	-42%
114.	Senta Medicare Clinic	7,455	408	537	5	5,469	201	515	164	***21,034***	15,079	-39%
115.	Paragon Kampala	3,579	1,294	1,141	103	5,362	443	487	265	***20,740***	27,354	24%
116.	Saidina Abubakar Islamic	8,483	941	391	102	9,501	166	403	37	***18,715***	19,091	2%
117.	Bethany Women and Family	3,150	1,957	611	23	1,348	238	474	271	***18,435***	11,592	-59%
118.	Galilee Community	3,759	555	1,817	416	7,891	157	289	47	***12,791***		#DIV/0!
119.	Divine Mercy	2,600	1,101	922	-	398	849	222	52	***12,306***		#DIV/0!
120.	New Hope	1,323	397	620	305	662	427	204	60	***8,511***		#DIV/0!
121.	Old Kampala	4,629	60	60	17	2,690	22	131	34	***7,991***		#DIV/0!
122.	Novik	3,681	593	1,287	6	4,763	337		-	***7,262***	6,585	-10%
123.	Tumu	843	195	161	556	902	40	203	-	***4,724***	6,395	26%
124.	Kololo	2,305	207	292	5	2,096	155		-	***3,751***		#DIV/0!
125.	Family Care	1,208	152	49	77	1,108	37	60	5	***2,754***		#DIV/0!
126.	Jaro	931	57	18	218	355	12	48	17	***2,269***		#DIV/0!
127.	UMC Victoria	1,372	48	30	-	156			-	***1,442***		#DIV/0!
128.	Gulu Independent	145	1		236	-		62	-	***1,194***	18,144	93%
129.	Lira University	993	19		-	525			-	***1,108***		#DIV/0!
130.	Ntinda	200	12	11	10	66	6		-	***260***		#DIV/0!

3.10 Annex 10: Quality Parameters for General Hospitals 2017/18 FY

No.	Hospital	Beds	Admissions	Patient Days	Deliveries	Caesarean Sections	Immunization	Major Operation	Fresh Still births	Maternal deaths	Macerated still births	BOR	ALOS	Maternal Mortality Risk	FSB Risk
1.	Aber	178	8,442	34,740	2,187	505	15,474	1,019	53	4	40	53	4	183	24
2.	Abim	129	5,939	28,945	752	100	5,808	217	11	0	8	61	5	0	15
3.	Adjumani	131	9,782	38,237	2,124	745	11,100	960	30	7	28	80	4	330	14
4.	Amai Community	87	1,253	6,105	293	150	4,834	274	24	1	5	19	5	341	82
5.	Amudat	113	2,925	10,394	434	69	7,454	71	13	0	8	25	4	0	30
6.	Anaka	100	5,895	20,682	955	103	15,274	161	11	2	7	57	4	209	12
7.	Angal St. Luke	220	11,752	56,007	2,537	928	16,818	1,477	42	9	54	70	5	355	17
8.	Apac	100	7,135	33,108	2,006	233	17,860	624	12	7	30	91	5	349	6
9.	Atutur	400	10,954	35,678	1,640	60	14,830	444	10	1	18	24	3	61	6
10.	Bamu	65	1,400	4,473	497	132	-	237	20		9	19	3	0	40
11.	Bethany Women and Family	20	474		238	131	1,348	271	4		1	0	0	0	17
12.	Bombo General Military	166	8,241	35,989	3,191	855	10,713	1,338	61	6	52	59	4	188	19
13.	Bududa	107	9,778	24,630	1,236	221	11,685	285	17	2	18	63	3	162	14
14.	Bugiri	104	6,385	30,277	2,574	530	17,449	1,428	64	7	40	80	5	272	25
15.	Buikwe St. Charles Lwanga	79	4,468	7,422	1,288	324	9,054	548	47	5	15	26	2	388	36
16.	Bukwo General	35	3,980	11,917	488	56	9,630	79	15	3	4	93	3	615	31
17.	Buliisa	36	1,462	2,793	252	23	5,461	54	4	1	2	21	2	397	16
18.	Buluba	120	3,416	13,918	1,311	593	7,305	705	30	4	14	32	4	305	23
19.	Bundibugyo	104	9,686	36,213	2,113	542	17,501	1,002	31	9	30	95	4	426	15
20.	Busolwe	71	9,942	17,888	1,834	489	7,238	1,059	28	7	30	69	2	382	15
21.	Buwenge NGO	41	1,401	2,750	836	22	21,080	83	1	0	3	18	2	0	1
22.	Bwera	135	12,166	46,268	3,730	1,138	40,045	1,881	19	5	42	94	4	134	5
23.	Bwindi Community	121	6,114	26,743	1,840	604	8,602	982	18	4	18	61	4	217	10
24.	Comboni	100	4,860	12,001	1,450	386	7,491	618	20	6	25	33	2	414	14
25.	Dabani	73	3,206	7,048	805	311	7,213	510	36	7	24	26	2	870	45
26.	Devine Mercy Clinic	22	120	485	694	42	4,447	102	4	1	6	6	4	144	6
27.	Divine Mercy	16	222	120	849	42	398	52				2	1	0	0
28.	Entebbe	200	9,811	30,402	5,993	1,593	40,967	2,109	71	10	91	42	3	167	12
29.	Family Care	32	60	75	37	1	1,108	5	-		1	1	1	0	0
30.	Galilee Community General	25	289	216	157	33	7,891	47	2	0		2	1	0	13
31.	Gombe	100	9,929	29,906	3,602	981	13,847	1,301	58	7	52	82	3	194	16
32.	Gulu Military	50	934	3,732	43		1,100	61	1			20	4	0	23
33.	Ibanda	178	9,644	34,488	2,259	865	9,413	1,319	51	7	63	53	4	310	23
34.	Iganga	104	19,146	55,098	6,326	1,644	34,201	2,877	128	13	125	145	3	206	20
35.	International Kampala (IHK)	100	1,429	5,878	449	189	2,287	407	-	0	2	16	4	0	0
36.	Ishaka Adventist	87	3,906	9,646	918	250	15,560	473	12	1	14	30	2	109	13
37.	Itojo	165	8,586	29,629	1,761	463	7,208	647	26	3	24	49	3	170	15
38.	Kaabong	143	11,006	49,991	904	270	27,820	288	29	5	17	96	5	553	32

No.	Hospital	Beds	Admissions	Patient Days	Deliveries	Caesarean Sections	Immunization	Major Operation	Fresh Still births	Maternal deaths	Macerated still births	BOR	ALOS	Maternal Mortality Risk	FSB Risk
39.	Kabarole	61	3,762	8,006	800	343	12,131	534	10	1	21	36	2	125	13
40.	Kabasa Memorial	45	605	1,960	653		6,163	147	3	0	10	12	3	0	5
41.	Kagadi	104	13,182	38,001	4,669	1,339	26,055	1,720	111	15	81	100	3	321	24
42.	Kagando	210	17,388	74,114	2,771	1,338	17,575	2,427	48	9	48	97	4	325	17
43.	Kakira Worker's	78	2,661	5,859	385	-	7,390	70	3	0	3	21	2	0	8
44.	Kalisizo	107	7,870	15,821	3,078	1,285	16,303	1,421	50	1	62	41	2	32	16
45.	Kalongo Ambrosoli Memorial	271	13,460	68,521	3,547	556	15,263	1,285	18	1	16	69	5	28	5
46.	Kambuga	100	4,140	16,945	1,061	246	7,053	372	11	2	23	46	4	189	10
47.	Kamuli	100	8,882	4,200	2,082	276	20,220	825	30	10	43	12	0	480	14
48.	Kamuli Mission	160	6,666	19,899	2,266	963	13,687	1,584	93	14	78	34	3	618	41
49.	Kanginima	45	1,076	2,515	353	3	9,556	115			1	15	2	0	0
50.	Kapchorwa	118	5,519	41,131	1,680	435	13,461	993	46	8	39	95	7	476	27
51.	Katakwi General	112	11,131	37,346	1,196	198	12,981	444	13	2	12	92	3	167	11
52.	Kawolo	109	11,619	30,766	3,966	953	24,651	1,417	52	10	46	77	3	252	13
53.	Kayunga	104	8,179	21,709	3,011	845	15,960	1,716	51	3	47	57	3	100	17
54.	Kiboga	100	8,127	21,964	3,259	565	11,071	695	56	7	54	60	3	215	17
55.	Kibuli	117	7,888	26,136	2,649	1,194	31,109	1,713	9	2	26	61	3	76	3
56.	Kida	30	1,625	2,767	369	51	5,539	83	5	0	2	25	2	0	14
57.	Kilembe	205	8,199	38,048	1,467	504	13,172	1,486	31	5	21	51	5	341	21
58.	Kiryandongo	111	10,528	32,846	2,771	657	21,278	1,033	64	11	49	81	3	397	23
59.	Kisiizi NGO	308	7,749	57,617	2,130	681	18,113	1,492	22	6	25	51	7	282	10
60.	Kisoro	142	9,226	50,060	3,008	552	13,712	736	17	2	23	97	5	66	6
61.	Kisubi	62	4,021	13,142	1,464	614	36,991	1,114	17	1	17	58	3	68	12
62.	Kitagata	169	9,129	31,773	2,975	757	10,227	1,442	36	0	54	52	3	0	12
63.	Kitgum	219	9,604	50,277	2,038	263	11,847	893	24	1	13	63	5	49	12
64.	KIU Teaching	290	17,107	60,996	2,941	1,292	9,446	1,947	23	6	42	58	4	204	8
65.	Kiwoko	231	8,555	42,224	2,710	945	19,370	1,521	64	7	39	50	5	258	24
66.	Koboko	100	7,041	26,956	2,665	278	29,751	547	35	2	36	74	4	75	13
67.	Kuluva	208	5,772	44,388	1,267	556	15,300	1,128	35	4	16	58	8	316	28
68.	Kumi NGO	210	5,250	24,622	1,616	544	10,727	1,550	28	2	22	32	5	124	17
69.	Kyenjojo	95	7,158	15,005	2,408	299	36,984	310	26	0	35	43	2	0	11
70.	Life Link HOSP	16	361	291	168	44	3,269	108	-		3	5	1	0	0
71.	Lubaga	236	13,680	40,704	4,833	2,009	53,715	3,023	62	14	53	47	3	290	13
72.	Lugazi Scoul	43	2,150	5,460	270	-	3,743	-	3	1	2	35	3	370	11
73.	Lwala	100	2,801	14,585	956	311	7,732	447	32	2	20	40	5	209	33
74.	Lyantonde	92	4,814	10,994	1,865	76	14,177	97	12	2	27	33	2	107	6
75.	Maracha	214	4,260	23,131	1,052	452	8,118	890	31	2	23	30	5	190	29
76.	Masafu General	91	9,638	30,657	1,659	256	17,536	581	21	2	16	92	3	121	13
77.	Masindi	160	9,836	29,975	4,094	651	31,089	1,049	55	5	81	51	3	122	13

No.	Hospital	Beds	Admissions	Patient Days	Deliveries	Caesarean Sections	Immunization	Major Operation	Fresh Still births	Maternal deaths	Macerated still births	BOR	ALOS	Maternal Mortality Risk	FSB Risk
78.	Matany	250	9,927	83,229	1,283	376	22,374	909	26	2	17	91	8	156	20
79.	Mayanja Memorial	100	3,061	7,645	2,097	1,074	8,507	1,218	16	1	21	21	2	48	8
80.	Mbarara Community	90	817	1,456	849	358	2,840	372	18	1	15	4	2	118	21
81.	Mengo	249	12,977	39,936	5,045	1,624	45,644	3,567	15	11	52	44	3	218	3
82.	Mildmay Uganda	38	433	3,830	134	46	2,862	55	-	0	1	28	9	0	0
83.	Mityana	146	13,227	40,050	5,833	1,548	27,760	2,703	79	5	75	75	3	86	14
84.	Mount Elgon	33	1,036	2,644	175	76	1,771	220	2			22	3	0	11
85.	Moyo	157	7,668	23,824	1,435	511	6,200	1,091	18	3	31	42	3	209	13
86.	Mukwaya General	52	660	1,914	332	79	2,429	130	3		3	10	3	0	9
87.	Murchison Bay Main	189	2,040	14,525	1,066	1	6,810	30	-	0	1	21	7	0	0
88.	Mutolere (St. Francis)	200	8,576	47,543	2,052	831	11,114	1,596	18	1	21	65	6	49	9
89.	Nakaseke	159	7,362	36,562	3,088	1,158	65,446	1,909	49	3	45	63	5	97	16
90.	Nakasero	77	5,032	21,353	1,481	1,069	14,065	2,158	2	0	9	76	4	0	1
91.	Nakasongola Military	97	1,419	8,424	87	-	1,605	70	-	0	0	24	6	0	0
92.	Nebbi	167	9,666	35,895	2,246	454	27,744	791	30	6	25	59	4	267	13
93.	New Hope	75	204	729	427	60	662	60	6	1	7	3	4	234	14
94.	Ngora Ngo	91	2,498	6,574	312	159	6,388	243	4	0	3	20	3	0	13
95.	Nkokonjeru	61	1,709	4,576	562	197	7,152	306	16	3	13	21	3	534	28
96.	Nkozi	100	4,924	14,695	1,661	628	11,543	870	34	6	50	40	3	361	20
97.	Nyapea	139	5,472	20,168	1,509	650	17,510	983	30	6	30	40	4	398	20
98.	Oriajini	48	1,022	2,395	425		5,760	4	4		8	14	2	0	9
99.	Pallisa	161	8,428	33,914	2,895	258	15,164	405	53	3	62	58	4	104	18
100.	Paragon Kampala	22	487	1,630	443	223	5,362	265		0	2	20	3	0	0
101.	Pioneer	16	1,344	4,826	1		-	10	-		0	83	4	0	0
102.	Rakai	76	7,014	18,969	2,060	524	9,205	890	29	3	35	68	3	146	14
103.	Rhema	19	938	1,637	212	72	270	255	4		1	24	2	0	19
104.	Rubongi Military	58	2,100	6,509	920		8,340	-			1	31	3	0	0
105.	Rugarama	132	4,317	22,753	1,277	439	7,491	648	16	2	19	47	5	157	13
106.	Ruharo Mission	105	4,736	17,105	879	422	6,111	615	10	5	13	45	4	569	11
107.	Rushere Community	86	3,080	8,801	799	283	9,316	378	18	0	23	28	3	0	23
108.	Ruth Gaylord	34	811	1,429	364	115	5,847	197	2		8	12	2	0	5
109.	Saidina Abubakar Islamic	20	403	795	166	17	9,501	37	3	1	4	11	2	602	18
110.	Senta Medicare CLINIC	30	515	802	201	95	5,469	164				7	2	0	0
111.	St. Anthony's Tororo	93	1,716	7,500	174	56	2,994	194	1	1	3	22	4	575	6
112.	St. Francis Naggalama	115	5,278	14,203	1,687	760	17,121	1,142	42	5	25	34	3	296	25
113.	St. Francis Nsambya	277	13,048	59,799	4,504	2,266	56,602	3,616	14	8	64	59	5	178	3
114.	St. Francis Nyenga	74	1,499	4,297	343	137	7,878	194	10	1	4	16	3	292	29
115.	St. Joseph Kitovu	252	7,601	28,636	1,921	856	9,769	1,734	56	13	31	31	4	677	29
116.	St. Joseph's Kitgum	280	7,882	31,313	2,252	440	13,908	1,302	23	3	43	31	4	133	10

No.	Hospital	Beds	Admissions	Patient Days	Deliveries	Caesarean Sections	Immunization	Major Operation	Fresh Still births	Maternal deaths	Macerated still births	BOR	ALOS	Maternal Mortality Risk	FSB Risk
117.	St. Karolii Lwanga Nyakibale	170	8,008	29,770	1,279	536	11,183	1,077	6	2	37	48	4	156	5
118.	St. Mary's Lacor	482	25,879	121,933	5,976	1,583	28,536	4,168	102	26	93	69	5	435	17
119.	Tororo General	224	13,540	47,744	6,909	625	22,624	1,315	48	4	66	58	4	58	7
120.	UPDF 2nd Div.	45	584	3,456	89	1	3,214	15		0		21	6	0	0
121.	Villa Maria	126	3,613	14,403	879	448	6,793	715	40	5	16	31	4	569	46
122.	Virika	207	5,907	15,271	1,558	788	13,499	1,166	39	8	17	20	3	513	25
123.	Yumbe	206	4,506	17,313	1,145	271	32,642	601	28	5	13	23	4	437	24
	Total	**4,323**	**172,542**	**666,179**	**50,731**	**15,590**	**466,714**	**28,497**	**719**	**120**	**770**	**36**	**4**	**237**	**14**

3.11 Annex 11: HC IV Functionality

No.	District	HC IV	HMIS 108:1 Reporting rate	108-3 MSP Caesarian Sections	108-5a Number of units transfused (mls)
1.	Mukono	Mukono T.C.	100	1,533	71
2.	Kasese	St. Paul	100	1,054	146
3.	Kamwenge	Rukunyu	100	803	174
4.	Mpigi	Mpigi	100	585	4,150
5.	Isingiro	Rwekubo	100	534	88
6.	Kyegegwa	Kyegegwa	100	506	
7.	Mukono	Mukono CoU	100	493	231,303
8.	Yumbe	Midigo	100	426	33,147
9.	Kampala	Kisenyi	66.7	392	
10.	Bundibugyo	Busaru	100	366	289
11.	Rubirizi	Rugazi	100	366	53
12.	Hoima	Azur HC III	91.7	333	116
13.	Kakumiro	Kakindo	100	331	
14.	Luwero	Bishop Asili Ceaser	100	320	142,720
15.	Kasese	Rwesande	91.7	307	53
16.	Kakumiro	Kakumiro	91.7	285	10,975
17.	Amuria	Amuria	100	271	22,018
18.	Mubende	Kiganda	100	255	
19.	Jinja	Budondo	100	254	
20.	Serere	Serere	100	240	220
21.	Bushenyi	Kyabugimbi	91.7	215	20
22.	Kampala	Benedict Medical centre	100	202	264
23.	Luwero	Luwero	100	201	8,893
24.	Kamwenge	Ntara	100	189	8,100
25.	Sironko	Budadiri	100	186	82
26.	Kasese	Bishop Masereka Christian Foundation	100	184	15
27.	Kagadi	St. Ambrose Charity	100	178	426
28.	Wakiso	Kasangati	100	176	
29.	Apac	Aduku	100	173	3,155
30.	Mubende	Kassanda	100	172	20
31.	Namisindwa	Magale	91.7	166	253
32.	Wakiso	Namayumba	100	161	1
33.	Sembabule	Ssembabule	100	160	
34.	Oyam	Anyeke	100	149	11,688
35.	Ngora	Ngora Gvt	100	148	
36.	Rukungiri	North Kigezi	91.7	145	2271
37.	Lira	PAG Mission	100	144	153,933
38.	Kalungu	St. Joseph of the Good Shephard Kyamulibwa Ngo	100	143	139,109

No.	District	HC IV	HMIS 108:1 Reporting rate	108-3 MSP Caesarian Sections	108-5a Number of units transfused (mls)
39.	Nakapiripirit	Tokora	100	140	52,439
40.	Kayunga	Kangulumira	100	135	3
41.	Kyotera	Kakuuto	100	134	147
42.	Jinja	Buwenge	91.7	127	
43.	Kibuku	Kibuku	100	127	83,108
44.	Kabarole	Bukuku	100	123	11
45.	Bulambuli	Muyembe	100	119	272
46.	Mayuge	Kigandalo	91.7	117	
47.	Kibaale	Kibaale (Kibaale)	100	113	8
48.	Hoima	Kyangwali	100	107	32,064
49.	Budaka	Budaka	100	105	13,778
50.	Kaberamaido	Kaberamaido	100	102	29
51.	Mukono	Kojja	100	102	
52.	Mbarara	Kinoni	100	100	
53.	Sironko	Buwasa	100	98	9
54.	Namayingo	Buyinja	100	92	167
55.	Wakiso	Wagagai	100	91	72,183
56.	Busia	Busia	100	90	
57.	Sheema	Kabwohe	100	90	109
58.	Mbale	Bufumbo	100	89	16,970
59.	Kalungu	Bukulula	100	85	7
60.	Serere	Apapai	100	85	14
61.	Sheema	Shuuku	100	83	
62.	Adjumani	Mungula	100	81	31,047
63.	Nakasongola	St. Franciscan	100	81	64,010
64.	Ntungamo	Rwashamaire	100	81	23
65.	Iganga	Bugono	91.7	78	
66.	Bunyangabu	Kibiito	100	77	
67.	Ibanda	Ruhoko	100	74	245
68.	Masindi	Bwijanga	100	73	9
69.	Isingiro	Kabuyanda	100	70	39
70.	Ntungamo	Kitwe	100	69	
71.	Ntungamo	Rubaare	100	69	39
72.	Kanungu	Kihiihi	100	67	948
73.	Lamwo	Padibe	100	66	242
74.	Ibanda	Ishongororo	100	64	
75.	Jinja	Bugembe	100	64	
76.	Kole	Aboke	100	64	
77.	Mbale	Busiu	100	63	8
78.	Rukungiri	Bugangari	91.7	63	

No.	District	HC IV	HMIS 108:1 Reporting rate	108-3 MSP Caesarian Sections	108-5a Number of units transfused (mls)
79.	Kalangala	Kalangala	91.7	60	14
80.	Mitooma	Mitooma	100	60	
81.	Kaliro	Bumanya	100	57	312
82.	Wakiso	Wakiso	100	55	
83.	Bundibugyo	Kikyo	100	53	900
84.	Kotido	Kotido	100	53	
85.	Mbale	Namatala	100	53	
86.	Kyankwanzi	Ntwetwe	100	50	
87.	Rukungiri	Kebisoni	100	49	
88.	Mbarara	Bwizibwera	100	48	
89.	Amuria	Kapelebyong	100	43	1,035
90.	Buhweju	Nsiika	100	43	
91.	Lira	Ogur	100	39	
92.	Iganga	Busesa	91.7	38	70
93.	Kiruhura	Kiruhura	100	31	
94.	Bundibugyo	Nyahuka	100	30	78
95.	Wakiso	Buwambo	100	29	
96.	Bukomansimbi	Butenga	100	26	44
97.	Kyenjojo	Kyarusozi	100	26	
98.	Rukungiri	Buhunga	100	26	
99.	Dokolo	Dokolo	100	25	21,123
100.	Amolatar	Amolatar	100	24	11
101.	Bukwo	Bukwa	100	23	1,000
102.	Nakapiripirit	Nabilatuk	91.7	23	14,107
103.	Nakasongola	Nakasongola	100	23	31
104.	Omoro	Lalogi	100	23	44,001
105.	Otuke	Orum	100	21	86
106.	Lwengo	Kiwangala	100	19	4
107.	Kiruhura	Kazo	100	18	
108.	Kisoro	Chahafi	100	18	
109.	Gulu	Awach	100	16	
110.	Kaabong	Karenga	100	14	
111.	Tororo	Nagongera	100	13	
112.	Luwero	Kalagala	100	12	
113.	Ntoroko	Karugutu	100	12	
114.	Soroti	ATIRIR	100	12	
115.	Kisoro	Rubuguri	100	11	1
116.	Masaka	Kiyumba	100	11	
117.	Butebo	Butebo	100	10	59
118.	Mayuge	Kityerera	100	10	86

No.	District	HC IV	HMIS 108:1 Reporting rate	108-3 MSP Caesarian Sections	108-5a Number of units transfused (mls)
119.	Alebtong	Alebtong	100	9	5,572
120.	Soroti	Princes Diana	91.7	9	3
121.	Luuka	Kiyunga	100	8	19
122.	Masaka	Kyannamukaaka	100	8	
123.	Buvuma	Buvuma	100	7	
124.	Jinja	Walukuba	91.7	7	
125.	Mityana	Kyantungo	91.7	7	
126.	Luwero	Nyimbwa	100	6	
127.	Lwengo	Lwengo	100	6	9
128.	Mityana	Mwera	100	6	
129.	Pakwach	Pakwach	100	6	58,630
130.	Kiboga	Bukomero	100	5	
131.	Wakiso	Ndejje	100	5	
132.	Buyende	Kidera	100	4	48
133.	Manafwa	Bugobero	100	4	
134.	Pader	Pajule	100	4	2,799
135.	Arua	Omugo	100	3	
136.	Kabale	Rubaya	100	3	
137.	Kamuli	Namwendwa	100	3	463
138.	Lwengo	Kyazanga	100	3	
139.	Bugiri	Nankoma	100	2	
140.	Lamwo	Madi-Opei	100	1	18,280
141.	Nakaseke	Semuto	100	1	
142.	Rubanda	Hamurwa	100	1	
143.	Arua	River Oli	100	0	
144.	Bushenyi	Bushenyi	100	0	
145.	Hoima	Kigorobya	91.7	0	
146.	Isingiro	Nyamuyanja	100	0	
147.	Jinja	Mpumudde	100	0	
148.	Kabale	Maziba Gvt	100	0	
149.	Kalangala	Bukasa	100	0	
150.	Kanungu	Kanungu	91.7	0	
151.	Kasese	Nyamirami	91.7	0	
152.	Kayunga	Bbaale	91.7	0	
153.	Kitgum	Namokora	100	0	32,620
154.	Masindi	Masindi Military	100	0	
155.	Moyo	Obongi	100	0	62
156.	Nakaseke	Ngoma	100	0	
157.	Sembabule	Ntuusi	100	0	
158.	Amuru	Atiak	100		

No.	District	HC IV	HMIS 108:1 Reporting rate	108-3 MSP Caesarian Sections	108-5a Number of units transfused (mls)
159.	Arua	Adumi	100		
160.	Arua	Rhino Camp	100		
161.	Bukedea	Bukedea	100		
162.	Buliisa	Buliisa	100		
163.	Gomba	Maddu	91.7		
164.	Hoima	Kikuube			
165.	Isingiro	Rugaaga	100		
166.	Kabale	Kamukira			
167.	Kabarole	Kataraka	100		
168.	Kamuli	Nankandulo	91.7		25,137
169.	Kasese	Hiima Iaa (Uci)	83.3		
170.	Katakwi	ASTU			
171.	Kisoro	Busanza	100		
172.	Kumi	Kumi	91.7		
173.	Kween	Kaproron	100		
174.	Lira	Amach	100		
175.	Lira	Ayira Health Services	100		
176.	Manafwa	Bubulo	100		
177.	Mbarara	Bugamba	100		
178.	Mbarara	Mbarara Mun. Council			
179.	Mityana	Ssekanyonyi	91.7		
180.	Namutumba	Nsinze	100		
181.	Rubanda	Muko	100		
182.	Rukiga	Kamwezi	100		
183.	Rukiga	Mparo	100		
184.	Tororo	Mukuju	100		
185.	Tororo	Mulanda	100		
186.	Yumbe	Yumbe	100		

3.12 Annex 12: SUO for HC IVs 2017/18 FY

No.	HC IV	Admissions	OPD Total attendance	Deliveries	ANC Total attendance	FP Total visits	Total Immunization	Postnatal Attendances	SUO
1.	Kisenyi	8,022	83,771	9,608	39,397	5,412	39,678	18,747	291,855
2.	Mukono T.C.	10,168	33,602	7,690	14,216	4,406	83,379	5,333	253,225
3.	Luwero	6,253	44,512	2,584	11,256	2,456	26,510	4,643	165,707
4.	Kumi	5,789	58,395	755	4,380	3,342	19,994	3,343	158,536
5.	Budadiri	7,119	20,101	1,788	6,303	686	18,700	2,806	144,464
6.	Budaka	6,267	26,981	2,063	6,010	1,012	12,454	667	137,636
7.	Amuria	6,784	22,645	1,405	4,172	804	10,010	2,983	137,412
8.	Serere	6,830	21,017	1,471	3,912	865	11,565	3,704	137,376
9.	Mpigi	5,858	22,124	2,729	9,522	1,954	20,862	2,183	134,641
10.	Kasangati	4,305	33,823	3,217	13,189	2,349	39,115	2,545	131,348
11.	Rukunyu	5,836	24,050	2,128	3,072	1,266	11,902	6,116	129,837
12.	Omugo	4,547	47,373	1,130	6,627	1,047	10,093	1,438	127,803
13.	Yumbe	5,853	22,577	1,695	5,043	1,105	22,186	966	126,841
14.	Busia	4,597	31,268	2,394	9,936	2,887	24,491	3,362	125,184
15.	Kibuku	5,897	23,785	1,236	3,819	1,366	13,461	2,216	124,813
16.	Kyangwali	5,747	23,491	1,316	5,652	496	16,801	1,204	123,312
17.	Busiu	5,592	28,220	1,043	1,915	1,618	10,325	2,411	122,352
18.	Wakiso	3,120	27,574	2,530	13,124	3,527	113,451	782	118,431
19.	Kotido	5,655	27,998	530	1,155	36	4,117	1,508	117,646
20.	St. Paul	5,962	7,351	2,095	3,393	3,199	10,366	4,432	114,841
21.	Bugobero	4,215	40,825	563	3,216	1,646	11,671	1,410	112,335
22.	Bukedea	4,968	21,727	1,127	5,006	973	16,289	1,220	108,739
23.	Nyahuka	4,827	20,721	1,374	6,108	664	11,899	2,276	106,900
24.	Kidera	4,383	26,481	842	3,942	1,738	23,908	2,128	105,122
25.	Kyegegwa	4,184	24,138	1,744	5,229	2,066	17,467	2,364	103,941
26.	Midigo	5,066	12,525	1,544	3,170	1,991	14,079	902	102,082
27.	Pakwach	4,057	25,565	1,175	4,339	2,116	17,665	4,442	101,277
28.	Kangulumira	2,990	34,822	1,780	6,559	2,697	24,635	4,526	100,390
29.	Azur	5,061	7,257	2,020	2,961	1,737	13,640	3,922	100,310
30.	Buyinja	5,118	12,790	1,054	3,609	1,325	7,833	2,289	100,008
31.	Anyeke	4,565	20,311	1,008	2,841	1,474	8,838	1,595	98,549
32.	PAG Mission	5,350	9,956	472	1,943	225	14,422	2,354	97,711
33.	Kiyunga	4,074	23,216	1,083	6,034	1,003	12,839	3,062	97,358
34.	Mulanda	3,704	28,128	1,065	3,801	3,438	10,795	1,919	95,751
35.	Bukomero	3,158	29,759	1,349	6,758	893	17,946	2,892	92,735
36.	Mungula	3,418	31,244	885	3,948	645	9,530	2,339	92,311
37.	Buwenge	4,236	16,660	1,190	3,886	1,419	8,798	3,388	92,256
38.	Kaberamaido	3,595	27,976	1,065	2,226	1,465	9,497	2,053	91,997
39.	Bufumbo	4,296	16,017	1,014	3,203	2,773	9,998	2,158	91,594
40.	Kassanda	3,808	11,226	1,975	7,375	3,661	23,890	4,701	90,868
41.	Bugembe	2,411	35,497	1,458	6,626	4,114	20,353	3,210	89,998

No.	HC IV	Admissions	OPD Total attendance	Deliveries	ANC Total attendance	FP Total visits	Total Immunization	Postnatal Attendances	SUO
42.	Kyarusozi	3,395	29,046	972	3,781	900	6,850	1,907	89,495
43.	Kakumiro	3,371	19,539	2,099	9,483	882	15,866	605	89,257
44.	Atirir	4,074	19,619	649	2,255	633	8,532	1,502	87,875
45.	Magale	4,069	8,757	1,525	4,502	325	28,821	4,553	87,871
46.	Nagongera	3,522	18,688	1,540	6,329	2,218	17,442	665	87,312
47.	Kapelebyong	3,973	20,181	643	2,526	630	7,953	1,038	86,679
48.	Muyembe	3,817	15,251	1,388	5,245	1,064	11,738	1,785	85,841
49.	Rwesande	4,266	12,294	798	4,163	1,153	8,104	2,364	85,735
50.	Karenga	4,188	17,811	398	2,164	43	5,366	851	85,223
51.	Kabwohe	3,524	18,624	1,438	5,477	1,189	10,333	1,952	85,050
52.	Kibaale	3,807	13,044	1,680	5,475	563	13,220	1,458	84,941
53.	Mukono CoU	3,189	22,426	1,159	3,240	423	23,257	3,346	84,212
54.	Karugutu	3,607	18,989	986	3,449	436	14,591	1,440	83,605
55.	Kiganda	2,995	13,836	2,042	7,152	9,679	17,775	4,102	82,993
56.	Dokolo	3,236	25,327	549	2,978	1,123	11,363	3,132	82,501
57.	Buliisa	3,922	16,713	579	2,648	682	8,250	949	82,228
58.	Ntwetwe	2,981	21,737	1,550	6,540	883	16,679	1,816	82,157
59.	Butebo	3,449	18,443	1,112	6,939	1,008	9,881	244	81,810
60.	Nabilatuk	3,875	17,657	384	1,850	1,505	7,836	1,211	81,552
61.	Kitwe	3,540	11,257	1,518	6,399	1,810	19,918	2,852	81,461
62.	Kyabugimbi	2,991	23,440	1,313	3,722	668	9,387	3,764	80,824
63.	Rugazi	3,142	17,672	1,867	3,236	1,338	8,703	4,566	80,448
64.	Kihiihi	3,185	19,820	830	3,842	1,363	7,288	3,684	77,647
65.	Obongi	3,179	24,257	478	1,916	494	4,020	1,036	76,859
66.	Bumanya	3,685	14,387	581	3,063	552	9,171	1,071	76,744
67.	Tokora	3,487	15,226	405	2,366	6,636	6,657	1,875	76,326
68.	Awach	2,895	22,781	681	1,998	1,410	20,372	1,823	76,301
69.	Nankandulo	3,136	19,529	918	2,949	1,065	8,616	2,674	76,226
70.	Princes Diana	3,002	20,341	755	3,194	4,595	11,629	1,442	76,087
71.	Mitooma	2,128	35,663	744	3,605	1,487	8,531	964	76,037
72.	Bwizibwera	3,585	13,178	813	3,125	467	9,482	2,515	75,968
73.	Mukuju	2,526	28,009	769	3,314	2,491	9,603	2,713	75,924
74.	Lalogi	2,859	24,933	676	2,686	1,489	8,892	910	75,519
75.	River Oli	2,833	17,820	1,206	6,706	1,266	19,622	1,871	75,191
76.	Busaru	3,916	7,491	721	2,880	57	13,502	2,320	75,165
77.	Ndejje	1,895	26,132	1,524	7,823	1,749	39,924	319	75,107
78.	Nakasongola	3,110	20,709	819	3,160	608	5,743	354	74,664
79.	Amolatar	3,267	15,731	1,019	3,636	912	7,494	1,646	74,427
80.	Pajule	3,102	18,147	875	2,755	1,102	8,447	1,819	73,579
81.	Nankoma	2,557	16,525	1,075	5,590	2,119	28,372	5,281	72,424

No.	HC IV	Admissions	OPD Total attendance	Deliveries	ANC Total attendance	FP Total visits	Total Immunization	Postnatal Attendances	SUO
82.	Bubulo	2,703	19,989	805	3,441	5,409	9,727	2,182	72,020
83.	Kabuyanda	3,028	14,672	1,181	5,130	1,038	7,773	2,618	71,945
84.	Bukuku	2,400	18,661	1,577	4,979	2,070	10,084	7,123	71,649
85.	Kakindo	2,871	11,224	1,271	9,586	1,072	19,420	2,980	71,347
86.	Kakuuto	2,821	18,176	1,221	3,363	577	8,440	551	70,530
87.	Apapai	2,759	20,426	727	1,975	373	8,667	1,449	69,078
88.	Namayumba	2,131	25,508	1,198	5,608	1,547	6,338	1,101	68,859
89.	Ngora Gvt	2,076	27,447	1,168	3,365	363	9,296	1,233	68,767
90.	Bugono	2,534	22,373	873	3,712	655	3,201	1,678	68,411
91.	Walukuba	2,280	24,241	662	4,304	1,534	8,318	1,584	67,126
92.	Ntara	2,714	13,748	1,021	3,017	1,084	17,839	2,626	66,494
93.	Chahafi	2,461	22,335	549	2,966	1,192	6,344	1,424	66,055
94.	Aduku	2,279	21,046	1,044	3,827	2,054	10,337	592	65,755
95.	Kityerera	1,759	24,492	1,209	6,527	1,233	14,360	4,112	65,730
96.	Kigandalo	1,836	27,891	1,001	4,361	640	8,310	2,061	65,629
97.	Bishop Asili Ceaser	3,153	10,839	902	1,715	-	3,106	2,105	65,175
98.	Ishongororo	2,695	14,526	807	3,956	999	11,109	1,813	64,592
99.	Rwashamaire	2,568	14,734	1,190	3,644	755	7,717	2,343	64,118
100.	Namokora	2,595	17,170	701	2,075	867	11,378	1,414	64,054
101.	Semuto	2,322	17,935	879	4,888	949	12,065	1,536	63,260
102.	Rwekubo	2,791	8,890	1,521	1,727	2,172	3,975	2,590	62,400
103.	Ogur	2,657	12,355	1,005	3,449	1,373	11,499	96	61,994
104.	Aboke	2,408	15,030	984	3,023	2,493	10,909	1,488	61,754
105.	Kigorobya	2,182	17,042	1,082	4,835	1,322	11,098	978	60,969
106.	Busesa	2,159	18,352	893	4,357	1,258	5,509	1,159	59,691
107.	Mpumudde	1,776	21,144	962	5,158	1,135	11,508	3,025	59,555
108.	Lwengo	1,443	22,757	586	2,990	16,342	6,755	1,138	58,918
109.	Bbaale	1,941	22,210	545	3,003	627	9,987	1,234	58,479
110.	Buwambo	1,508	25,565	736	3,524	1,033	16,850	1,682	58,355
111.	Kanungu	2,476	15,711	333	1,209	1,275	3,260	521	56,671
112.	Rhino Camp	2,206	17,260	468	1,945	1,181	6,704	1,135	56,161
113.	Benedict Medical centre	1,400	30,283	489	1,989		3,654	1,398	56,152
114.	Rubaare	1,686	15,103	1,082	2,900	7,784	15,557	2,627	55,570
115.	Alebtong	1,953	17,227	684	3,110	1,236	14,033	1,137	55,490
116.	Kikyo	2,459	13,146	386	1,720	615	8,956	972	55,406
117.	Padibe	1,919	22,002	499	1,008	890	3,511	649	55,258
118.	Nyimbwa	1,547	22,573	637	4,524	1,185	8,870	1,611	54,397
119.	Bukulula	1,674	20,222	891	2,796	1,506	7,460	1,847	54,354
120.	Bugangari	1,700	19,596	840	2,458	2,114	7,043	2,438	54,210
121.	Kaproron	2,030	19,749	358	1,441	400	4,426	480	54,035

No.	HC IV	Admissions	OPD Total attendance	Deliveries	ANC Total attendance	FP Total visits	Total Immunization	Postnatal Attendances	SUO
122.	Amach	1,637	20,098	801	2,778	1,286	14,671	316	53,782
123.	Kyazanga	1,497	22,294	659	4,320	1,970	3,591	1,383	52,599
124.	Ssembabule	1,626	15,051	1,186	5,250	2,619	13,169	636	52,257
125.	Nsinze	1,486	22,343	726	2,082	1,636	3,897	1,657	51,730
126.	Budondo	1,997	12,426	944	2,929	1,137	6,925	1,666	51,352
127.	Buwasa	1,493	21,112	816	3,516	474	6,661	580	51,204
128.	Kebisoni	1,603	14,568	1,258	3,275	1,264	8,587	3,109	50,444
129.	Ruhoko	2,078	11,442	851	3,043	692	4,086	1,660	50,382
130.	Kalagala	1,898	14,986	491	3,862	1,337	7,701	368	50,235
131.	Namatala	1,560	17,533	600	4,626	1,508	11,024	1,682	50,046
132.	Atiak	1,863	18,407	127	1,715	843	6,685	409	49,808
133.	Madi-Opei	1,558	21,825	347	1,326	324	4,889	829	49,147
134.	Namwendwa	1,620	13,003	905	4,790	1,623	11,872	2,381	48,599
135.	Hamurwa	1,223	22,540	579	3,090	1,415	7,814	1,499	48,345
136.	Kazo	1,343	18,812	780	4,890	969	9,943	615	48,083
137.	Kojja	856	21,981	968	4,371	1,820	17,109	2,714	47,535
138.	Shuuku	1,788	13,743	581	2,609	1,110	5,647	2,153	47,533
139.	Kibiito	1,662	11,169	1,140	4,510	1,376	6,406	2,888	47,467
140.	Wagagai	650	33,302	280	1,350	1,228	3,865	838	46,933
141.	Kiwangala	1,054	24,245	361	2,362	2,357	11,823	234	46,701
142.	Adumi	1,683	13,682	576	3,418	876	10,115	989	46,472
143.	Nyamuyanja	1,780	14,733	359	2,024	1,206	3,556	819	45,964
144.	Buvuma	1,181	17,957	581	3,114	974	11,734	2,136	44,036
145.	Kinoni	1,507	13,594	787	2,251	431	4,653	1,400	43,106
146.	Ssekanyonyi	1,114	17,343	719	3,736	696	7,356	991	41,831
147.	Rubuguri	1,149	19,352	450	1,700	1,114	4,655	1,234	41,792
148.	Kiruhura	1,390	15,169	491	2,157	731	6,501	1,068	41,752
149.	Kalangala	1,146	19,122	350	1,925	1,880	5,684	703	41,453
150.	Nsiika	1,342	12,662	589	1,487	1,183	6,391	1,182	38,941
151.	Bishop Masereka Christian Foundation	1,807	6,322	382	2,350	569	8,148	172	38,512
152.	Mparo	1,459	12,197	311	1,759	1,133	1,766	1,238	38,055
153.	Maddu	1,165	12,564	716	3,371	796	7,358	1,644	37,996
154.	Bwijanga	1,260	9,435	892	4,361	1,705	6,790	933	37,653
155.	Kyannamukaaka	1,368	12,531	342	1,593	803	3,914	966	37,225
156.	Muko	1,040	17,205	254	1,352	2,765	3,446	596	37,121
157.	Orum	1,403	11,837	261	1,340	924	4,772	956	36,751
158.	Rubaya	1,118	13,504	419	3,228	1,646	4,570	1,449	36,445
159.	Butenga	1192	11485	660	2847	1292	4404	848	36039
160.	St. Joseph of the Good Shephard Kyamulibwa Ngo	1,544	7,399	402	507	159	3,456	896	34,041

No.	HC IV	Admissions	OPD Total attendance	Deliveries	ANC Total attendance	FP Total visits	Total Immunization	Postnatal Attendances	SUO
161.	Busanza	810	18,458	258	1,354	408	2,531	996	33,783
162.	Kyantungo	1,130	12,742	258	1,224	550	5,831	1,036	33,553
163.	North Kigezi	1,482	5,290	534	1,188	2,136	3,448	1,643	33,363
164.	Buhunga	897	13,151	697	1,276	675	5,855	1,639	33,057
165.	Kamwezi	979	13,059	366	1,989	891	5,141	1,379	32,732
166.	Maziba Gvt	764	16,057	365	2,585	823	3,078	1,219	32,271
167.	Kiyumba	674	16,842	395	1,637	480	3,509	752	31,063
168.	Mwera	995	11,637	318	1,615	802	5,772	857	30,943
169.	Masindi Military	894	14,206	82	578	485	1,422	279	28,981
170.	Ngoma	434	18,189	150	2,470	562	8,634	181	28,782
171.	Rugaaga	469	15,700	415	2,698	400	8,544	1,038	28,587
172.	Kikuube		19,066	867	4,917	805	8,100	1,350	28,557
173.	Kamukira		23,378	189	1,716	2,248	4,408	1,182	27,778
174.	St. Ambrose Charity	1,400	2,306	298	1,265	821	6,415	858	27,551
175.	5Th Military Division	1,044	10,048	127	580	177	1,010	279	27,063
176.	Bukasa	374	18,409	159	864	421	3,570	353	26,347
177.	Bugamba	720	9,602	498	2,137	736	6,344	540	25,867
178.	Bushenyi	278	17,629	242	2,017	811	4,263	680	25,616
179.	Mbarara Municipal Council		15,231	355	6,229	706	12,389	5,070	25,486
180.	Nyamirami	615	9,459	199	1,397	674	4,450	233	21,721
181.	St. Franciscan	1,010	3,937	265	341	-	2,447	744	21,444
182.	Bukwa	766	6,082	193	806	275	6,323	1,106	20,895
183.	Kataraka	120	14,936	118	1,348	1,326	3,419	713	19,703
184.	Ntuusi	240	11,151	241	2,972	1,444	6,490	365	19,645
185.	ASTU		13,514	-	7	884	-	-	13,960
186.	Ayira Health Services	694	1,216	2	8	-	1,879	1	12,016
187.	Hiima Iaa (Uci)	94	4,941	3	24	80	145	15	6,455
	Total	**503,888**	**3,597,388**	**182,774**	**719,095**	**274,756**	**2,101,126**	**350,033**	**13,161,745**

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