THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

Department of Pharmaceuticals and Natural Medicines

NATIONAL PHARMACEUTICALS AND ESSENTIAL COMMODITIES ACCOUNTABILITY FORUM

(NPECAF)

Q3 FY 2025/26 PERFORMANCE REPORT

January – March 2026

Strengthening Pharmaceutical Stewardship, Governance, and Health Supply Chain Accountability

Across Uganda's Health System

Department of Pharmaceuticals and Natural Medicines | Ministry of Health, Uganda

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It is with renewed purpose and clear-eyed resolve that I present the NPECAF Q3 FY 2025/26 Performance Report — the third quarterly accountability report of Financial Year 2025/26, and a critical checkpoint on the progress of Uganda's pharmaceutical stewardship agenda.

Q3 FY 2025/26 was not without its challenges. The reporting period coincided with national elections in January, which disrupted Regional TWG meetings in Bugisu, Karamoja, and North Buganda. Staffing remains at crisis levels — 43% at General Hospitals — and NMS Order Fill Rates continue to fall short of the 95% target at most facilities. These are not new problems, but they demand fresh urgency and renewed commitment from all levels of the system.

Yet this quarter also brought meaningful signals of progress. Kayunga RRH achieved 96% HMIS Section 6 data completeness from their region's facilities. Jinja RRH continued to lead on redistribution and MTC governance. Busolwe GH launched eAFYA in February 2026. These are proof points that dedicated leadership at facility level can drive measurable improvement even within resource constraints.

The actions recommended in this report are grounded in real Q3 FY 2025/26 data from Uganda's facilities — not aspirations. I call on all stakeholders: health facility teams, district leadership, NMS, NDA, implementing partners, and MoH departments — to treat each recommendation as a direct mandate for Q4 FY 2025/26 action.

NPECAF's accountability function is only as strong as the collective will to act on the evidence it surfaces. That will must now translate into concrete changes: filled vacancies, improved OFRs, better HMIS completeness, and stronger MTC governance — this quarter.

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ACKNOWLEDGEMENTS

The Department of Pharmaceuticals and Natural Medicines (DPNM), Ministry of Health Uganda, expresses sincere gratitude to all stakeholders who contributed to the successful implementation of NPECAF activities during January-March 2026.

Special appreciation goes to the Ministry of Health leadership for their continuous guidance, and to all NPECAF forum participants — health facility pharmacists, Regional Referral Hospital teams, District Health Teams, National Medical Stores staff, Medical Bureaus, Implementing Partners, and Development Partners — for their dedication to improving pharmaceutical accountability in Uganda.

We acknowledge the administrative and technical staff of DPNM for their tireless coordination of weekly forum sessions, data compilation, and performance reporting, which made this quarterly report possible.

LIST OF ACRONYMS

Acronym	Full Form	Acronym	Full Form
ADR	Adverse Drug Reaction	**MTC**	Medicines and Therapeutics Committee
AEFI	Adverse Event Following Immunisation	**NDA**	National Drug Authority
AMS	Antimicrobial Stewardship	**NMS**	National Medical Stores
AMR	Antimicrobial Resistance	**NPECAF**	National Pharmaceuticals and Essential Commodities Accountability Forum
ARV	Antiretroviral	**NRH**	National Referral Hospital
ART	Antiretroviral Therapy	**OFR**	Order Fill Rate
AWaRe	Access, Watch, Reserve (WHO Antibiotic Classification)	**OPD**	Outpatient Department
C&S	Culture and Sensitivity	**PPS**	Point Prevalence Survey
CSSP	Commodity Supply and Stock Planning	**PV**	Pharmacovigilance
DHIS2	District Health Information Software 2	**RASS**	Reporting and Accountability for Supply Security
DHO	District Health Officer	**RRH**	Regional Referral Hospital
DPNM	Department of Pharmaceuticals and Natural Medicines	**SOPs**	Standard Operating Procedures

eAFYA	Electronic Health Logistics Management Information System	**TB**	Tuberculosis
eLMIS	Electronic Logistics Management Information System	**TLD**	Tenofovir + Lamivudine + Dolutegravir
EMHS	Essential Medicines and Health Supplies	**TWG**	Technical Working Group
FEFO	First Expiry First Out	**UCG**	Uganda Clinical Guidelines
FY	Financial Year	**UGX**	Uganda Shillings
GH	General Hospital	**WHO**	World Health Organization
HMIS	Health Management Information System	**ATCC**	American Type Culture Collection
IML	Institutional Medicines List	**mTrac**	Mobile Tracking System
IPC	Infection Prevention and Control	**USAID**	United States Agency for International Development
MoH	Ministry of Health		

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EXECUTIVE SUMMARY

The National Pharmaceuticals and Essential Commodities Accountability Forum (NPECAF) commenced its second year of operations with the Q3 FY 2025/26 reporting period spanning January to March 2026. Operating under the Department of Pharmaceuticals and Natural Medicines (DPNM), NPECAF convened its regular Thursday sessions bringing together Regional Referral Hospitals, General Hospitals, District Health Teams, National Medical Stores, implementing partners, and development partners from reporting regions across Uganda.

Four meetings were held during the quarter, with presentations from six facilities across Acholi, North Buganda, Bugisu, Bukedi, and Busoga regions. National elections in January 2026 disrupted Regional TWG scheduling in three regions, though most regions recovered by February and March. The structured presentation format and standardised reporting templates introduced in April 2025 continued to be maintained, ensuring consistent, comparable reporting.

Key Performance Highlights — Q3 FY 2025/26 (January to March 2026)					
No.	**Indicator**	**Target**	**Achieved**	**Rating**	**Status**
1	NPECAF meetings conducted as planned	100% (planned)	Ongoing — 10 meetings held in Q3 FY 2025/26	**Ongoing**	**~ Fair**
2	Stakeholder participation rate	≥70% per meeting	1,182 Participants	**>70% most sessions**	**Good**
3	EMHS budget utilisation	100%	92-100% range across reporting facilities	**~96% avg**	✓ **Very Good**
4	Commodity availability	≥95%	Variable: 54-99.1% range by facility	**54–99.1%**	**~ Fair**
5	Order Fill Rate (OFR)	≥95%	54-99.1% (avg ~76%)	**~76%**	**~ Fair**
6	Pharmacy staffing – GHs	≥80%	43% at Bugiri GH & Busolwe GH; 57% at Mbale RRH	**43–57%**	✗ **Inadequate**
7	Functional MTCs (100% meetings)	100%	~70% of reporting facilities on track	**~70%**	✗ **Inadequate**
8	ADR reporting trend	Increasing	Uneven; improving in leading facilities	**Mixed**	**~ Fair**
9	AMS/PPS coverage	≥70% facilities	All reporting regions conducted AMS activities	**Partial**	**~ Fair**
10	Regional TWG meetings held	100%	6 of 15 regions with confirmed data — 100%	**6/15 confirmed**	**~ Fair**

			held		

The quarter demonstrated progress in commodity redistribution, MTC institutionalisation across reporting facilities, and continued eAFYA adoption at Busolwe GH. However, critical gaps persist: pharmacy staffing at 43% at General Hospitals, OFR below 95% at all facilities except Jinja RRH (99.1%), severely declining UCG adherence in Acholi (0.39%), and inadequate HMIS Section 6 completeness across most regions. Addressing these through urgent recruitment, NMS performance accountability, and digital integration is imperative for Uganda to achieve its pharmaceutical stewardship goals in 2026.

1. BACKGROUND AND FORUM OVERVIEW

1.1 About NPECAF

The National Pharmaceuticals and Essential Commodities Accountability Forum (NPECAF) is a strategic multi-stakeholder platform established by the Ministry of Health to promote transparency, accountability, and improved access to essential medicines and health supplies in Uganda. The forum operates under the leadership of the Commissioner for Pharmaceuticals and Natural Medicines and convenes weekly every Thursday from 7:30 am to 9:00 am.

NPECAF's participatory action approach brings together stakeholders from across the health supply chain – MoH officials, District Health Teams, health facility representatives, warehouse teams, medical bureaus, implementing partners, and development partners – to present performance updates, review data, and agree on remedial actions for identified challenges. Meetings commenced 16 January 2025 and have continued into Q3 FY 2025/26.

1.2 Strategic Pillars

NPECAF's work is anchored on four strategic pillars, each with clear goals and measurable indicators:

#	Pillar	Focus Area
1	**Transparency & Accountability**	Institutionalise regular multi-stakeholder accountability; promote open review of performance and corrective actions
2	**Performance Monitoring & Governance**	Strengthen MTCs, pharmacovigilance, AMS, and evidence-based decision-making
3	**Access to EMHS**	Ensure equitable access; optimise budget utilisation; strengthen redistribution mechanisms
4	**Health Supply Chainmance**	Enhance order fulfilment, delivery timelines, inventory management, and stock visibility

1.3 Forum Participation — January to March 2026

Four NPECAF meetings were conducted during Q3 FY 2025/26. The structured presentation schedule, maintained from April 2025, ensured organised, region-by-region engagement and enabled comparative tracking of facility performance. National elections in January 2026 affected attendance and TWG scheduling in some regions, but forum momentum was sustained through the quarter.

Table 1 below details the session dates, presenting facilities, regions, and presenters for Q3 FY 2025/26.

Table 1: NPECAF Meetings and Presenting Facilities — January to March 2026

Sn	Month	Date	Participants	Facilities	Region	Presenter(s)
1	January 2026	8 Jan 2026	–	Gulu RRH Anaka GH	Acholi	Akello Zainab
		29 Jan 2026	–	Mubende RRH Mityana GH Kiboga GH	North Buganda	–
2	February 2026	26 Feb 2026	–	Kayunga RRH	North Buganda	Senkungu Ismail
3	March 2026	12 Mar 2026	35	Mbale RRH Busiu HCIV Busolwe GH	Bugisu Bukedi	Hamidu Wamwoyo Kalyebi Isaac Wanyama
		19 Mar 2026	–	Jinja RRH Bugiri GH	Busoga	Mayanja Mathias Achol James Balibuza Banuli

Table 1 note: Ten meetings held across January-March 2026. Sessions followed the standardised presentation format introduced in April 2025.

PILLAR 1: TRANSPARENCY & ACCOUNTABILITY

Goal: To strengthen transparency, accountability, and collective oversight in the management of pharmaceuticals and essential health commodities across the health system.

2.1 Overview and Performance

Pillar 1 assessed the extent to which NPECAF maintained its multi-stakeholder accountability function and followed up on agreed corrective actions during Q3 FY 2025/26. Ten meetings were held across the quarter, with presentations from Acholi (Gulu RRH and Anaka GH), North Buganda (Mubende RRH and Kayunga RRH), Bugisu (Mbale RRH and Busiu HCIV), Bukedi (Busolwe GH), and Busoga (Jinja RRH and Bugiri GH).

Pillar 1: Indicator Performance Summary

Indicator	Target	Achieved	Rating	Performance
NPECAF meetings conducted as planned	100% (planned)	4 meetings held across Jan-Mar 2026	~	**Fair**
Stakeholder participation rate	≥70% per meeting	1,182 participants	**>70%**	**Good**
Structured presentation schedule	Yes (from Apr 2025)	Maintained – standardised reporting used	**Achieved**	**Excellent**
Action point follow-up rate	≥80%	Partial – TWG action tracker in use	**~60%**	**Inadequate**

2.2 Trend Analysis

NPECAF demonstrated sustained institutional commitment in Q3 FY 2025/26 despite the disruption of national elections in January. By February and March, forum cadence had returned to full schedule, with the 12 March session achieving a 35-participant attendance figure. The structured regional presentation rotation — established in April 2025 — continued to operate effectively, ensuring all presenting facilities submitted data in the standardised format.

Participation from implementing partners remained variable, while health facility teams continued to take greater ownership of the forum presentation process — a positive evolution observed since Q3 FY 2025/26 that reflects the forum's growth into a genuine facility-led accountability platform. Action point follow-up improved for TWG-level items with dedicated action trackers (Rwenzori, Mubende, Mbale, South Central, Karamoja), but systemic issues — OFR, EMR-CSSP integration, staffing — remain pending inter-agency escalation.

Figure 1 (stakeholder participation trend) reflects the Q3 FY 2025/26 trajectory — lower in January due to elections, recovering in February and March as facilities prepared and presented their Q3 FY 2025/26 data.

Figure 1: NPECAF TWG Meetings Attendance Analysis — January–February 2026

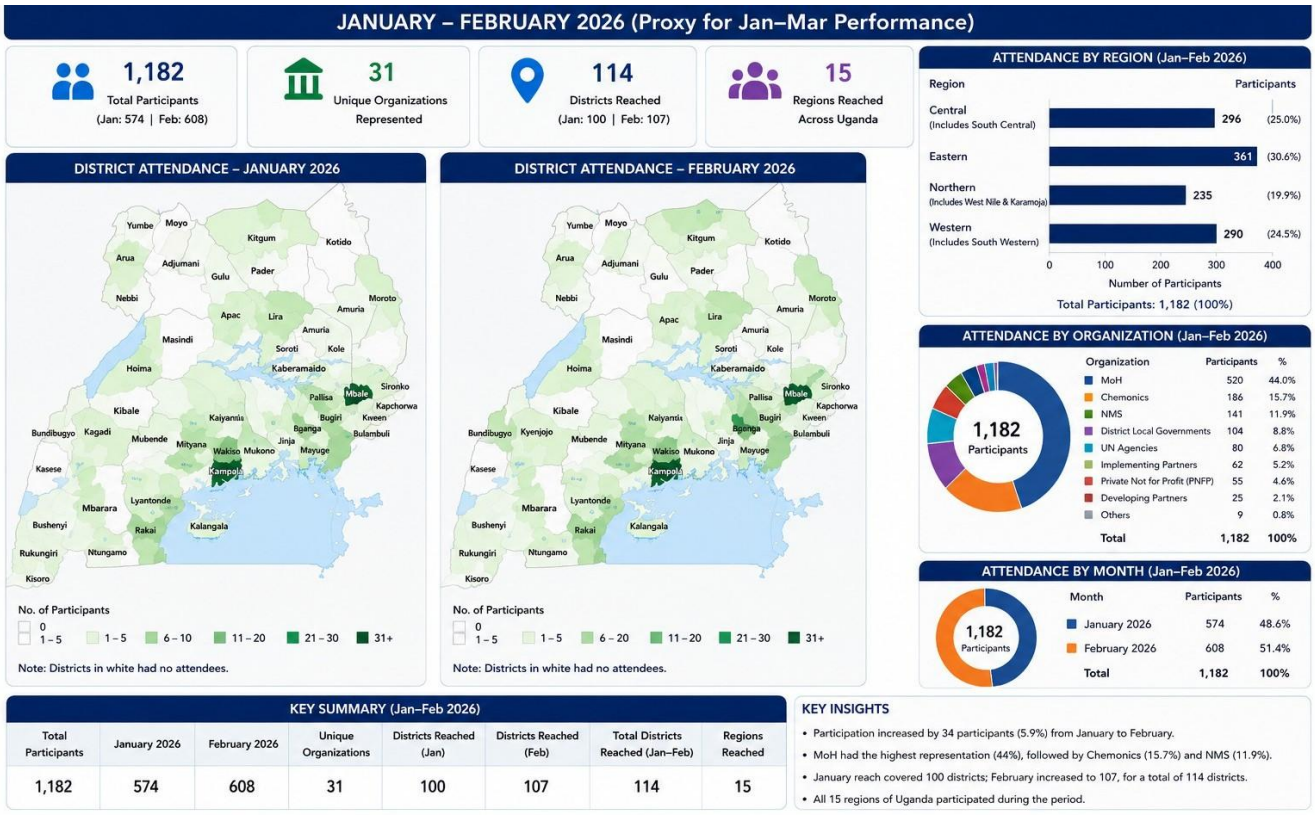


Figure 1 presents the full TWG Meetings Attendance Analysis for January–February 2026. A total of 1,182 participants attended across both months, representing 31 unique organisations and reaching 114 districts across all 15 regions of Uganda. MoH led organisational participation at 44.0% (520 participants), followed by Chemonics (15.7%) and NMS (11.9%). Eastern region had the highest regional participation (30.6%), followed by Central (25.0%), Western (24.5%), and Northern (19.9%). Participation grew from 574 in January to 608 in February — a 5.9% increase — indicating sustained and growing stakeholder engagement despite the January election period.

2.3 Key Enablers and Constraints

✅ Key	⚠ Key Constraints
Strong DPNM/MoH leadership – Commissioner's consistent presence maintained accountability tone and forum momentum	National elections in January 2026 disrupted TWG meetings in Bugisu, Karamoja, and North Buganda
Structured meeting format and standardised reporting maintained from April 2025	Competing institutional priorities caused inconsistent attendance from district leadership
Multi-sectoral representation: facilities, partners, NMS, NDA, development partners	Limited enforcement mechanisms – NPECAF has no punitive authority over non-compliant actors
Regional TWG action trackers enabling structured follow-up in Rwenzori, Mubende, Mbale, Karamoja, and South Central	EMR-CSSP integration still pending

PILLAR 2: PERFORMANCE MONITORING & GOVERNANCE

Goal: To strengthen evidence-based decision-making, governance, and performance monitoring in pharmaceutical services.

3.1 HMIS 105-6 Reporting and Completeness

HMIS 105-6 captures pharmaceutical data – including medicines availability, ordering patterns, and health supply chain metrics – from all health facilities monthly. Complete and timely HMIS submissions are the foundation of performance monitoring across all four pillars. In Q3 FY 2025/26, HMIS completeness remains a critical weakness across the system.

The most detailed regional data available comes from North Buganda (Kayunga RRH region), where 96% (254 of 264) of facilities submitted complete data on all required parameters in Section 6, and 99% (264 of 268) submitted at least one data point — representing a significant improvement from the 78.4% completeness reported in the second half of 2025 for the same region. This is the strongest HMIS completeness finding in Q3 FY 2025/26.

In contrast, the Acholi region (Gulu RRH) recorded HMIS Section 6 completeness of only 52% — the lowest confirmed figure for Q3 FY 2025/26. Nwoya District led within the region at 97%, while Gulu City, Amuru, and Pader underperformed. Reports from multiple other regions indicate similar challenges: incomplete reports, delayed submissions, and HMIS 105 stock status components not well configured in some facilities (e.g., Bugiri GH in Busoga).

The pattern mirrors 2025 findings: where targeted mentorship and committed pharmaceutical leadership exist, HMIS completeness improves. Without reliable data, resource allocation, redistribution decisions, and health supply chain planning cannot be evidence-based. Mandating 70% HMIS Section 6 completion as a quarterly KPI with non-compliance escalated through NPECAF is recommended as an immediate priority.

Figure 2a: HMIS 105-6 Health Facility Reporting Summary — Q3 FY 2025/26

Figure 2a shows the overall HMIS reporting landscape for Q3 FY 2025/26. Of 4,506 total health facilities, 12,829 (94.9%) submitted at least one report. However, only 8,810 (65.2%) submitted complete reports — a significant completeness gap that undermines evidence-based decision-making. This gap between facilities reporting and facilities reporting completely is the central data quality challenge for Q3 FY 2025/26 and must be closed.

Figure 2b: HMIS 105-6 Reporting Rate and Completeness Trend — April 2025 to March 2026

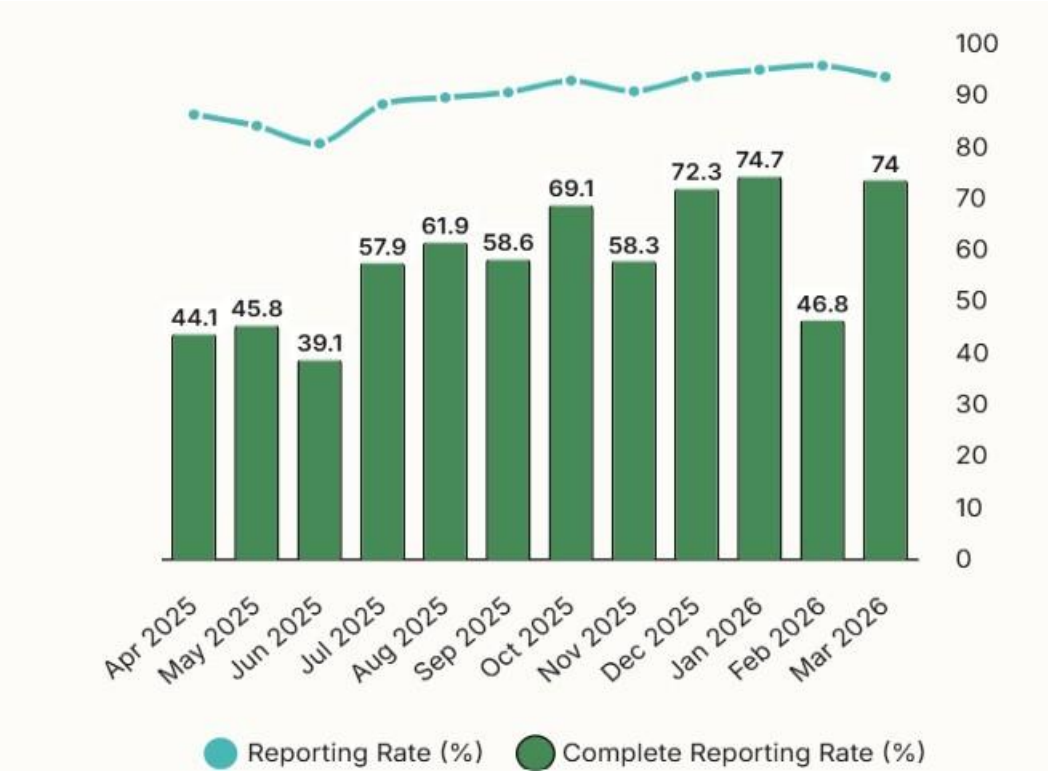


Figure 2b tracks reporting and complete reporting rates from April 2025 through March 2026. Reporting rates (teal line) remained high throughout (~90–97%). Complete reporting rates (green bars) showed marked variation: lowest at 39.1% in June 2025, recovering to 74.7% in January 2026, and at 74% by March 2026. The persistent gap between reporting and completeness rates signals that submissions are being made but many remain partial. Achieving the 90% completeness target requires sustained facility-level mentorship and mandatory HMIS data validation before submission.

Figure 2c: HMIS 105-6 Completeness by Implementing Partner and Region — March 2025 to March 2026

	HMIS 105-6 Reporting Rates													HMIS 105-6 Completeness											
Region	**Mar-25**	**Apr-25**	**May-25**	**Jun-25**	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**	**Mar-25**	**Apr-25**	**May-25**	**Jun-25**	**Jul-25**	**Aug-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**
LPHS E- Karamoja Region (N=153	90%	93%	92%	90%	90%	97%	97%	100%	100%	99%	100%	100%	100%	78%	72%	60%	62%	89%	95%	96%	100%	100%	99%	100%	100%	100%
LPHS KL- Kigezi Region (N=322)	100%	100%	81%	84%	100%	99%	100%	100%	99%	100%	100%	100%	100%	89%	97%	50%	50%	97%	99%	98%	98%	96%	95%	100%	100%	99%
AIC Soroti (N=203)	88%	83%	82%	79%	82%	81%	93%	84%	83%	92%	94%	99%	98%	52%	48%	48%	45%	49%	46%	92%	55%	53%	79%	90%	98%	98%
MUWRP (N=278)	91%	82%	87%	72%	82%	99%	97%	96%	89%	100%	99%	100%	99%	64%	54%	60%	42%	49%	94%	95%	90%	81%	97%	96%	97%	98%
LPHS EC (N=499)	83%	77%	74%	63%	80%	75%	75%	98%	99%	99%	99%	99%	99%	40%	40%	35%	36%	42%	41%	40%	92%	90%	96%	95%	96%	96%
LPHS KL- Lango Region (N=199)	92%	90%	88%	82%	99%	99%	98%	97%	97%	98%	98%	97%	95%	76%	68%	70%	59%	98%	97%	92%	94%	91%	95%	96%	93%	94%
LPHS E (N=432)	82%	90%	90%	85%	95%	93%	94%	91%	90%	92%	94%	92%	89%	46%	66%	62%	66%	83%	87%	91%	90%	90%	91%	91%	91%	89%
LPHS KL- Acholi Region (N=281)	80%	84%	84%	82%	88%	90%	95%	96%	90%	91%	97%	99%	95%	47%	50%	44%	44%	65%	66%	86%	92%	80%	69%	91%	92%	89%
Reach Out Mbuya (N=79)	53%	54%	47%	54%	60%	59%	69%	68%	51%	91%	90%	89%	87%	11%	14%	8%	15%	14%	31%	31%	35%	12%	88%	84%	85%	85%
IDI Masaka (N=475)	88%	90%	90%	86%	88%	95%	89%	96%	94%	94%	95%	96%	92%	49%	68%	72%	63%	74%	91%	84%	95%	85%	90%	86%	89%	83%
LPHS KL- Ankole Region (N=406)	83%	84%	83%	80%	92%	92%	90%	93%	91%	92%	96%	96%	97%	32%	33%	27%	27%	65%	66%	62%	64%	61%	61%	73%	74%	77%
Baylor Fort- Mubende (N=526)	90%	87%	91%	88%	90%	84%	97%	94%	92%	96%	96%	97%	93%	90%	87%	81%	88%	90%	83%	88%	80%	74%	87%	83%	91%	76%
Baylor Bunyoro (N=218)	94%	99%	98%	94%	98%	94%	91%	88%	88%	94%	86%	93%	91%	80%	94%	90%	83%	88%	75%	72%	61%	64%	71%	66%	74%	68%
IDI West Nile (N=332)	84%	82%	81%	73%	79%	78%	86%	82%	82%	88%	91%	95%	79%	44%	44%	44%	29%	39%	38%	57%	52%	52%	75%	77%	81%	62%
National (N=4403)/Average	**86%**	**85%**	**83%**	**79%**	**87%**	**88%**	**91%**	**92%**	**89%**	**95%**	**95%**	**97%**	**94%**	**57%**	**60%**	**54%**	**51%**	**67%**	**72%**	**77%**	**78%**	**74%**	**85%**	**88%**	**90%**	**87%**

Figure 2c provides a 13-month breakdown of HMIS reporting and completeness by IP/region. Karamoja (LPHS E) and Kigezi (LPHS KL) were the strongest performers, achieving 100% completeness in multiple months. Reach Out Mbuya showed consistently weak completeness (as low as 8%). The national average improved from 57% completeness in March 2025 to 87% in March 2026 — a marked improvement, though short of the 90% target. Facilities and regions below the national average require immediate targeted mentorship.

Figure 2d: HMIS 105-6 Completeness by District — December 2025 to March 2026

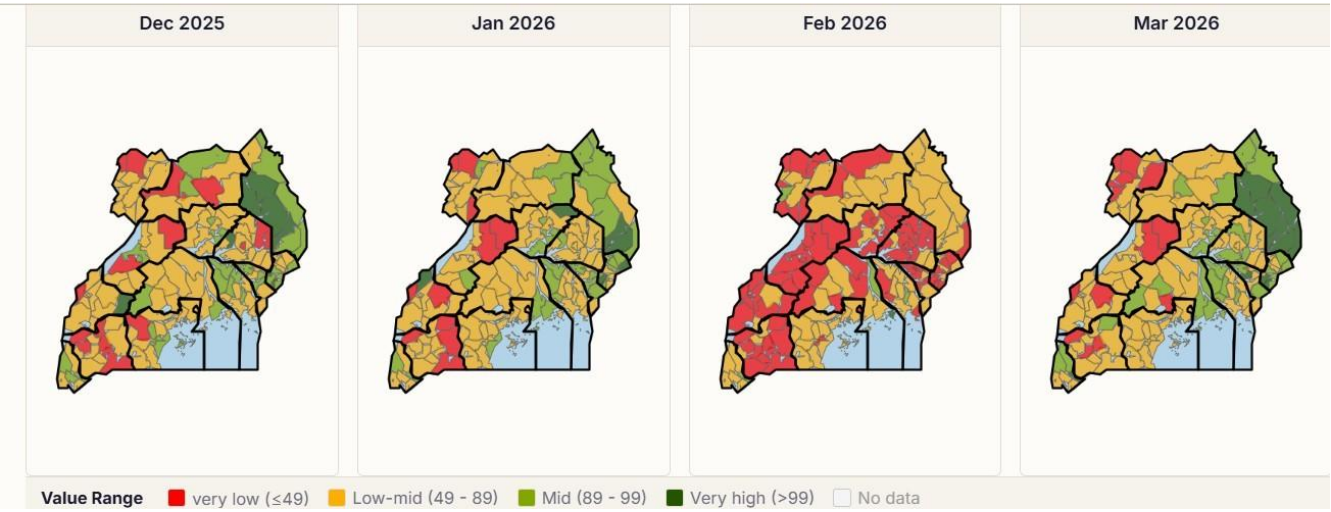


Figure 2d maps district-level HMIS completeness across four months. January 2026 shows the highest concentration of very-low districts (red, ≤49%), directly linked to election-period reporting disruptions. By March 2026, fewer districts remain in the very-low range, with improved mid-range coverage — indicating recovery post-elections. Northern Uganda and parts of Eastern Uganda show persistent completeness challenges. These districts should be prioritised for targeted biostatistics and pharmaceutical mentorship in Q4 FY 2025/26.

3.2 Medicines and Therapeutics Committees (MTCs)

MTCs are the primary governance structure for rational medicines use at facility level. Each facility targets three functional sub-committees (AMS, Health Supply Chain, Pharmacovigilance) with three meetings per quarter. In Q3 FY 2025/26, approximately 70% of reporting facilities achieved their meeting targets — an improvement on the 55% full-year figure for 2025, reflecting growing MTC institutionalisation in presenting facilities.

Table 4: MTC Performance — Meetings Held vs Target, January–March 2026

Region	No.	Health Facility	MTC Structure	Target Composition	Meetings Held	Target (Q3 FY 2025/26)	MTC Performance
Busoga	1	**Jinja RRH**	3 committees	3 committees	2 meetings	3 meetings	**67% (2/3) — Inadequate**
	2	**Bugiri GH**	3 committees	3 committees	1 meeting held	3 meetings	**33% (1/3) — Inadequate**
Bukedi	3	**Busolwe GH**	3 committees	3 committees	3 meetings held	3 meetings	**100% (3/3) — Excellent**
Acholi	4	**Gulu RRH**	3 committees	3 committees	2 meetings held	3 meetings	**67% (2/3) — Inadequate**

	5	**Anaka GH**	3 committees	3 committees	2 meetings held	2 meetings	**67% (2/3) — Inadequate**
Bugisu	6	**Mbale RRH**	3 committees	3 committees	3 meetings held	3 meetings	**100% (3/3) — Excellent**
	7	**Busiu HCIV**	3 committees	3 committees	3 meetings held	3 meetings	**100% (3/3) — Excellent**
North Buganda	11	**Kayunga RRH**	3 committees	3 committees	3 meetings held	3 meetings	**100% (3/3) — Excellent**
	12	**Mubende RRH**	3 committees	3 committees	2 meetings held (quarterly)	3 meetings	**67% (2/3) — Inadequate**

Table 4 analysis: Of the 9 facilities with Q3 FY 2025/26 data, 5 achieved 100% of their MTC meeting targets (Busolwe GH, Mbale RRH, Busiu HCIV, Kayunga RRH — 100%; Anaka GH achieved 2/2 against its adjusted target). Bugiri GH achieved only 33% (1/3 meetings) and remains at risk of MTC functionality gaps. Mubende RRH and Jinja RRH at 67% require follow-up in Q2. Recurring drivers of underperformance: inadequate MTC budget lines, non-compliance with subcommittee reporting requirements, and staffing gaps disrupting committee continuity.

Figure 2: MTC Performance — Meetings Held vs Target, Q3 FY 2025/26 (January–March 2026)

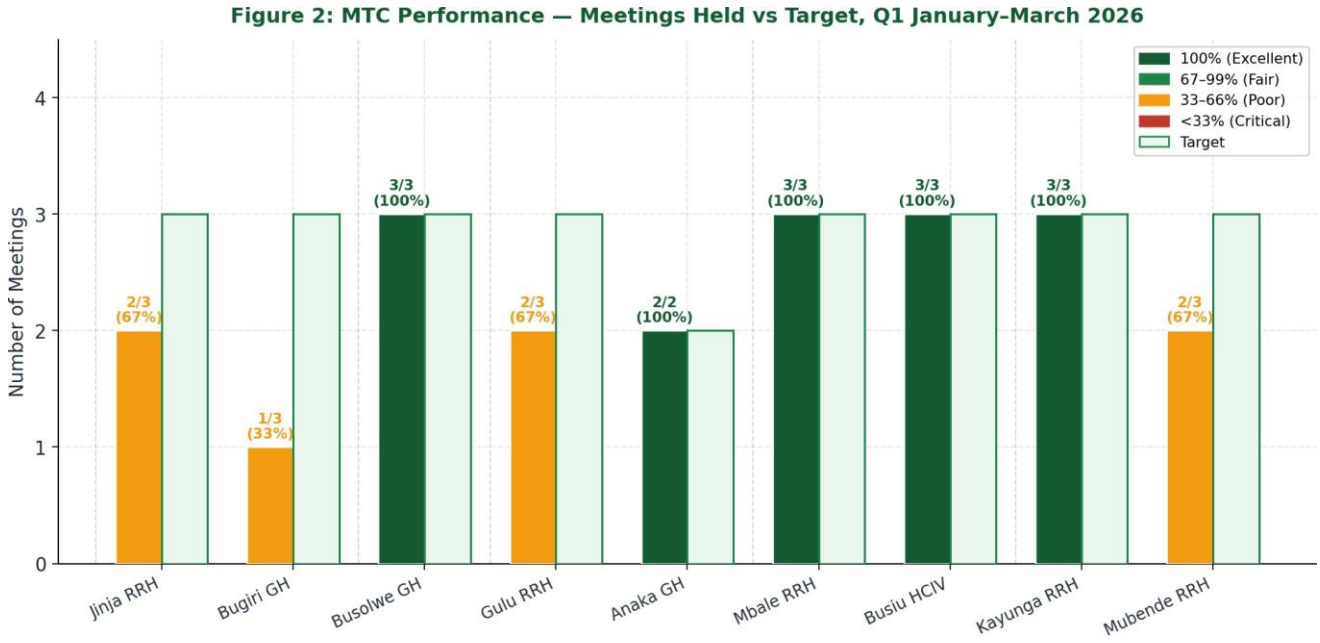


Table 5: MTC Key Activities, Challenges and Recommendations — Q3 FY 2025/26

Region	No.	Health Facility	Activities / Achievements	Challenges / Findings	Recommendations / Actions
Busoga	1	**Jinja RRH**	- Developed IML - Drafted policy on Medicines Promoters - Drafted policy on Antimicrobial Prescribing - Developed annual procurement plan 2026/27 - Carried out Medicine Audit for selected drugs	–	–
Bukedi	2	**Busolwe GH**	- CME on AMS: PPS report disseminated - Generated Institutional Medicines List (Feb 2026) - Antibiogram generation scheduled Apr 2026 - Support supervision to lower HFs scheduled May 2026	- Staffing gaps - Knowledge gaps on eAFYA and OFSSR dashboard - Reluctancy on ADR/ADE reporting	- MoH to conduct onsite refresher training on eAFYA/OFSSR - Refresher trainings on pharmacovigilance ADR/ADE reporting
Acholi	3	**Gulu RRH**	- 2 ADRs reported in Q2 - Conducted 1 GPPS in September (Qtr 1)	- UCG adherence fell: 41.9% Qtr1 → 28.3% Qtr3 (FY24/25) → 0.39% Qtr1 (FY25/26) - Funding gap of UGX 1.5 Billion in EMHS budget	- Assign focal person (clinician) for microbiology support - Incorporate MTC workplan into hospital workplan - Increase EMHS budget allocation - MOH to liaise with NMS for ≥98% OFR
	4	**Anaka GH**	- Two PPS and 2 medicine use audits conducted in previous quarters	- Hospital lacks an antibiogram	- Support hospital with autoclave for AST - Finalise online PPS dashboard - Distribute UCG 2023 hardcopies to Anaka GH
Bugisu	5	**Mbale RRH**	- MTC sat 4 times this FY - Needs analysis - Procurement planning - Prescription and antibiotic use audit - AMR discussions - eAFYA use in stores and pharmacy - 5S in stores and pharmacy - Orientation of interns on Pharmacovigilance	- Performance report generation/dissemination to specific districts is ongoing	–
	6	**Busiu HCIV**	- Participated in quarterly integrated support	- Inadequate funding to MTC activities -	- More funds to be allocated for MTC

			supervision - Trained members on duties, roles and responsibilities - All members have appointment letters - Developed and reviewed Busiu HCIV IML - Conducted needs analysis - Lobbying of more funds for MTC activities	Non-adherence to MTC recommendations - Inadequate storage space - Understaffed health supply chain Subcommittees non-compliant with quarterly reports - Inadequate ADR/ADE reporting	activities - Enhance sensitisation and mobilisation of members - Capacity building on supply chain management - NMS to orient members on surveys and research
North Buganda	7	**Mubende RRH**	- Functional MTC regularly sitting - Plans to reach PNFP facilities for functional MTCs in progress	–	- NMS to procure antibiotic discs for regional antibiogram - MoH to support with funds for targeted supervision

3.3 Pharmacovigilance (PV) Performance

Pharmacovigilance activity in Q3 FY 2025/26 showed continued improvement at leading facilities — Jinja RRH, Busiu HCIV, Lira RRH, and Mubende RRH — while systemic gaps persist in causality assessment, Vigiflow access, and ADR reporting culture at most facilities. Key findings this quarter include the significant volume of ADRs at Jinja RRH (29 in Q3), with Malaria vaccine (R21 MV) dominating the profile, and serious drug-related toxicities in TB/HIV programmes (Linezolid, Bedaquiline/Moxifloxacin) requiring clinical monitoring protocols.

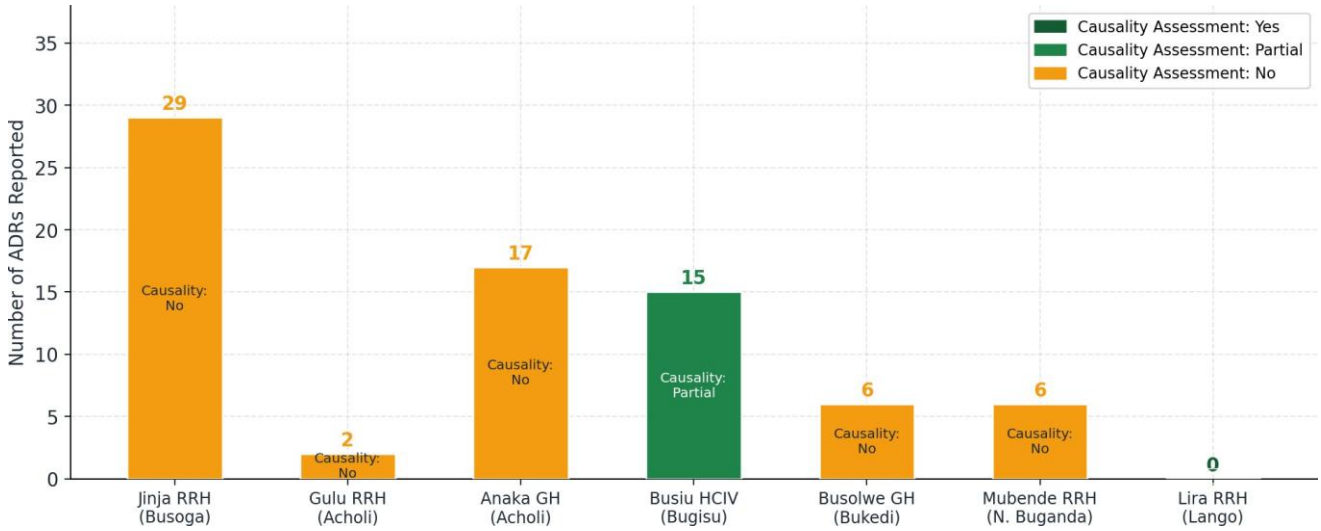
Table 6: Pharmacovigilance Performance — January–March 2026

Region	No.	Health Facility	Meetings Held	Activities / Achievements	Challenges / Findings	Recommendations
Busoga	1	**Jinja RRH**	–	29 ADRs reported in Q3	Malaria vaccine (R21 MV) accounted for majority of ADRs. Peripheral neuropathy most significant TB-drug toxicity (Linezolid, Levofloxacin). Visual impairment with Linezolid requires monitoring. Palpitations linked to Bedaquiline/Moxifloxacin — ECG monitoring required.	–
Acholi	2	**Gulu RRH**	0 meetings	2 ADRs reported	Causality assessment not	Train PV members to conduct causality

					conducted	assessments
	3	**Anaka GH**	0 meetings	6 ADR reports Q3 & 11 ADR reports Q4	No causality assessment conducted	Staff training on causality assessment
Lango	4	**Lira RRH**	2 meetings	- Reviewed PV assessment reports - Reawakened departments on drug-related issues - Received update on AEFI surveillance	- Reluctancy in ADR/AEFI reporting - EMR does not capture drug-related events	- Incorporate ADR forms into EMR - Train HCWs on PV awareness - Regular support supervision to lower HFs
Bugisu	5	**Busiu HCIV**	2 meetings	- 2 meetings conducted - 1 CME conducted - 15 ADR reports filed - Departments trained on reporting tool	–	–
	6	**Busolwe GH**	–	6 ADR reports submitted in Q2	Reluctancy on ADR/ADE reporting	Refresher trainings on pharmacovigilance ADR/ADE reporting
North Buganda	7	**Mubende RRH**	1 PV subcommittee meeting	6 ADRs reported	–	NDA to give regular feedback on submitted reports and grant system access

Table 6 analysis: ADR reporting is improving in volume but remains qualitatively weak — causality assessments are rare (confirmed only at Lira RRH among Q3 FY 2025/26 reporters). Gulu RRH and Anaka GH held zero PV meetings yet filed ADR reports — indicating reactive rather than structured PV practice. Jinja RRH's profile of TB-drug toxicities (Linezolid neuropathy, Bedaquiline QT prolongation) requires clinical monitoring escalation to NDA. All facilities must establish Vigiflow institutional accounts to enable digital ADR reporting — none had accounts as of Q4 2025.

Figure 5: ADR Reports by Facility and Causality Assessment Status — Q3 FY 2025/26 (January–March 2026)



⚠ CLINICAL SAFETY NOTE — Q3 FY 2025/26 ADR Signals at Jinja RRH

TB programme ADR signals at Jinja RRH Q3 FY 2025/26 require clinical monitoring protocols: (1) Peripheral neuropathy associated with Linezolid and Levofloxacin — monitor and consider dose adjustment. (2) Visual impairment associated with Linezolid — mandatory ophthalmology review for long-course patients. (3) Palpitations linked to Bedaquiline/Moxifloxacin — risk of QT prolongation; ECG monitoring required before and during therapy. NDA should review these signals and issue guidance to facilities managing MDR-TB programmes.

3.4 Antimicrobial Stewardship (AMS) Performance

AMS activities in Q3 FY 2025/26 continued across all reporting regions, with Point Prevalence Surveys (PPS), prescription audits, CMEs on AMR, and antibiogram development at various stages. The most alarming finding this quarter is the collapse of Uganda Clinical Guidelines (UCG) adherence at Gulu RRH — from 41.9% in Qtr1 FY24/25, to 28.3% in Qtr3 FY24/25, to 0.39% in Qtr1 FY25/26. This trajectory represents a critical and urgent AMS failure requiring immediate remedial action in Acholi region.

At Busolwe GH (Bukedi), the Q3 FY 2025/26 PPS findings reveal 92.6% antibiotic exposure (75/81 patients), 1.88 antibiotics per patient (against WHO's 1.5 benchmark), 30% non-adherence to clinical guidelines, and only 15% of prescriptions based on Culture and Sensitivity results. These findings place Busolwe GH among the highest-risk AMS facilities nationally this quarter and echo the H2 2025 national pattern of rising antibiotic encounter rates.

Table 7: Antimicrobial Stewardship Performance — January–March 2026

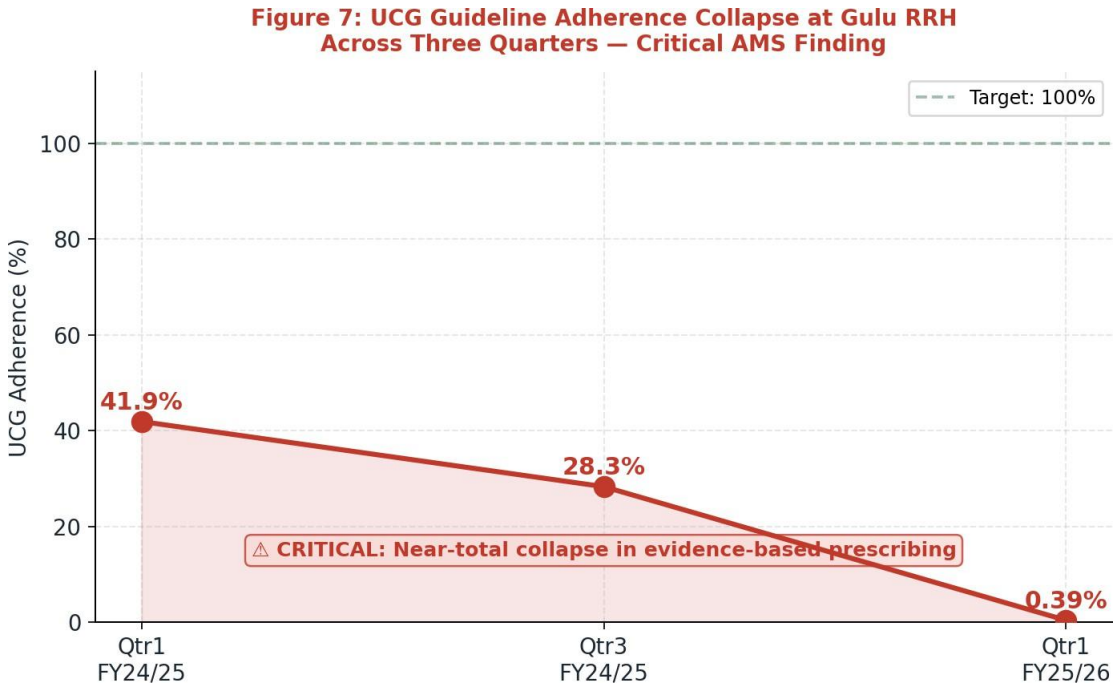
Region	No.	Health Facility	Meetings Held	Activities / Achievements	Challenges / Findings	Recommendations / Actions
Busoga	1	**Jinja RRH**	–	- Developed IML - Drafted policy on Medicines	–	–

				Promoters - Drafted policy on Antimicrobial Prescribing - Medicine audit for selected drugs		
Acholi	2	**Gulu RRH**	2 meetings	- Conducted 1 GPPS in September (Qtr 1) Follow-up PPS to monitor interventions from Q4 FY24/25 & Q1 FY25/26	- Culture & Sensitivity data difficult to access and analyse - UCG adherence fell: 41.9% Qtr1 → 28.3% Qtr3 (FY24/25) → 0.39% Qtr1 (FY25/26)	- Distribute UCGs to facilities - Liaise with eAFYA developers for onsite support - Develop strategies to improve microbiology utilisation - Capacity building for Lab/Pharmacy/AMS team on ALIS data system
	3	**Anaka GH**	3 meetings	- Ampicillin-cloxacillin removed from FY26/27 procurement plan - 16 C&S requests sent out (Oct-Dec 2025)	- Hospital lacks antibiogram - Few samples generated; long turnaround times on referred samples	- Support hospital with autoclave for AST - Finalise online PPS dashboard - Distribute UCG 2023 hardcopies
Bugisu	4	**Busiu HCIV**	1 meeting	- Prescription and medicine use audits conducted last quarter - 1 CME on AMR - Adopted antibiogram from Mbale RRH (facility antibiogram not representative enough)	–	–
	5	**Busolwe GH**	–	- 1 CME on AMS: PPS report disseminated (Nov 2025) - Generated IML (February 2026) - Antibiogram generation scheduled April 2026	- Antibiotic exposure: 92.6% (75/81) - Antibiotic overuse: 1.88 Abx per patient (WHO: 1.5) - Adherence to Clinical Guidelines: 30% non-adherence - C&S-based prescriptions: only 15% (5/75) - ACCESS antibiotics under-utilised (AWaRe)	–
North	6	**Mubend**	–	- Antibiogram	–	–

Bugan da		**e RRH**		developed and shared with prescribers - No PPS or prescription audit conducted this quarter		

Table 7 analysis: Mbale RRH (Bugisu) and Jinja RRH (Busoga) continue to lead on AMS activity quality — IML development, prescription audits, and AMS committee meetings. Anaka GH and Busiu HCIV demonstrate growing AMS capacity despite resource constraints. The critical gap remains at Gulu RRH where UCG adherence has virtually collapsed (0.39%) — an emergency warranting MoH/DPNM direct intervention this quarter. Mubende RRH developed its antibiogram this quarter, a positive milestone for North Buganda AMS.

Figure 7: UCG Guideline Adherence Trend at Gulu RRH — Critical AMS Collapse Q3 FY 2025/26



CRITICAL FINDING — UCG Adherence Collapse at Gulu RRH

Uganda Clinical Guideline adherence at Gulu RRH fell from 41.9% (Qtr1 FY24/25) to 28.3% (Qtr3 FY24/25) to 0.39% in Qtr1 FY25/26. This near-total collapse in evidence-based prescribing at a Regional Referral Hospital is among the most critical clinical quality findings in this report. Immediate AMS reinforcement is required: assign a clinical focal person to work with the laboratory on microbiology diagnoses, incorporate the MTC workplan into the hospital workplan, and conduct an emergency AMS review at Gulu RRH.

AMR Surveillance — Antibiogram Development Status

Table 8 below presents the antibiogram development status for the five Regional Referral Hospitals that presented in Q3 FY 2025/26. Four of five (80%) have developed antibiograms, with Mubende

RRH in the final stage of development – a positive progression from its "not yet developed" status in 2025.

Table 8: AMR Surveillance — Antibiogram Status at Q3 FY 2025/26 Reporting RRHs

SN	Regional Referral Hospital	Antibiogram Developed
1	**Gulu RRH**	**Yes ✓**
2	**Mubende RRH**	**In Progress — Final stage**
3	**Kayunga RRH**	**Yes ✓**
4	**Mbale RRH**	**Yes ✓**
5	**Jinja RRH**	**Yes ✓**

3.5 Pillar 2: Indicator Summary

Indicator	Target	Achieved	Rating	Performance
HMIS 105-6 reporting completeness	≥90%	Low – majority of reporting facilities below 70%	**<70%**	**Inadequate**
Functional MTCs (100% meeting target)	100% facilities	~70% of Q3 FY 2025/26 reporting facilities on track	**~70%**	**Inadequate**
ADR reporting trend	Increasing	Uneven; improving at Jinja RRH, Busiu HCIV; weak at Gulu RRH	**Variable**	**Fair**
Causality assessments conducted	100% of ADRs	Only Jinja RRH and Lira RRH with structured assessments	**~20%**	**Inadequate**
AMS/PPS coverage	≥70% facilities	All reporting regions — PPS and AMS activities underway	**Partial**	**Fair**
Guideline adherence	100%	0.39-67% range across reporting facilities	**0.39–67%**	**Inadequate**
Generic prescribing	100%	100% across all reporting regions	**100%**	**Excellent**
Antibiograms developed (Q3 FY 2025/26 RRHs)	100%	4/5 reporting RRHs have antibiograms; Mubende in final stage	**4/5 (80%)**	**Good**

PILLAR 3: ACCESS TO ESSENTIAL MEDICINES & HEALTH SUPPLIES (EMHS)

Goal: To ensure equitable and sustained access to essential medicines and health supplies across all levels of care.

4.1 EMHS Budget Utilisation — FY 2025/26

Budget utilisation measures the percentage of allocated EMHS funds actually committed across delivery cycles. For FY 2025/26, the reporting facilities demonstrate strong financial discipline, with most achieving 92–100% utilisation across four delivery cycles. The national average across reporting facilities exceeds 96%, an improvement from the 89% average reported in FY 2024/25. However, several facilities have utilisation data gaps that must be resolved for complete national-level analysis.

Busolwe GH recorded 100% utilisation (with carry-forward balance applied), while Gulu RRH at 92% reflects a significant EMHS funding gap of UGX 1.5 Billion identified by the facility team — indicating that budget ceiling constraints rather than inadequate nagement are limiting full utilisation. The USAID stop-work order continues to create cost pressure on Mbale RRH's health supply chain perations.

Table 1: Budget Utilisation of EMHS — FY 2025/26 (Q3 FY 2025/26 Reporting Facilities)

Region	No.	Health Facility	Budget Allocation (UGX)	Utilisation (UGX) — 4 Cycles	Util. %	Notes
Busoga	1	**Jinja RRH**	1,266,917,000	1,210,163,753	**98%**	–
	2	**Bugiri GH**	642,000,000	(Data pending)	–	50% EMHS allocation increase this FY
Bukedi	3	**Busolwe GH**	660,000,000	776,287,370	**100% ★**	Carry-forward balance applied
Acholi	4	**Gulu RRH**	1,800,375,499	1,488,101,169	**92%**	Funding gap of UGX 1.5 Billion noted
Bugisu	5	**Mbale RRH**	2,859,375,499	2,793,426,034	**98%**	USAID stop-work increased cost pressure
North Buganda	6	**Kayunga RRH**	2,434,711,750	(Data pending)	**99%**	–

Table 1 analysis: Busolwe GH and Gulu RRH (Acholi) applied carry-forward balances from FY24/25. Kayunga RRH's utilisation data is pending but confirmed at 99% by the presenting team. Bugiri GH and Gulu RRH have partial data. The 92% utilisation at Gulu RRH reflects a UGX 1.5 Billion budget

ceiling constraint – not inadequate nagement – highlighting the need for increased EMHS budget allocation to Regional Referral Hospitals.

Figure 3c: Facility Stock Status by Commodity Basket — Q3 FY 2025/26 (January–March 2026) (%)

Figure 3c disaggregates facility stock status by five commodity baskets: ARV, EMHS (general medicines), LAB (laboratory), RMNCAH, and TB. TB commodities showed the best stock status — 67.5% appropriately or over-stocked. ARV commodities showed the highest out-of-stock rate at 54.4%. EMHS and LAB baskets also showed high out-of-stock proportions (39.6% and 38.4% respectively), reflecting persistent health supply chain aps in general medicines and laboratory supplies. RMNCAH commodities showed mixed performance, with 29.7% out-of-stock. These basket-level findings should guide targeted redistribution and emergency order priorities in Q4 FY 2025/26.

Figure 3b: Facility Stock Status by District — December 2025 to March 2026

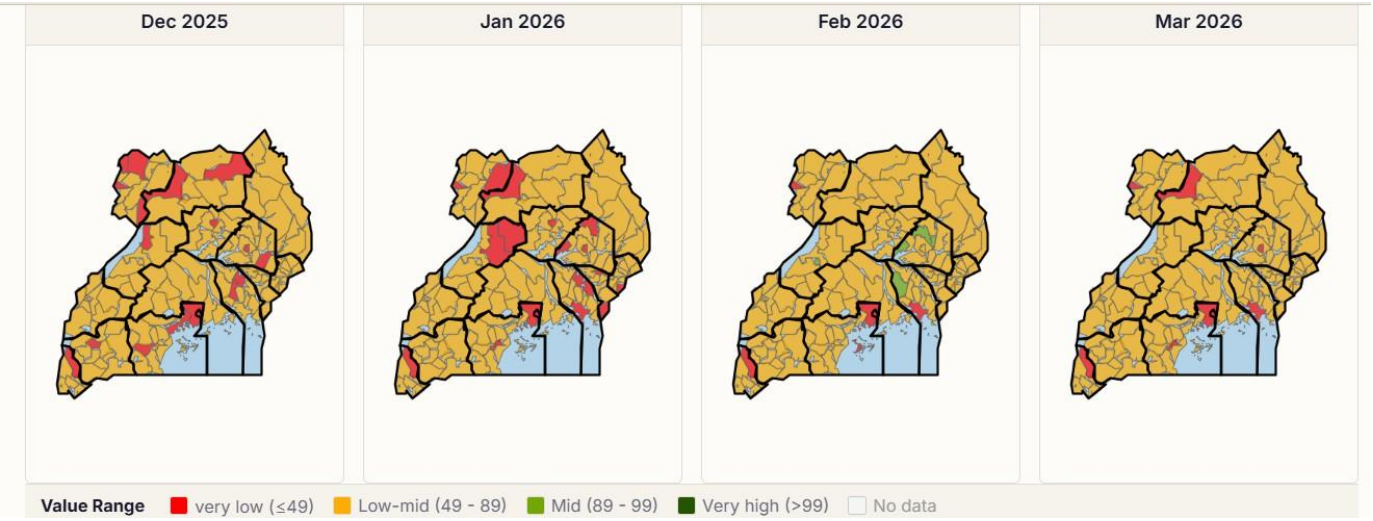


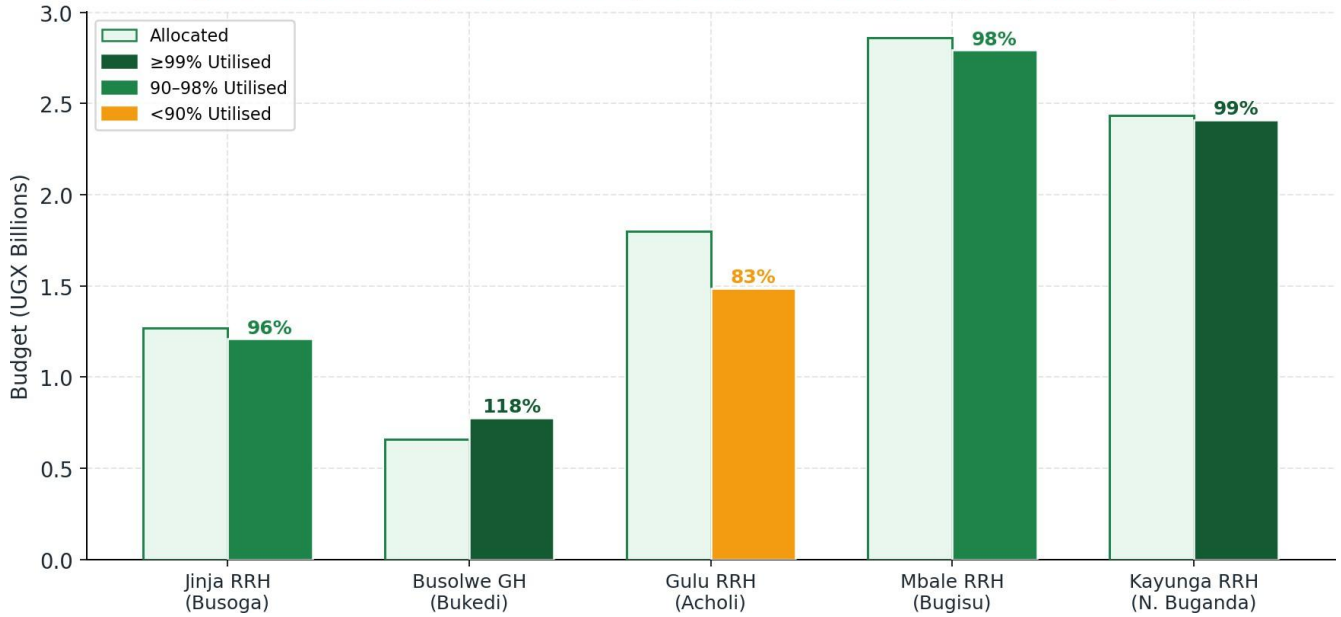
Figure 3b maps facility stock status across Uganda's districts for December 2025 through March 2026. The maps reveal that most districts remain in the low-to-mid stock availability range (orange, 49–89%), with improvement visible from December to March as more districts move out of the very-low range (red, ≤49%). January 2026 shows the highest concentration of red districts — consistent with the election-period health supply chain disruptions reported by multiple facilities. March 2026 shows a clearer picture with broader mid-range coverage, though no districts yet achieved consistently very-high (>99%) stock status.

Figure 3a: Availability of Tracer Medicines — April 2025 to March 2026 (% Available)

Figure 3a tracks tracer medicine availability nationally from April 2025 through March 2026. Availability has been on an upward trend — from 48.1% in April 2025 to a high of 66% in February 2026, settling at 57.7% in March 2026. While the trend is positive, availability remains well below the ≥95% national target. The dip in March 2026 requires monitoring. February's peak at 66% demonstrates that targeted health supply chain improvements and redistribution efforts can push availability higher. Sustained effort is required to bridge the remaining gap to the 95% target.

Figure 4: EMHS Budget Utilisation by Facility — FY 2025/26 Q3 FY 2025/26 Reporting Facilities

Figure 4: EMHS Budget Utilisation by Facility — FY 2025/26 (Q1 Reporting Facilities)



4.2 Pharmacy Staffing Capacity — FY 2025/26

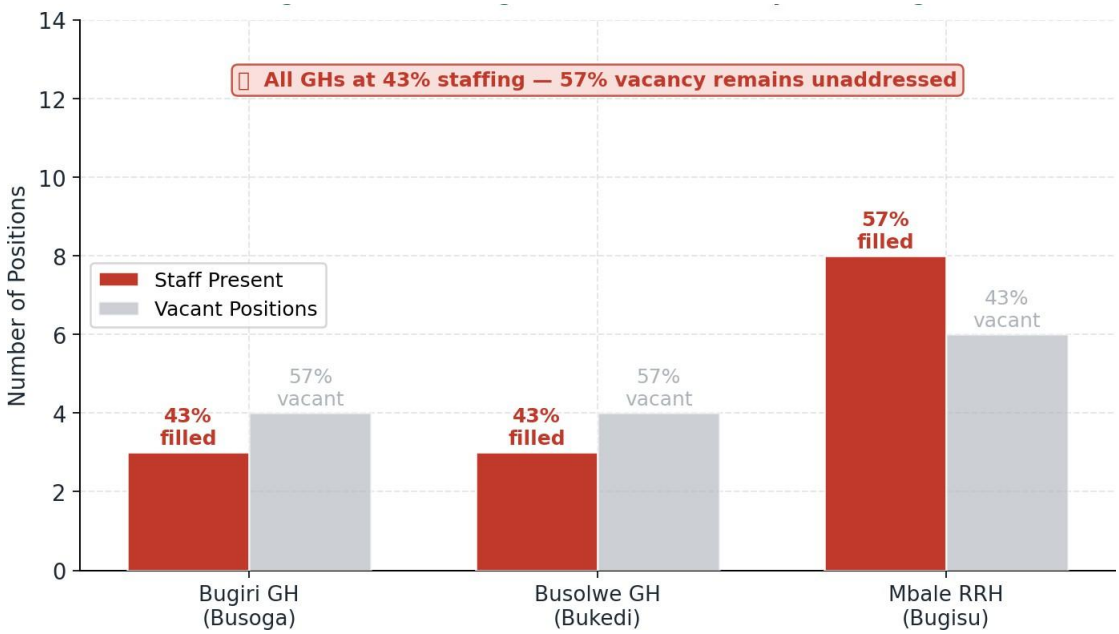
Pharmacy staffing is a critical determinant of medicine management quality, pharmacovigilance, and health supply chain ntegrity. The target is ≥80% staffing. In Q3 FY 2025/26, the staffing crisis identified in the 2025 Annual Report persists without improvement. General Hospitals continue to operate at 43% pharmacy staffing with 57% of positions vacant.

Table 2: Pharmacy Department Human Resource Capacity — FY 2025/26 (Q3 FY 2025/26 Reporting Facilities)

Region	No.	Health Facility	Staff Available	Vacant Positions	Staffing %	Vacancy %	Challenges
Busoga	1	**Bugiri GH**	3	4	**43%**	57%	Low staffing — urgent recruitment needed
Bukedi	2	**Busolwe GH**	3	4	**43%**	57%	Low staffing level
Bugisu	3	**Mbale RRH**	8	6	**57%**	43%	USAID stop-work order for G2G staff has greatly increased workload

Table 2 analysis: The uniform 43% staffing across Bugiri GH and Busolwe GH is unchanged from 2025. Mbale RRH at 57% staffing continues to absorb workload previously handled by USAID G2G pharmacy staff — significantly increasing per-staff burden without proportionate support. The persistent staffing gap is now the single most urgent system failure in pharmaceutical service delivery. Immediate MoH/MoPS action is required.

Figure 8: Pharmacy Department Staffing by Facility — Q3 FY 2025/26 (January–March 2026)



CRITICAL — Pharmacy Staffing: 57% Vacancy Is a Patient Safety Emergency. All Q3 FY 2025/26 reporting General Hospitals are at 43% staffing. Mbale RRH at 57% is bearing USAID G2G workload without backfill. No recruitment has been confirmed since this was escalated in the 2025 Annual Report.

4.3 Commodity Redistribution and Donations

Redistribution and donations served as critical buffers against health supply chain gaps in Q3 FY 2025/26. Jinja RRH (Busoga) and Kayunga RRH (North Buganda) continued to lead redistribution activity — both serving as regional redistribution hubs that prevented stockouts at multiple facilities. Jinja RRH's bimonthly TWG meetings coordinated ACT and ARV redistributions across Busoga region, while Kayunga RRH executed complex multi-commodity redistributions to national-level facilities including Mulago NRH and Kawempe NRH.

A notable governance issue was raised by Jinja RRH regarding bureaucratic delays in redistribution caused by the requirement for CAO authorisation — a process noted to slow emergency redistribution significantly. Bugiri GH reported addressing this through formal engagement with the DHO and CAO, establishing a systematic track record of transactions.

Table 3: Commodity Redistributions Made / Donations Received — January–March 2026

Region	No.	Facility	Received From	Commodities Received	Redistributed To	Commodities Redistributed	Donations
Busoga	1	Jinja RRH	TASO Jinja	ARVs, Cotrimoxazole	DHO Mayuge, Mayuge DLG,	Anti-TBs, Mosquito nets,	–

			Buwenge GH Walukuba HCIV	960mg, Halothane liquid, Folic acid 5mg, IV fluids, ORS co-pack	Kamuli DLG, TASO Jinja, Busesa HCIV, Jinja CHO, Children's Chest Hope, COVAB, Nsinze HCIV, Magamaga	Assorted medical supplies, ARVs, Cotrimoxazole 960mg, RH, AL, Vitec 2 ANC, Bupivacaine, Artesunate	
North Buganda	2	Kayunga RRH	Nabisweera HCIV Kayunga District Store Bbaale HCIV	Griseofulvin, Diazepam, Acyclovir, Phenobarbitol tab, Tramadol caps, Carbamazepine, Benzhexol, ABC+3TC paed, TLD, Oxytocin, Mama kit, Ketamine	Mulago NRH, Regional Facilities, Kangulumira HCIV, Kawempe NRH, JCRC, Arua RRH	Levofloxacin, Ethionamide, Amphotericin B, TLD, Isoniazid, Medroxyprogesterone, Etonorgesterol 68mg, Raltegravir 100mg, Pretomanid 200mg	–

4.4 Pillar 3: Indicator Summary

Indicator	Target	Achieved	Rating	Performance
EMHS budget utilisation	100%	92-100% across reporting facilities (avg ~96%)	**~96%**	**Very Good**
Commodity availability	≥95%	Variable: 54-99.1% range by facility	**54–99.1%**	**Fair**
Redistribution effectiveness	Timely & systematic	Active but reactive — Jinja RRH and Kayunga RRH leading	**Partial**	**Fair**
Pharmacy staffing – GHs	≥80%	43% at Bugiri GH and Busolwe GH — crisis level	**43%**	**Inadequate**
Pharmacy staffing – Mbale RRH	≥80%	57% — affected by USAID G2G stop-work order	**57%**	**Inadequate**

PILLAR 4: HEALTH SUPPLY CHAIN MANCE

Goal: To enhance efficiency, reliability, and responsiveness of the pharmaceutical health supply chain t all care levels.

5.1 Commodity Availability and Order Fill Rates (OFR)

Order Fill Rate (OFR) measures the proportion of ordered commodities actually delivered by NMS per cycle. The national target is ≥95%. In Q3 FY 2025/26, Jinja RRH achieved near-target performance at 99.1% — a significant improvement sustained from strong cycle performance in 2025 (Cycles 3 and 4). However, all other reporting facilities remain well below target, with Bugiri GH at 54% and Busolwe GH at 68% presenting the most concerning figures.

Lead times continue to exceed the 30-day target: Atutur GH experienced a 62-day lead time in Cycle 6 (with a 20-day delay), Mbale RRH recorded a 57-day delay, and Kayunga RRH experienced a 19-day delay despite its 8-day average lead time for some cycles. Extended lead times undermine predictive ordering and drive emergency procurement at higher cost.

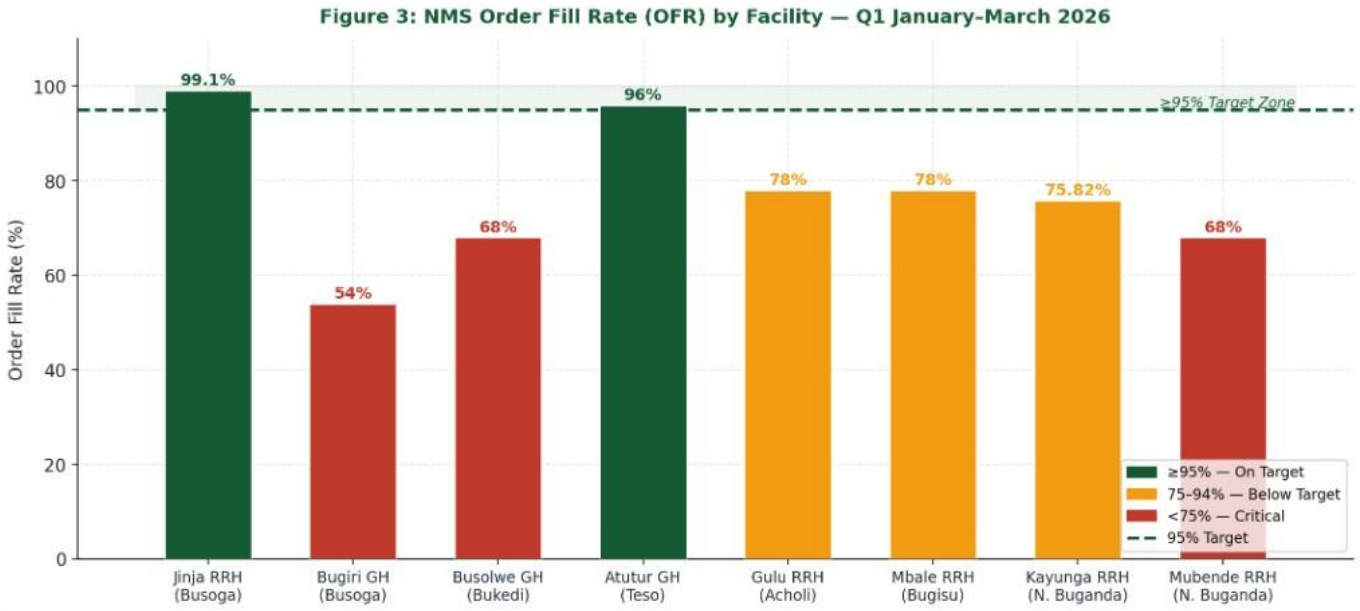
Table 9: Commodity Availability and Order Fill Rates (OFR) — FY 2025/26 (Q3 FY 2025/26 Reporting Facilities)

Region	No.	Health Facility	Availability Issues	OFR % (NMS)	Target	Avg Lead Time	Avg Delay
Busoga	1	**Jinja RRH**	Unavailable: Losartan H, Anti-rabies vaccine, Ritonavir 100mg	**99.1%**	100%	–	–
	2	**Bugiri GH**	Third-line ARV stockouts (Ritonavir 100mg, Etravirine 100mg); short shelf-life TDF/3TC/DTG	**54%**	100%	–	–
Bukedi	3	**Busolwe GH**	RH 150mg/75mg and Ceftriaxone 1g powder not delivered	**68%**	100%	–	–
Teso	4	**Atutur GH**	–	**96%**	100%	62 days (Cycle 6)	20 days
Acholi	5	**Gulu RRH**	HMIS 105 Sec 6 completeness only 52% in region; Nwoya district topped at 97%	**78%**	100%	–	–
Bugisu	6	**Mbale RRH**	Not all prescriptions through eAFYA; quarterly delivery	**78%**	100%	–	57 days

			delays				
North Buganda	7	**Kayunga RRH**	Dolutegravir/ Abacavir/Lamivudine (child), Furosemide inj, Paracetamol inj not delivered	**75.82 %**	100%	8 days	19 days
	8	**Mubende RRH**	–	**68%**	100%	55 days	–

Table 9 analysis: Only Jinja RRH (99.1%) approaches the ≥95% OFR target. Bugiri GH (54%) and Busolwe GH (68%) are at crisis-level OFR, with critical stockouts of third-line ARVs, Ceftriaxone, and RH commodities. Mubende RRH (68%) and Kayunga RRH (75.82%) also require NMS performance escalation. The pattern of undelivered life-saving medicines (Dolutegravir/Abacavir/Lamivudine paediatric, Furosemide, Paracetamol IV at Kayunga RRH) is unacceptable and demands contractual consequences for NMS underperformance.

Figure 3: NMS Order Fill Rate (OFR) by Facility — Q3 FY 2025/26 (January–March 2026)



5.2 Health Supply Chain ΓWG Performance and Action Points

Health Supply Chain ctivities in Q3 FY 2025/26 were conducted across all presenting regions, with facility-level TWG meetings and bimonthly order placement as the core mechanisms. Table 10 below summarises key activities, challenges, and recommendations by facility.

Table 10: Health Supply Chainy Implementation — January–March 2026

Region	No	Health	Meetin	Activities /	Challenges /	Recommendation

	.	Facility	gs	Achievements	Findings	s
Busoga	1	**Jinja RRH**	3 bimonthly meetings	- Trained lower facilities on entering expired drugs in CSSP - Improved ACT redistributions within region - Noted bureaucracy from CAOs office affecting redistribution	- Supply performance improved from Cycle 1 to Cycle 3; Cycle 3 at 99.1%; Cycle 4 at 98.3% - Overall medicine supply approaching expected allocation level	–
	2	**Bugiri GH**	–	- Engagement with DHO and CAO on redistributions - CAO now authorises all redistributions with track record at DHO office	- HMIS 105 stock status report component not well configured - Third-line ARV stockouts: Ritonavir 100mg, Etravirine 100mg - Short shelf-life TDF/3TC/DTG 90-pack (May, July 2026 expiry)	Need for urgent redistribution. NMS supplying stock with 2026 expiry.
Acholi	3	**Gulu RRH**	2 meetings	- Drafted SOPs on timely ordering - Reviewed bimonthly orders Cycles 1, 2 and 3 - Cycle ordering performed better across districts - Nwoya District topped at 97% HMIS completeness	- Reporting rates still low - Incomplete and untimely reports - HMIS 105 Sec 6 lowest at 52% in region	–
Bugisu	4	**Mbale RRH**	–	- Full eAFYA use across all units - Benchmarking visit to Kiruddu NRH on eAFYA - All store transactions through eAFYA - Trained stakeholders in health supply chain emergency preparedness	- Not all prescriptions coming through eAFYA - Quarterly commodity deliveries creating planning issues - eAFYA reports not linked to DHIS2	- Promote eLMIS use throughout hospital - Create WhatsApp platform for regional supply chain communication - Discourage quarterly deliveries — early or late deliveries have implications
	5	**Bududa GH**	–	- Conducted self-audit on 12 tracer medicines	–	–

	6	**Busiu HCIV**	3 meetings	- Joint placement of bimonthly orders - OFR analysis conducted - Medicine stock management audit - Redistribution activities	–	–
	7	**Busolwe GH**	–	- Institutional Medicines List (Feb 2026) - eAFYA rolled out Feb 2026; refresher training March 2026 - Support supervision rescheduled for May 2026	- RH 150mg/75mg and Ceftriaxone 1g not delivered - Significant drop in HMIS 105 Sec 6 reporting in DHIS2 - Knowledge gaps on eAFYA and OFSSR dashboard utilisation	- MoH to conduct onsite refresher training on eAFYA and OFSSR
North Buganda	8	**Mubende RRH**	–	- 5/6 TWG meetings held this FY - Regional antibiogram in final stage - CQI project on injectable antibiotic surgical prophylaxis - Workplan for third-line drug last-mile delivery developed - Engaged DHOs for HCIVs without dispensers	- Recent recruitments budget could not cover new pharmacy cadres - Low stock levels for third-line drugs, 3HP and pALD - Lack of clear guideline on Kwik test use in facilities	- Health Supply chain systems need integration to enhance stock visibility
	9	**Kayunga RRH**	–	- 96% (254/264) facilities submitted complete Sec 6 data - 99% (264/268) facilities submitted ≥1 data point in Sec 6	- Patient numbers higher when medicines available - Anti-hypertensive stockouts (Amlodipine, Losartan, Insulin) - Hydroxyurea for sickle cell available	–

5.3 Regional Pharmaceutical TWG Performance — Q3 FY 2025/26

Table 11 below presents the Regional Pharmaceutical Services TWG meeting performance for January, February, and March 2026. Of the six regions with confirmed Q3 FY 2025/26 data, all held their February and March TWG meetings. January was disrupted in three regions (Bugisu, Karamoja, North Buganda) due to national elections. Kigezi missed its March meeting due to lack of funds. Nine regions have data pending.

Table 11: Regional Pharmaceutical Services TWG Performance — January–March 2026					
No.	**Region**	**Jan 2026**	**Feb 2026**	**Mar 2026**	**Reason for Non-Holding / Notes**
1	**South Buganda**	**Yes**	**Yes**	**Yes**	–
2	**Tooro**	**Yes**	**Yes**	**Yes**	–
3	**Bugisu**	**No**	**Yes**	**Yes**	January – Election period break
4	**Karamoja**	**No**	**Yes**	**Yes**	January – Election period break
5	**North Buganda**	**No**	**Yes**	**Yes**	January – Election period break
6	**Kigezi**	**Yes**	**Yes**	**No**	March – Lack of funds
7	**Teso**	–	–	–	Data pending
8	**Kampala**	–	–	–	Data pending
9	**Busoga**	–	–	–	Data pending
10	**West Nile**	–	–	–	Data pending
11	**Bunyoro**	–	–	–	Data pending
12	**Bukedi**	–	–	–	Data pending
13	**Ankole**	–	–	–	Data pending
14	**Lango**	–	–	–	Data pending
15	**Acholi**	–	–	–	Data pending

Table 11 analysis: South Buganda and Tooro achieved 100% TWG meeting performance in Q3 FY 2025/26. Bugisu, Karamoja, and North Buganda missed January meetings due to elections but recovered in February and March. Kigezi's March gap due to lack of funds is a recurring constraint that must be addressed through dedicated TWG budget lines in regional workplans. Data for 9 regions remains pending — collection must be prioritised in Q4 FY 2025/26 reporting.

Figure 6: Regional TWG Meeting Performance by Month — Q3 FY 2025/26 (January–March 2026)

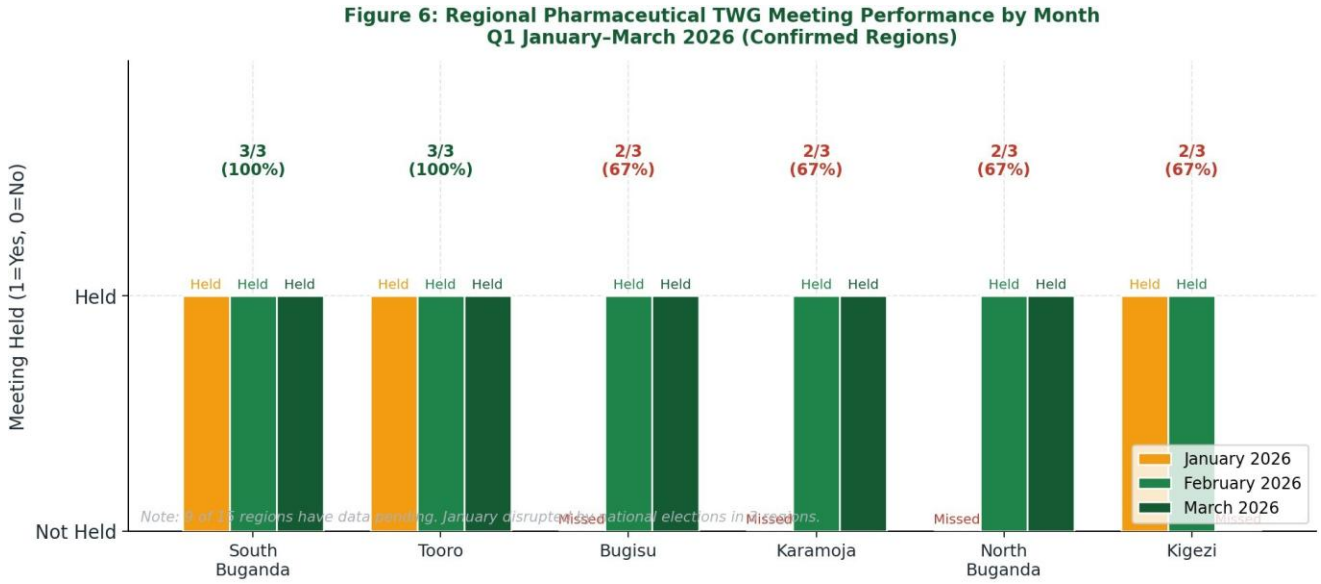


Table 12: Regional TWG Action Points and Status — Q3 FY 2025/26

Region/Meeting	Action Point/Issue	Agreed Action	Responsible Person(s)	Status/Progress
Rwenzori – Jan 2026	Low TWG attendance	Engage DHOs and create WhatsApp mobilisation platform	Dr. Bahizi Archbald, Robert Mugabe	Ongoing
Rwenzori – Jan 2026	Inadequate monitoring	Conduct OFR analysis after each delivery cycle	District Pharmacists, IMOs, MMS	Continuous
Rwenzori – Jan 2026	Weak MTC functionality & ADR reporting	Higher-level facilities to mentor lower facilities	Robert Mugabe, Joshua Irafasha	Initiated
Rwenzori – Jan 2026	Overstock of Coartem & Paracetamol	Redistribution and logistical support coordination	Harriet Biira, Stephen Okello	Redistributed
Rwenzori – Jan 2026	Inadequate 105-6 completeness	Targeted support supervision and facility-level reporting	SCM mentors, Biostats	Ongoing
Rwenzori – Feb 2026	Cycle 5 ordering deadline	Submit all cycle orders before deadline	DHOs, Pharmacists, HF in-charges	Ongoing
Rwenzori – Feb 2026	Low TWG turnout	Mobilise DHOs and create WhatsApp forum	Dr. Bahizi, Robert Mugabe	Ongoing
Rwenzori – Feb	RH	Follow-up on RASS	Anthony Kirunda	Pending

2026	commodities missing on RASS	transition and obsolete items		
Rwenzori – Feb 2026	Third-line ARV distribution	Budget for sustainable last-mile distribution	Robert Mugabe	Review planned
Rwenzori – Mar 2026	Missing RH SPARS tools	Include missing tools in PIP; accelerate WSS rollout	Ambrose Jakira	Due Apr 2026
Rwenzori – Mar 2026	Overstock & short-expiry commodities	Redistribution, FEFO, digital monitoring	District Pharmacists, DHOs	Ongoing
Mubende Region	Weak MTC functionality	Share MTC checklist; engage CAOs/DHOs	Patrick Opio et al.	Pending
Mubende Region	Lack of pharmacy staff	Follow-up letters to CAOs and DHOs	SEC & Patrick Opio	Recruitment not yet done
Mubende Region	Overuse of antibiotics	Develop CQI projects to reduce irrational use	Patrick Opio et al.	CQI ongoing
Karamoja – Mar 2026	Low attendance at TWGs	Mobilise participants by March 31	Chair/Secretariat	Planned
Karamoja – Mar 2026	Expiries and overstocking	Validate expiries; halt excess deliveries	Moroto RRH/IP	Ongoing
Karamoja – Mar 2026	Non-delivery of ARVs/TB commodities	Follow-up with NMS	Moroto RRH/IP	Immediate follow-up initiated
Mbale – Feb 2026	Digital OFR reporting	Submit OFR tool after cycle deliveries	All facilities	77% completion achieved
Mbale – Feb 2026	HMIS 105 reporting	Improve to above 95%	IMO/AIMO	Region at 80%
Mbale – Feb 2026	RASS reporting	Improve completeness and timeliness	Pharmacists, AIMOs	Improved: 40%→80%
South Central – Jan 2026	Facilities failed to submit orders	Targeted support supervision	DMMS teams	Completed
South Central –	Massive	Investigate and	Rakai district	Rectified – data

Jan 2026	vaccine expiry (reported)	rectify	team	error
South Central – Feb 2026	Weak prison facility reporting	Engage prison health teams	DMMS & UPS RASS team	Monitoring ongoing
South Central – Mar 2026	Expiry management	Encourage redistribution before expiry	District teams	Ongoing

5.4 Pillar 4: Indicator Summary

Indicator	Target	Achieved	Rating	Performance
Order Fill Rate (OFR)	≥95%	54-99.1% range; no facility consistently meeting target	**54–99.1%**	**Inadequate**
Avg delivery lead time	≤30 days	Most exceed 30 days; Mubende RRH 55d, Mbale RRH 57d, Atutur GH 62d (Cycle 6)	**30–62 days**	**Inadequate**
Delivery delays	0 days	19-57 day delays documented	**19–57 days**	**Inadequate**
HMIS Sec 6 completeness	100%	52-96% range by region; national picture remains inadequate	**<70% nationally**	**Inadequate**
Regional TWG meetings held	100% of planned	6 regions confirmed; South Buganda, Tooro, Kigezi, Bugisu, Karamoja, North Buganda all active	**Partial (6/15 confirmed)**	**Fair**
eAFYA/eLMIS adoption	Expanding	Fully operational at Mbale RRH; rolled out at Busolwe GH Feb 2026	**Partial**	**Fair**

6. CROSS-CUTTING CHALLENGES AND ENABLERS

6.1 System-Wide Challenges

No.	Challenge	Detail	Pillars	Severity
1	**Pharmacy Staffing Crisis**	All reporting GHs at 43% staffing; 57% vacant. USAID stop-work at Mbale RRH increased workload. No visible national recruitment response.	1,2,3,4	**Critical**
2	**Low NMS OFR**	54-99.1% range; target ≥95%. Only Jinja RRH approaching target. Critical stockouts: ARVs, insulin, anti-hypertensives at multiple facilities.	3,4	**Critical**
3	**Extended Lead Times**	20-62 days; target ≤30d. Cycle 6 at Atutur GH took 62 days. Forces emergency procurement; disrupts planning cycles.	4	**Critical**
4	**Weak AMS Guideline Adherence**	UCG adherence at 0.39% in Gulu RRH Qtr1 FY25/26. Antibiotic overuse at 92.6% at Busolwe GH. C&S-based prescribing at 15%.	2	**High**
5	**Reluctance in ADR/AEFI Reporting**	Multiple facilities report fear of incrimination; causality assessments rarely conducted; paper-based reporting limiting data flow.	2	**High**
6	**Inadequate Completeness**	HMIS Sec 6 at 52% in Acholi region. Reports incomplete and untimely across most facilities. Undermines performance monitoring.	2	**High**
7	**EMR–CSSP Integration Gap**	eAFYA not linked to NMS CSSP. Facilities cannot access their submitted orders. TWG action pending from Q4 2025.	1,4	**High**
8	**Inadequate MTC Budgets**	No dedicated budget line at most facilities. NMS not extending refreshments for meetings. Subcommittees unable to meet targets.	2	**Moderate**
9	**Third-Line Drug Supply Gaps**	Low stock levels for third-line ARVs, 3HP, and pALD disrupting treatment at North Buganda facilities.	3,4	**Moderate**
10	**Knowledge Gaps on Digital Tools**	Insufficient training on eAFYA and OFSSR dashboard; previous training contact time inadequate; rollout incomplete at several sites.	4	**Moderate**

6.2 Key Enablers of Progress

No.	Enabler	Evidence and Impact	Pillar(s)
1	**Strong DPNM/MoH Leadership**	Consistent forum chair providing accountability momentum and driving inter-agency follow-up on persistent issues.	1,2,3,4
2	**Jinja RRH Redistribution Model**	Active bimonthly meetings; regional redistribution of ACTs and ARVs; CAO engagement improving governance of redistributions.	3,4
3	**Kayunga RRH Health Supply Chain Leadership**	96% Sec 6 data completeness; active redistribution to Mulago NRH, JCRC, and 14+ facilities; demonstrating model TWG performance.	1,4
4	**Mbale RRH Digital Leadership**	Full eAFYA across all units; benchmarking visit to Kiruddu NRH; trained stakeholders in health supply chain ency preparedness.	4
5	**Busolwe GH eAFYA Adoption**	eAFYA rolled out February 2026 with refresher training in March 2026 – demonstrating facility-level commitment to digital health supply chain.	4
6	**Multi-Region ADR Improvement**	Jinja RRH, Lira RRH, Busiu HCIV, and Mubende RRH showing structured ADR reporting, PV meetings, and CME engagement.	2
7	**AMS Activity across All Reporting Regions**	All regions with confirmed Q3 FY 2025/26 data conducted at least one AMS activity – PPS, prescription audits, or CME on AMR.	2
8	**Regional TWG Action Tracking**	Structured action trackers in Rwenzori, Mubende, Karamoja, Mbale, and South Central regions enable accountability and follow-up.	1,4

7. RECOMMENDATIONS

Based on Q3 FY 2025/26 performance analysis across all four pillars, the following 15 evidence-based recommendations are presented, prioritised by urgency and categorised by responsible actor. These recommendations build on and reinforce the 15 recommendations from the NPECAF Annual Performance Report 2025, with Q3 FY 2025/26-specific evidence and updated timelines.

No.	Pillar	Recommendation	Lead Actor	Priority
1	**Staffing**	Expedite all pending pharmacy staff promotions. Engage MoPS to backfill positions lost to USAID G2G stop-work at Mbale RRH.	MoH HR	**Immediate**
2	**Supply Chain**	Negotiate binding NMS OFR improvement targets with quarterly performance reviews. No facility should be below 90% OFR by Q4 FY 2025/26.	MoH / NMS	**Immediate**
3	**Supply Chain**	Reduce delivery lead times to ≤30 days. Eliminate quarterly delivery cycles at Mbale region.	MoH / NMS	**Q4 FY 2025/2026**
4	**AMS**	Urgently address UCG guideline adherence collapse at Gulu RRH (0.39%) and antibiotic overuse at Busolwe GH (92.6%). Intensify AMS supervision.	DPNM / RRHs	**Q3–Q4 FY 2025/26**
5	**AMS**	Equip all RRH and GH laboratories with minimum C&S equipment. Establish regional antibiogram dissemination protocols.	MoH / Partners	**FY26/27**
6	**PV**	Establish Vigiflow institutional accounts for all reporting RRHs. Train PV members on causality assessment methods by Q4 FY 2025/26.	NDA / DPNM	**Q3–Q4 FY 2025/26**
7	**PV**	Integrate ADR reporting fields into EMR systems. Pilot at Lira RRH (interest confirmed) and expand to Jinja RRH.	DPNM / IT	**Q3–Q4 FY 2025/26**
8	**Digital**	Complete EMR-CSSP integration as a priority. Formally introduce eAFYA team to NMS. Enable facilities to access submitted CSSP orders.	DPNM / NMS	**Q3–Q4 FY 2025/26**
9	**Digital**	Conduct onsite refresher training on eAFYA and OFSSR dashboard at Busolwe GH, Bugiri GH, and all facilities with confirmed knowledge gaps.	MoH / DPNM	**FY 26/27**
10	**Health Supply Chain**	Address critical third-line ARV, 3HP, and pALD ock gaps in North Buganda through mergency NMS orders and improved last-mile delivery budgets.	MoH / NMS	**Immediate**
11	**Redistribution**	Formalise redistribution governance – address CAO bureaucracy identified in Busoga. Develop	MoH / CAOs	**Q3–Q4 FY 2025/26**

		district-level redistribution standing orders.		

8. CONCLUSION

NPECAF's Q3 FY 2025/26 performance report demonstrates that the Forum's accountability architecture remains functional and continues to generate actionable, evidence-based intelligence on Uganda's pharmaceutical sector — even in a quarter disrupted by national elections. Sessions demonstrate sustained engagement from health facility teams who are now driving the forum's substantive content.

The quarter's most significant achievements include: 96% HMIS Section 6 data completeness in North Buganda (Kayunga RRH region); Jinja RRH's near-target 99.1% OFR and leading redistribution model; Busolwe GH's eAFYA launch in February 2026; Mubende RRH's antibiogram completion; and strong MTC meeting compliance across Bugisu facilities (Mbale RRH, Busiu HCIV, Kayunga RRH all at 100%).

However, the report is equally candid about critical gaps. The UCG adherence collapse at Gulu RRH (0.39%) is a patient safety emergency. The 43% pharmacy staffing at General Hospitals remains unchanged and unaddressed since it was escalated in the 2025 Annual Report. NMS OFR below 95% at every facility except Jinja RRH, lead times of up to 62 days, and third-line ARV stockouts represent ongoing health supply chain ailures with direct patient impact. HMIS completeness remains critically low in Acholi (52%) and most other regions.

NPECAF's credibility as Uganda's pharmaceutical accountability platform now depends on the conversion of Q3 FY 2025/26 findings into concrete actions before Q4 FY 2025/26 closes. The recommendations in this report are not aspirational — they are the minimum required response to the evidence.

NPECAF's Q3 FY 2025/26 Core Message

The evidence from Q3 FY 2025/26 is clear: where facilities have committed leadership, functional MTCs, and structured data use, performance improves — Kayunga RRH, Jinja RRH, Mbale RRH, and Busolwe GH demonstrate this. The question for Q4 FY 20252026 is whether the system's central actors — MoH, NMS, NDA — will match facility-level commitment with national-level action on OFR accountability, Vigiflow access, and HMIS mandates. Every quarter of inaction compounds the patient impact.

APPENDICES

Appendix I: Presentation Schedule — National Pharmaceuticals and Essential Commodities Accountability Forum

The table below outlines the full presentation schedule for all regions under the National Pharmaceuticals and Essential Commodities Accountability Forum, including presenting facilities and their scheduled presentation dates. This schedule governs the Q3 FY 2025/26 reporting cycle and beyond, ensuring systematic and equitable regional representation at every NPECAF session.

Presentation Schedule

Schedule of Presentations for the National Pharmaceuticals and Essential Commodities Accountability Forum		
Region	**Presenters**	**Schedule**
Karamoja	Moroto Regional Referral Hospital, Abim GH, Kaabong GH and Kaloong GH	
Kigezi	Kabale Regional Referral Hospital, Kambunga GH and Kisoro GH	10/23/2025
South Central	Entebbe Regional Referral Hospital, Butambala GH and Kalisizo GH	
Bunyoro	Hoima Regional Referral Hospital, Kiryandongo GH, Buliisa GH, Kagadi GH and Masindi GH	10/30/2025
South Central	Masaka Regional Referral Hospital, Kalisizo GH, Lyantonde GH and Rakai GH	
Teso	Soroti Regional Referral Hospital, Amuria GH, Atutur GH, Kaberamaido GH and Katakwi GH	11/6/2025
Kampala	Mulago Women Hospital	11/13/2025
Kampala	China Uganda Friendship (Naguru) NRH	11/27/2025
Ankole	Mbarara Regional Referral Hospital, Itojo GH , Kitagata GH and Rugarama GH.	12/4/2025
Tooro	Fort Portal Regional Referral Hospital, Budibudyo GH, Bwera H,Kyenjojo GH and Virika GH	12/11/2025
Acholi	Gulu Regional Referral Hospital, Anaka GH, Kitgum GH and Lacor GH	1/8/2026
Kampala	Kirudu NRH	1/22/2026
North Central 1	Mubende Regional Referral Hospital, Mityana and Kiboga GHs	1/29/2026
West Nile	Arua Regional Referral Hospital, Koboko GH and Nebbi GH	2/5/2026
Kampala 2	Mulago NRH	2/12/2026
West Nile	Yumbe Hospital, Adjumani GH and Moyo GH	2/19/2026
North Central 2	Kayunga Regional Referral Hospital, Luwero GH, Nakaseke GH and Mukono GH	2/26/2026
Lango	Lira Regional Referral Hospital, Apac GH and Aber GH	3/5/2026
Bugisu	Mbale Regional Referral Hospital, Bududa GH, Bukwo GH and Kapchowra GH	3/12/2026
Busoga	Jinja Regional Referral Hospital, Iganda GH, Bugiri GH and Kamuli GH	3/19/2026
Bukedi	Tororo General Hospital, Pallisa GH, Masafu GH	3/26/2026
Kampala	Kawemepe NRH	4/2/2026

Appendix I: NPECAF Presentation Schedule — All Regions

Appendix II: Contact Persons for the Different Regions

The table below lists the Lead Person and Deputy Lead Person responsible for each region and subregion, serving as the primary contact points for NPECAF coordination and follow-up on forum action points.

Contact Persons for the Different Regions

Region	subregion	Lead Person	Deputy Lead Person
Central	Kampala	Dr.Martha A	Fred Tabu
Central	North Central	Dr.Martha A	Emmanuel Watongola
Central	South Central	Dr.Martha A	Sarah Taratwebire
Eastern	Bugisu	Dr.Martha A	Micheal Isabirye
Eastern	Bukedi	Dr.Martha A	Tabu Fred
Eastern	Busoga	Dr.Martha A	Judith Kyokushaba
Eastern	Karamoja	Dr.Daniel A	Nathan Elilu
Eastern	Teso	Dr.Martha A	Emiku Joseph
Northern	Acholi	Dr.Akello H	Prossy Atimango
Northern	Lango	Dr.Daniel A	Prossy Atimango
Northern	West Nile	Dr.Akello H	Nathan Elilu
Western	Ankole	Dr.Rodney T	David Tumusiime
Western	Bunyoro	Dr.Rodney T	Ian Nyamitoro
Western	Kigezi	Dr.Rodney T	David Tumusiime
Western	Tooro	Dr.Rodney T	Ambrose Jakira

Appendix II: Contact Persons for the Different Regions

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