THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

Department of Pharmaceuticals and Natural Medicines

NATIONAL PHARMACEUTICALS AND ESSENTIAL COMMODITIES ACCOUNTABILITY FORUM

(NPECAF)

ANNUAL PERFORMANCE REPORT

January – December 2025

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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FOREWORD

Dr. Martha Grace Ajulong
Commissioner Health Services Pharmaceuticals and Natural Medicines Ministry of Health, Uganda

It is with great pride and deep satisfaction that I present the NPECAF Annual Performance Report for January to December 2025 — the first full calendar year of operations of the National Pharmaceuticals and Essential Commodities Accountability Forum.

This report is a testament to the collective commitment of Uganda's pharmaceutical community: the dedicated pharmacists, health supply chain officers, clinicians, district health teams, implementing partners, and Ministry of Health staff who, week after week, showed up to strengthen accountability, share evidence, and drive meaningful change in our pharmaceutical systems.

Through NPECAF, we have fostered a culture of transparency that Uganda's pharmaceutical sector has long needed. We have seen growing collaboration, stronger data use, and increased ownership of the health supply chain, pharmacovigilance, and antimicrobial stewardship functions across the country. The 89% budget utilisation rate, the development of antibiograms by 14 of 15 Regional Referral Hospitals, and the active redistribution networks that have prevented stockouts at critical facilities — these are not mere statistics. They represent lives protected and systems strengthened.

Our achievements are not without challenges. Pharmacy staffing at 43% capacity, order fill rates below the 95% target, and the alarming rise in antibiotic encounter rates in the second half of the year remind us that the work is far from finished. This report names these challenges with honesty, because accountability begins with truth.

As you read through this report, I encourage all stakeholders — policymakers, health managers, partners, and facility teams — to reflect on the shared lessons, celebrate genuine progress, and take bold, actionable steps to address the gaps identified. Every recommendation in this report is grounded in real data from Uganda's facilities. Every finding deserves a response.

Let us remain committed to transforming pharmaceutical systems for the betterment of health outcomes for every Ugandan.

Dr. Martha Grace Ajulong
Commissioner Health Services, Pharmaceuticals and Natural Medicines
Ministry of Health, Uganda

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–December 2025.

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, Joint Medical Stores, 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 annual report possible.

LIST OF ACRONYMS

ADR	Adverse Drug Reaction
AEFI	Adverse Event Following Immunization
AMS	Antimicrobial Stewardship
AMR	Antimicrobial Resistance
ARV	Antiretroviral
ART	Antiretroviral Therapy
C&S	Culture and Sensitivity
CHAI	Clinton Health Access Initiative
CSSP	Commodity Supply and Stock Planning
DHIS2	District Health Information Software 2
DHO	District Health Officer
DPNM	Department of Pharmaceuticals and Natural Medicines
eAFYA	Electronic Health Logistics Management Information System
eLMIS	Electronic Logistics Management Information System
EMHS	Essential Medicines and Health Supplies
FY	Financial Year
GH	General Hospital
HMIS	Health Management Information System
IPC	Infection Prevention and Control
MoH	Ministry of Health
MTC	Medicines and Therapeutics Committee
mTrac	Mobile Tracking System
NDA	National Drug Authority

NMS	National Medical Stores
NPECAF	National Pharmaceuticals and Essential Commodities Accountability Forum
NRH	National Referral Hospital
OFR	Order Fill Rate
OPD	Outpatient Department
PPS	Point Prevalence Survey
PV	Pharmacovigilance
RASS	Reporting and Accountability for Supply Security
RRH	Regional Referral Hospital
STG	Standard Treatment Guidelines
TB	Tuberculosis
TLD	Tenofovir + Lamivudine + Dolutegravir
UCG	Uganda Clinical Guidelines
UGX	Uganda Shillings
WHO	World Health Organization

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EXECUTIVE SUMMARY

The National Pharmaceuticals and Essential Commodities Accountability Forum (NPECAF) completed its first full calendar year of operations between January and December 2025, establishing itself as Uganda's premier multi-stakeholder platform for pharmaceutical accountability, transparency, and health supply chain oversight. Operating under the Department of Pharmaceuticals and Natural Medicines (DPNM), NPECAF convened weekly Thursday sessions bringing together Regional Referral Hospitals, General Hospitals, District Health Teams, National Medical Stores, implementing partners, and development partners from all 15 regions of Uganda.

Over the reporting period, 39 of 41 scheduled meetings were held (95% execution rate). A structured presentation schedule introduced in April 2025 significantly improved organisation and comparative reporting. Forum discussions addressed four strategic performance pillars: Transparency and Accountability; Performance Monitoring and Governance; Access to EMHS; and Health Supply Chain Performance.

Key Performance Highlights — January to December 2025

No.	Indicator	Target	Achieved	Rating	Status
1	NPECAF meetings held	100%	89% (17/19)	89%	✓ Good
2	Stakeholder participation rate	≥70%	Below 70%	<70%	✗ Inadequate
3	EMHS budget utilisation	100%	89% national avg	89%	✓ Good
4	Commodity availability	≥95%	54-96% range	Mixed	~ Fair
5	Order Fill Rate (OFR)	≥95%	50-96% (avg ~75%)	~75%	✗ Inadequa
6	Pharmacy staffing – GHs	≥80%	43% uniformly	43%	✗ Inadequate
7	Functional MTCs (100% meetings)	100%	~55% on track	55%	✗ Inadequate
8	ADR reporting trend	Increasing	Uneven; improving	Mixed	~ Fair

No.	Indicator	Target	Achieved	Rating	Status
9	AMS/PPS coverage	≥70% facilities	All 15 regions	100%	★ Excellent

The year demonstrated meaningful progress in commodity redistribution, MTC institutionalisation, pharmacovigilance awareness, and digital health supply chain adoption. However, critical gaps persist: pharmacy staffing at 43%, OFR below 95% at every facility, antibiotic encounter rates as high as 99% in Busoga in H2, and very low HMIS reporting completeness system-wide. Addressing these through targeted recruitment, funding, and digital integration is imperative for Uganda to achieve its pharmaceutical stewardship goals.

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.

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 Chain Performance**	Enhance order fulfilment, delivery timelines, inventory management, and stock visibility

1.3 Forum Participation — January to December 2025

NPECAF meetings commenced on 16th January 2025. During the full calendar year, 39 of 41 scheduled meetings were convened, representing an 95% execution rate. A structured presentation schedule and standardised reporting format, introduced on 14 April 2025, transformed forum quality — ensuring equitable regional representation and enabling national-level comparative performance tracking.

Table 1: *NPECAF Meetings and Presenting Facilities — January to December 2025*

No.	Month	Date	Presenting Facilities	Region	Presenter
1	January	08/01/2025	Anaka GH	Acholi	–

No.	Month	Date	Presenting Facilities	Region	Presenter
2	February	–	- (Meeting not held)	–	–
3	March	06/03/2025	Moyo GH	West Nile	–
4	May	15/05/2025	Mubende RRH, Mityana GH, Kiboga GH; Kisoro GH; Busolwe GH, Tororo GH; Kapchorwa GH; Atutur GH	North Buganda	Opio Patrick, Noela Banita, Kalyebi Isaac, Kizito Nicholas, Obore John Benard
5	June	19/06/2025	Gulu RRH, Kayunga RRH	Acholi, N. Buganda	Ismail Ssenkungu
6	June	12/06/2025	Mulago NRH	Kampala	Namakula Edith
7	June	26/06/2025	Lira RRH	Lango	–
8	July	03/07/2025	Jinja RRH, Bugiri GH, Bududa GH, Mbale RRH	Busoga, Bugisu	Mayanja Mathias, Achol James, Tenywa Alfred, Balibuza Banuli, Merab Babirye, Sande Alex
9	July	24/07/2025	Yumbe RRH, Moyo GH	West Nile	Matua Boniface, Engou Trinity, Kidega, Francis Kimong
10	August	07/08/2025	Kitgum GH, Mulago NRH	West Nile,	Aboda A.

No.	Month	Date	Presenting Facilities	Region	Presenter
				Kampala	Komakech
11	September	–	Nakaseke GH	North Buganda	Musanje Geofrey
12	September	11/09/2025	Luweero GH, Kayunga RRH, Jinja RRH, Buwenge GH, Kamuli GH	N. Buganda, Busoga	Danson Sembatya, Muhumuza Conrad, Mayanja Mathias, Ayo Jasper, Kibalya Ronald
13	September	25/09/2025	Mbale RRH, Katakwi GH	Bugisu, Teso	Sande Alex
14	October	30/10/2025	Kiryandongo GH, Hoima RRH, Entebbe RRH	Bunyoro, S. Buganda	Julius Ceaser Onyang, Abigaba Magaret
15	November	27/11/2025	Naguru (China-Uganda Friendship Hospital)	Kampala	–
16	November	06/11/2025	Masaka RRH, Lyantonde GH, Kumi Hospital, Atutur GH, Amuria GH, Kalisizo GH	Teso, South Buganda	Amulen Josephin, Obore John Benard, Ajaru Charles, Moses Walijjo
17	December	04/12/2025	Mbarara RRH, Kitagata GH	Ankole	–

Table 1 note: *39 of 41scheduled meetings held (95%). Two missed due to scheduling conflicts. The structured presentation schedule from April 2025 markedly increased the number of presenting facilities per session. Geographic coverage spanned all 15 administrative regions by year-end.*

1.4 Status of Key Implementation Actions

Two critical system integration actions were tracked throughout the year. Both remained unresolved at year end, requiring urgent inter-agency follow-up.

Table 2: *Status of Key Implementation Issues — January–December 2025*

No.	Issue	Action Required	Latest Update	Status	Priority
1	EMRs at health facility level (e.g., eAFYA) not integrated with NMS CSSP — limits order tracking and transparency	Formally integrate facility-level EMRs with NMS CSSP for real-time order tracking	NMS API published and available. MoH to officially introduce eAFYA team to NMS and request specific datasets for integration	IN PROGRESS	HIGH
2	Health facilities unable to retrieve copies of submitted CSSP orders — limits verification and accountability	Enable health facility access to submitted orders within NMS CSSP system	Resolution scheduled in the next CSSP system upgrade. Timeline not yet confirmed	PENDING	HIGH

PILLAR 1
TRANSPARENCY & ACCOUNTABILITY

Goal: Strengthen transparency, collective oversight, and accountability in pharmaceutical governance

2.1 Overview and Performance

Pillar 1 assessed the extent to which NPECAF institutionalised multi-stakeholder accountability and followed up on agreed corrective actions. The forum demonstrated strong institutional commitment, with 39 of 41meetings held and geographic coverage spanning all 15 regions by year end.

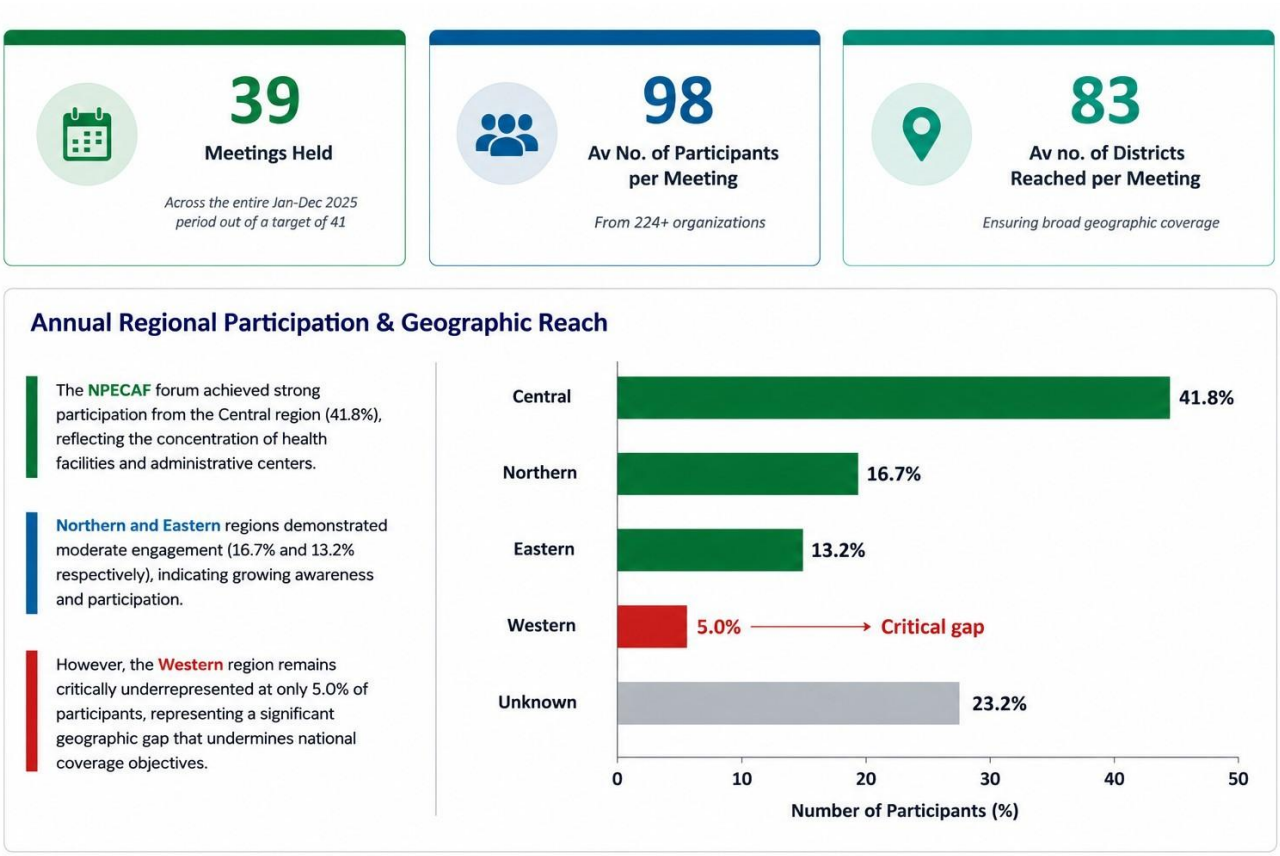
📊 Pillar 1: Indicator Performance Summary

Indicator	Target	Achieved	Rating	Performance
NPECAF meetings conducted as planned	100% (41/41)	39/41 meetings held	**95%**	✦ Very Good
Stakeholder participation rate	≥70% per meeting	Below 70% in most sessions	**<70%**	✗ Inadequate
Structured presentation schedule	Yes (from April 2025)	Implemented 14 April 2025	**Achieved**	★ Excellent
Action point follow-up rate	≥80%	Partial – systemic constraints limit resolution	**~50%**	✗ Inadequate
Regional geographic coverage	All 15 regions	All 15 regions covered by December	**100%**	★ Excellent

2.2 Trend Analysis

NPECAF demonstrated consistent institutional commitment throughout 2025. In Q3 FY 2024/25 (January-March), participation was primarily from implementing partners. By Q1 FY 2025/26 (July-September), virtually all Regional Referral Hospitals had presented at least once. The introduction of standardised reporting templates in April 2025 markedly reduced preparation burden and enabled direct facility-level comparison.

Figure 1: *Annual Stakeholder Engagement and Participation Trends*



📈 Pillar 1: Analysis of Trends and Participation

NPECAF meetings were conducted regularly throughout 2025, demonstrating strong institutional commitment to accountability. In the early months (January–March 2025), attendance was dominated by implementing partners. However, consistent reminders and direct engagement from the Chair — Ag. Commissioner Health Services, Pharmaceuticals and Natural Medicines, Ministry of Health — progressively encouraged more participation from general hospital pharmacists and regional referral hospitals.

Participation trends showed stronger engagement from health facility teams and technical departments, while attendance from some implementing partners and district leadership remained inconsistent. Follow-up on action points improved compared to previous periods, though implementation timelines were frequently affected by systemic constraints beyond forum control.

For implementing partners specifically, participation peaked in Q1 (January–March 2025) before declining as health facility teams took greater ownership of the forum from April 2025 onwards — following the introduction of the structured presentation schedule. This shift represents a positive evolution: from an IP-led forum toward a genuine facility-led accountability platform. However, implementing partners remain critical stakeholders whose sustained technical and operational support is essential for NPECAF continued effectiveness.

Figure 1 presents the full annual NPECAF participation and geographic reach dashboard for January-December 2025. Across 39 meetings held (out of a target of 41), an average of 98 participants attended each session, representing 224+ organisations, with an average of 83 districts reached per meeting. Regional participation was heavily concentrated in the Central region (41.8%), reflecting the proximity of Kampala-based health facilities and administrative centres to the weekly Thursday forums. Northern (16.7%) and Eastern (13.2%) regions showed moderate engagement, while the Western region was critically underrepresented at just 5.0% — a significant geographic gap that undermines the national coverage objective. The 23.2% classified as "Unknown" represents participants whose regional affiliation was not captured in attendance records, pointing to a data quality improvement needed in 2026 to enable accurate regional performance tracking.

2.3 Key Enablers and Constraints

☑ Key Enablers	⚠ Key Constraints
• Strong DPNM/MoH leadership — Commissioner's consistent presence set accountability tone • Structured meeting agendas and standardised reporting from April 2025 • Multi-sectoral representation: facilities, partners, NMS, NDA, development partners • Weekly meeting cadence maintained institutional momentum and regular feedback loops • Geographic coverage expanded to all 15 regions by year end	• Competing institutional priorities caused inconsistent attendance from district leadership • EMR-CSSP integration and CSSP order access stalled pending system upgrades • Internet connectivity limitations in some facilities restricted participation

PILLAR 2
PERFORMANCE MONITORING & GOVERNANCE

Goal: Strengthen evidence-based decision-making, MTCs, pharmacovigilance, and antimicrobial stewardship

3.1 HMIS 105-6 Reporting and Health Facility Completion Rates

A foundational prerequisite for performance monitoring is complete and timely data submission through the Health Management Information System (HMIS). HMIS 105-6 captures pharmaceutical data – including medicines availability, ordering patterns, and health supply chain metrics – from all health facilities monthly. The performance monitoring pillar depends entirely on the quality and completeness of this data.

HMIS 105-6 and Health Facility Reporting — Key Findings 2025

Indicator	Target	Achieved	Rating	Performance
HMIS 105-6 Section 6 data completeness (Kayunga region sample)	100%	68.6% (144/210 facilities with complete data)	69%	✗ Inadequate
Facilities submitting ≥1 data point in Section 6 (Kayunga region)	100%	78.4% (210/268 facilities)	78%	~ Fair
HMIS 105-6 completeness — national system-wide estimate	≥90%	Very low – majority of facilities below 70%	<70%	✗ Inadequate
Timeliness of HMIS submissions	Monthly (by 15th)	Inconsistent; delays widespread	Low	✗ Inadequate
Data use for decision-making	Active	Limited; data submitted but rarely applied	Low	✗ Inadequate

The most detailed data available comes from Kayunga RRH North Central region, where 78.4% (210 of 268) of facilities submitted at least one data point in Section 6 of their monthly OPD report — but only 68.6% (144 of 210) submitted complete data on all required parameters. This means fewer than 7 in 10 facilities provide complete HMIS pharmaceutical data, and the national picture is likely worse. Data quality and reporting emerged as a critical weakness across the system, significantly undermining performance monitoring and evidence-based decision-making at all levels.

Specific contributing factors identified include: limited access to digital reporting systems; inadequate training on HMIS tools; staff turnover disrupting reporting continuity; competing workload priorities; and limited feedback from national or district levels that would motivate better data submission.

Improvements in reporting completeness were observed in facilities where targeted mentorship and committed pharmaceutical leadership existed — notably at Hoima RRH (RASS reporting in the mid-90s%), Kayunga RRH, and Mulago NRH.

> 📋 **Key Action Required — HMIS 105-6 Reporting**
> HMIS Section 6 data completeness must be treated as a mandatory performance KPI. MoH should mandate 100% HMIS Section 6 completion and escalate non-compliance through NPECAF reporting channels. Without reliable HMIS data, resource allocation, redistribution decisions, and health supply chain planning cannot be evidence-based. Current performance (below 70% nationally) is insufficient for effective pharmaceutical governance.

Figure 5a: *HMIS 105-6 Monthly Reporting and Completeness Rates — January–December 2025*

Figure 5a tracks HMIS 105-6 Section 6 completeness and reporting rates nationally across all 12 months of 2025. The reporting rate (blue line, right axis) remained relatively stable throughout the year at 80-95%, indicating that most facilities are submitting HMIS reports. However, the completeness rate (green bars, left axis) tells a more concerning story: it began the year at 50.5% in January, dropped to a low of 37.7% in February, and did not cross 60% until July 2025. While there is a clear upward trend in the second half of the year — rising from 57.9% in July to a year-high of 72.2% in December — the national average of approximately 58% for the full year falls far short of the ≥90% completeness target. This persistent gap between the proportion of facilities that report (high) and those that report completely (low) represents the central HMIS data quality challenge: facilities are submitting reports but leaving critical fields in Section 6 incomplete, which directly undermines evidence-based medicine management, redistribution planning, and health supply chain oversight nationally.

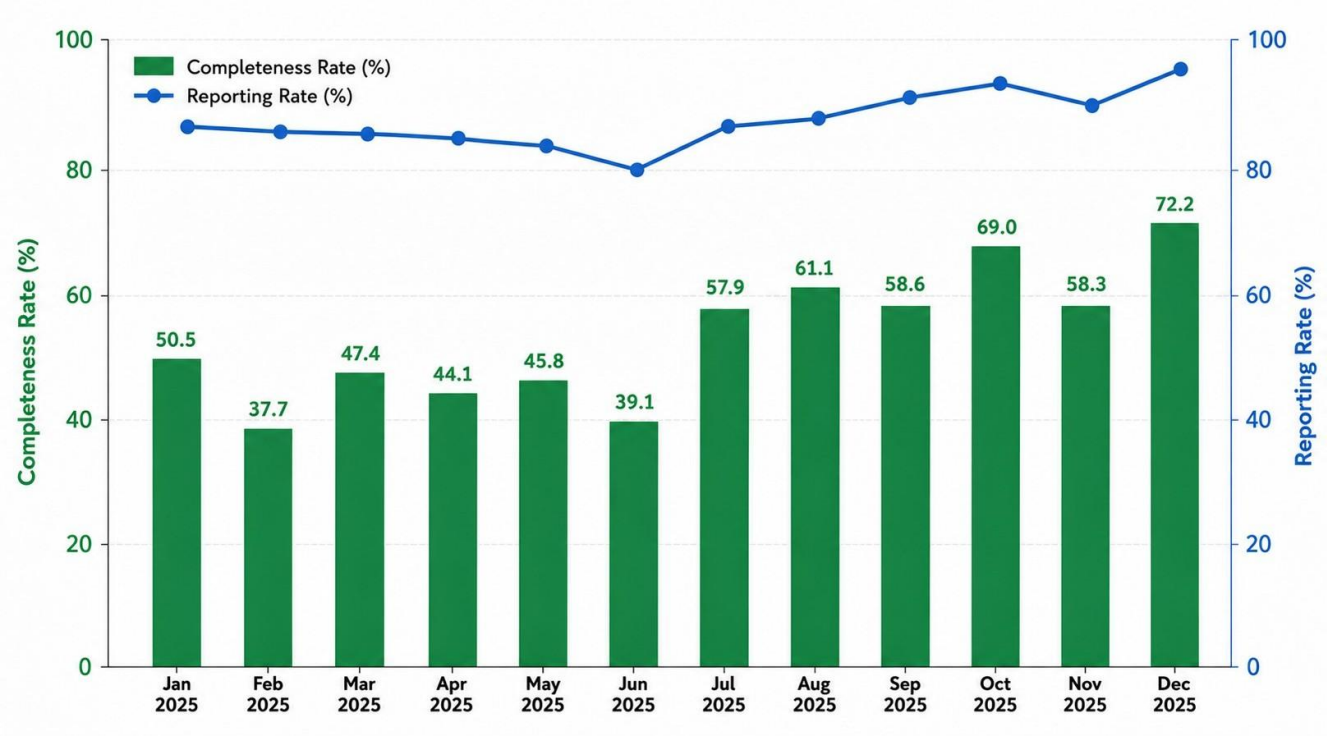
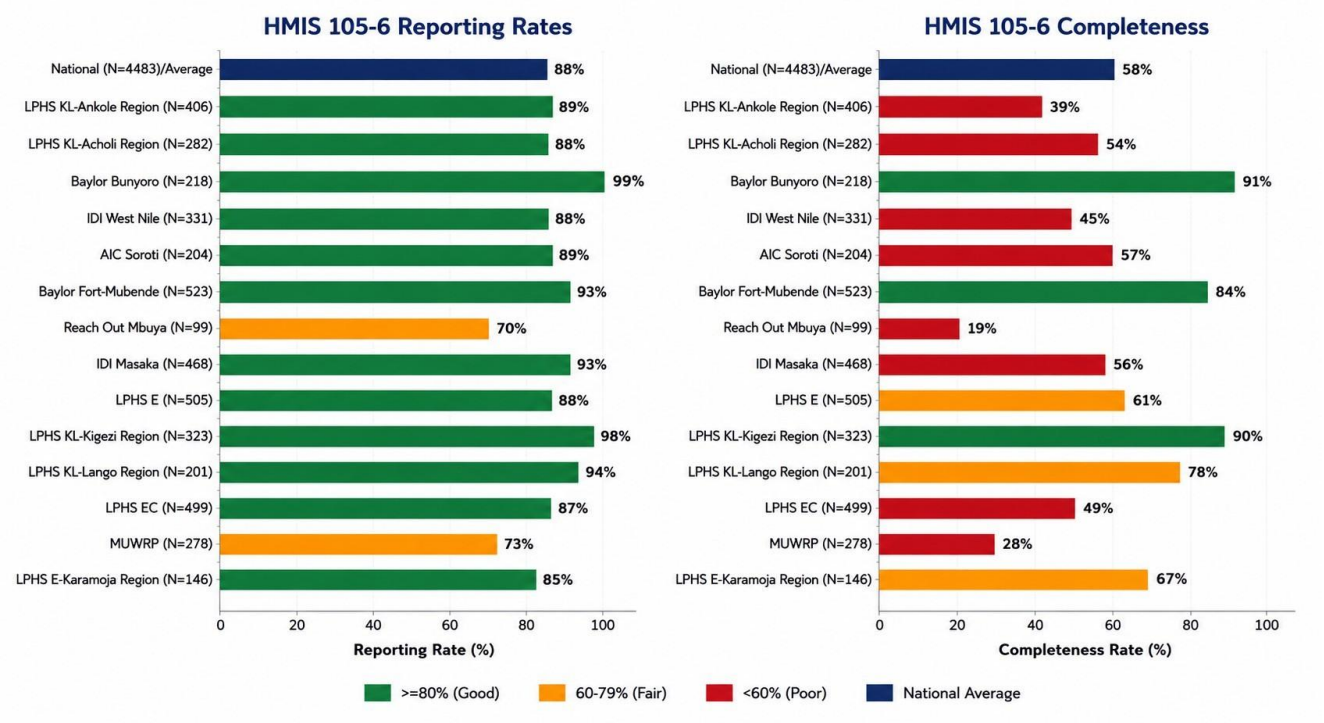


Figure 5b: *HMIS 105-6 Reporting Rates and Completeness by Implementing Partner/Region — January–December 2025*

Figure 5b disaggregates HMIS 105-6 reporting and completeness performance by implementing partner (IP) region for the full year 2025. On reporting rates (left panel), most IPs achieved ≥80% (shown in green), with Baylor Bunyoro leading at 99% and Baylor Fort-Mubende and IDI Masaka both at 93%. Reach Out Mbuya (70%) and MUWRP (73%) were the weakest reporters, falling into the orange "Fair" band (60–79%). On completeness (right panel), the picture is starkly different: only Baylor Bunyoro (91%), LPHS KL-Kigezi Region (90%), and Baylor Fort-Mubende (84%) performed well. Reach Out Mbuya recorded the lowest completeness nationally at just 19% — meaning fewer than 1 in 5 facilities in that IP region submitted complete pharmaceutical data. MUWRP (28%), IDI West Nile (45%), and LPHS EC (49%) were also critically below target. The national average completeness of 58% masks very wide variation: the best-performing IP (Baylor Bunyoro at 91%) outperforms the worst (Reach Out Mbuya at 19%) by over 70 percentage points. Targeted mentorship and data quality support must be directed urgently to the lowest-performing IPs in 2026.



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 Financial Year. Of 39 tracked facilities, approximately 55% achieved 100% of their meeting targets.

Table 3: *MTC Performance — Meetings Held vs Target, January–December 2025*

Region	No.	Health Facility	MTC Structure	Meetings Held	Target	Performance	Rating
Kampala	**1**	Mulago NRH	AMS, SC & PV	3	3	**100%**	★ **Excellent**
	2	Naguru (China-	AMS, SC &	3	3	**100%**	★ **Excellent**

Region	No.	Health Facility	MTC Structure	Meetings Held	Target	Performance	Rating
		Uganda)	PV				
Busoga	**3**	Jinja RRH	AMS, SC & PV	2	3	**67%**	✗ **Inadequate**
	4	Bugiri GH	AMS, SC & PV	1	3	**33%**	✗ **Inadequate**
	5	Buwenge GH	AMS, SC & PV	3	3	**100%**	★ **Excellent**
	6	Kamuli GH	AMS, SC & PV	3	3	**100%**	★ **Excellent**
Bukedi	**7**	Tororo GH ★	AMS, SC & PV	**4**	3	**100%+**	★ **Excellent**
	8	Busolwe GH ★	AMS, SC & PV	**4**	3	**100%+**	★ **Excellent**
Kigezi	**9**	Kisoro GH	Not fully functional	1	3	**33%**	✗ **Inadequate**
	10	Kambuga GH	Not fully functional	1	3	**33%**	✗ **Inadequate**
Teso	**11**	Atutur GH	SC, AMS, PV (partial)	3	3	**100%**	★ **Excellent**
	12	Katakwi GH	3 committees	3	3	**100%**	★ **Excellent**
	13	Kumi Hospital	3 committees	1	3	**33%**	✗ **Inadequate**
	14	Amuria GH	3 committees	3	3	**100%**	★ **Excellent**
Acholi	**15**	Gulu RRH	3 committees	2	3	**67%**	✗ **Inadequate**
	16	Anaka GH	3 committees	2	3	**67%**	✗ **Inadequate**

Region	No.	Health Facility	MTC Structure	Meetings Held	Target	Performance	Rating
Lango	17	Lira RRH	3 committees	3	3	100%	★ Excellent
Bugisu	18	Mbale RRH	3 committees	3	3	100%	★ Excellent
	19	Kapchorwa GH	3 committees	Pending	3	–	~ Fair
	20	Bududa GH ★	3 committees	3	3	100%	★ Excellent
Bunyoro	21	Hoima RRH	3 committees (quarterly)	2	3	67%	✗ Inadequate
	22	Kiryandongo GH	3 committees	3	3	100%	★ Excellent
	23	Buliisa GH	Not fully functional	–	3	<33%	✗ Inadequate
	24	Kagadi GH	3 committees	3	3	100%	★ Excellent
N. Central	25	Kayunga RRH	3 committees	3	3	100%	★ Excellent
	26	Mubende RRH	3 committees (quarterly)	2	3	67%	✗ Inadequate
	27	Mityana GH	3 committees (PV suboptimal)	1	3	33%	✗ Inadequate
	28	Nakaseke GH	3 committees	3	3	100%	★ Excellent
	29	Luweero GH	3 committees	3	3	100%	★ Excellent
	30	Kalisizo GH	3	2	3	67%	✗ Inadequate

Region	No.	Health Facility	MTC Structure	Meetings Held	Target	Performance	Rating
			committees				
West Nile	**31**	Yumbe RRH	3 committees (PV suboptimal)	2	3	**67%**	✗ **Inadequate**
	32	Moyo GH	3 committees	3	3	**100%**	★ **Excellent**
	33	Kitgum GH	3 committees (PV inactive)	–	3	**<33%**	✗ **Inadequate**
S. Buganda	**34**	Entebbe RRH	AMS, SC, PV + Research	3	3	**100%**	★ **Excellent**
	35	Masaka RRH	3 committees	1	3	**33%**	✗ **Inadequate**
	36	Lyantonde GH	3 committees	3	3	**100%**	★ **Excellent**
Ankole	**37**	Mbarara RRH	3 committees	3	3	**100%**	★ **Excellent**
	38	Kitagata GH ★	3 committees	**6**	3	**100%+**	★ **Excellent**

Table 3 analysis: *Of 38 facilities with available data, 55% achieved 100% of MTC meeting targets. Three facilities — Tororo GH, Busolwe GH, and Kitagata GH (marked ★) — exceeded targets, fulfilling regional mentorship roles. Seven facilities achieved only 33% (1/3 meetings). Kitgum GH PV committee and Buliisa GH were effectively inactive. Primary drivers of underperformance: staff transfer/attrition and lack of dedicated MTC budget lines.*

3.3 Key MTC Achievements and Challenges

The following figures and table summarise MTC performance outcomes across the system.

Table 4: *MTC Key Activities, Challenges and Recommendations — Selected Facilities 2025*

Facility	Key Achievements	Challenges	Recommendations
Mulago NRH	SOPs for store operations; AMS research; 2 PPS; 2 prescription audits; antibiogram compiled	NMS low OFRs; EMHS budget inadequate; stock-outs (Artesunate, Diazepam); manual inventory system	Increase dialysis budget; train staff on lab results interpretation; disseminate antibiogram hospital-wide
Naguru Hospital	Reconstituted MTC (10 members); draft IML generated; QI project on prescription errors; 18 ADRs reported Q1	HR remains a major challenge	MoH/DPNM to advocate for health supply chain personnel recruitment
Jinja RRH	Hospital antibiogram generated; medicine promoters policy drafted; MTC guidelines launched; medicines audit conducted	Staff turnover disrupts committee continuity	Formalise sub-committee appointments through Health Facility Management
Bugiri GH	2 product quality reports; 2 prescription audits; 5 ADR reports with Naranjo causality assessments	–	Maintain ADR reporting; expand to all wards
Tororo GH	Sub-committee reports reviewed; drug promoters guidelines drafted; MTC guidelines rolled out regionally	–	Continue regional mentorship role
Busolwe GH	Inpatient pharmacy established; daily dose dispensing; PPS; prescription audits; Pharmacist appointed as MTC Secretary	–	Scale mentorship model to neighbouring facilities
Bududa GH	Expiry rate reduced 10%→0.6%; formulary updated; test-and-treat policy adherence; eAFYA started	Low OFRs; network issues for eAFYA; no SC budget	Follow up wage bill to increase pharmacy staff from 4 to 9
Entebbe RRH	Fully constituted: AMS, SC, PV + Research sub-committees; appointment	–	Review treatment regimens for reserve antibiotics; more IPC staff training

Facility	Key Achievements	Challenges	Recommendations
	letters and TORs in place; bi-monthly meetings		
Mbarara RRH	Quarterly MTC meetings; antibiotic resistance profiles reviewed; needs analysis commenced; TB/HIV tools distributed to 21 facilities	–	Continue regional PV training and screening tool distribution
Kitagata GH	6 MTC meetings — highest frequency nationally in Q4	Stock-outs; inconsistent quantification; weak ward accountability; forecasting not aligned with consumption	Strengthen AMS; improve diagnostic labs; enforce UCG use; provide C&S equipment

3.4 Pharmacovigilance (PV) Performance

Pharmacovigilance activity in 2025 showed improving trends at leading facilities while systemic gaps persisted. The year's most significant safety event was bupivacaine (Spinesia-D) toxicity causing failed spinal blocks, patient deaths, and intraoperative awareness at Mulago NRH and Moyo GH — underscoring the critical importance of functional PV systems.

Table 5: *Pharmacovigilance Performance — January–December 2025 (Selected Facilities)*

Region	No.	Facility	PV Meetings	ADRs Reported	Key Challenges	Recommendations
Kampala	**1**	Mulago NRH	2 (quarterly)	50 ADRs (Q3); 10 to NDA Jul-Aug; 2 staff trainings	No Vigiflow account; bupivacaine toxicity (Spinesia-D) causing deaths; inadequate funding for causality assessment	NMS: procure better bupivacaine brand; establish Vigiflow account; more safety awareness campaigns
	2	Naguru Hospital	1	18 ADR/AFIs Q1; 1 CME; 0 causality assessments	–	Complete causality assessments; train on PV documentation
Busoga	**3**	Jinja RRH	2 (Q4)	34 ADRs	Paper-based	Appoint ward focal

Region	No.	Facility	PV Meetings	ADRs Reported	Key Challenges	Recommendations
				Q4; active only in TB & ART programmes	reporting; fear of incrimination; ward under-reporting; attrition	persons; obtain Vigiflow account; continue training
	4	Buwenge GH	–	27 ADRs; withdrew calcium gluconate (Lot KBU24001)	Inadequate documentation; ADRs normalised; fear to report errors	Reward best performers; report at morning meetings; link to Vigiflow
Acholi	5	Gulu RRH	1	39 ADRs reported	Causality assessments not conducted	Train PV members on causality assessment methods
	6	Anaka GH	0	6 ADRs Q1; 11 ADRs Q2	Causality assessments not conducted	Staff training on causality assessment
Lango	7	Lira RRH	2	Reviewed PV reports; AEFI updated; all depts reawakened	Reluctance in ADR/AEFI reporting; EMR does not capture drug events	Incorporate ADR forms into EMR; train HCWs; support lower HFs
Bugisu	8	Bududa GH	–	ADRs reported	–	Maintain reporting momentum
	9	Mbale RRH	2 + 1 CME	33 ADR/AFI reports Q4; operational research on PV knowledge underway	–	Continue research; scale PV training
Bunyoro	10	Hoima RRH	–	>15 ADR events	PV committee not very active	Reactivate committee; provide

Region	No.	Facility	PV Meetings	ADRs Reported	Key Challenges	Recommendations
				reported		budget for meetings
Busoga	**11**	Bugiri GH	–	5 ADR reports with Naranjo assessments; 2 product quality reports	–	Scale causality assessment practice to all wards
West Nile	**12**	Moyo GH	–	5 ADRs (formal causality); bupivacaine toxicity suspected	Limited technical awareness; insufficient PV sensitisation	Mandatory ADR reporting; raise awareness to prevent further fatalities
N. Buganda	**13**	Luweero GH	–	55 (Apr) + 105 (May) + 161 (Jun) = 321 ADRs total; no causality assessments	–	Conduct causality assessments; engage NDA for feedback
	14	Kayunga RRH	–	2 ADRs (malaria vaccine) noted and reported	–	Expand PV to blood transfusion reactions
Teso	**15**	Katakwi GH	1 (Q4)	17 ADRs to NDA Q4	–	Continue MTC mentorship on ADR reporting; scale to all wards
S. Buganda	**16**	Entebbe RRH	4	57 ADRs Q1 FY25/26; causality assessment	Brand-specific ADR: Cardipac — resolved by brand switch	Continue regional PV leadership; share bupivacaine management lessons

Region	No.	Facility	PV Meetings	ADRs Reported	Key Challenges	Recommendations
				conducted; regional bupivacaine retraining planned		
Ankole	**17**	Mbarara RRH	–	>200 PV cases; medication error at Ntungamo (mebendazole vs phenobarbital) managed	–	Continue PV training in 21 Ankole facilities (planned January)
	18	Kitagata GH	3	5 ADRs; causality done but no discussion meeting held	ADRs reported by specific individuals only — not systemic	PV sub-committee to meet more frequently; CME for all clinical staff

PATIENT SAFETY ALERT — Bupivacaine Toxicity (Spinesia-D)

Spinesia-D bupivacaine 5mg/ml in dextrose 80mg was associated with failed spinal blocks, patients awakening during surgery, and at least two fatalities at Mulago NRH due to high spinal toxicity. Mbarara RRH and Moyo GH reported similar concerns. NDA was notified, NMS supplied an alternative brand, and Entebbe RRH planned regional anaesthesia retraining. All facilities must cease use of implicated batches and implement enhanced bupivacaine monitoring protocols immediately.

3.4.1 ADR/AEFI Case Analysis — Lira RRH

Lira Regional Referral Hospital conducted systematic ADR/AEFI causality analysis during the reporting period using WHO-UMC criteria. The following cases were formally assessed and reported to NDA, providing one of the most structured pharmacovigilance outputs nationally in 2025.

Table 5a: *ADR/AEFI Causality Assessment — Lira RRH, January–December 2025*

ADR/AEFI	Suspected Drug	Findings	Recommendation / Action Taken
Amenorrhea	**Haloperidol**	Causality confirmed – patient had drug-induced amenorrhea with	Patient changed to Risperidone; response

ADR/AEFI	Suspected Drug	Findings	Recommendation / Action Taken
		clear temporal relationship to haloperidol administration	monitored
Renal dysfunction (2 cases)	**Tenofovir (TDF)**	Lab results confirmed reduced renal function following TDF-based regimen; temporal relationship established	Both patients changed to ABC-based regimen
Hyperglycemia and renal dysfunction (1 case)	**Dolutegravir (DTG)**	Increased blood sugar over time after regimen change; reduced renal function documented progressively	Patient changed to ATV/r and ABC regimen
Severe rashes and itching on all parts of body	**TDF/3TC/ DTG**	Assessment revealed patient had done well on a previous brand; brand-specific reaction suspected	Medicine withdrawn; treatment continued on alternative brand with monitoring

Serious ADRs reported at Lira RRH: Hepatotoxicity, Hyperglycemia, persistent bad dreams, paralysis, Renal dysfunction, and severe numbness. Additional cases included headache, abnormal dreams, discolouration of urine, Neuritis, rashes, stomach pain, polyuria, and changes in appetite.

AEFI category: All AEFI cases at Lira RRH were deemed unserious on assessment. Cases included raised body temperature (fever), localised rash and itching, swelling, and abscesses.

3.4.2 ADR Case Reports — Moyo GH, January–December 2025

Moyo General Hospital submitted 5 formally assessed ADR reports during the reporting period, all with completed causality assessments — making it one of the most structured PV reporters among general hospitals nationally. The following case summaries illustrate the facility pharmacovigilance capacity.

Report	Date	Drug Involved	ADR Observed	Management	Outcome
ADR 1	23 Jan 2025	Ciprofloxacin 500mg (food poisoning)	Skin hypersensitivity, erythema, intense itching (immediate after 1st dose)	Ciprofloxacin discontinued; Prednisone 20mg once daily × 3 days	Symptoms resolved fully following corticosteroid therapy
ADR 2	28 Jan 2025	Anti-snake venom (PANAF brand)	Severe hypotension, low-grade fever, generalised	IV Hydrocortisone 200mg; IV fluids administered	Patient stabilised following intervention

Report	Date	Drug Involved	ADR Observed	Management	Outcome
			body itching		
ADR 3	14 Feb 2025	Hepatitis B vaccine (1st dose)	Painful injection site, pain radiating to entire left arm, low-grade fever	Paracetamol administered for symptom management	Symptoms managed symptomatically with analgesics
ADR 4	16 Mar 2025	Piritex Syrup (Chlorphenira mine) — 2.5yr female	Generalised body itching, generalised weakness, skin rashes and urticaria	IV Hydrocortisone 100mg; Oral Prednisone 5mg	Patient treated successfully with corticosteroids
ADR 5	13 Jun 2025	IV Cloxacillin × 4/day × 5 days (diabetic wound)	Body itching, low-grade fever, hypotension	Cloxacillin discontinued; IV Hydrocortisone 200mg administered	Patient symptoms stabilised following treatment

Moyo GH PV note: *All 5 Moyo GH ADRs were formally assessed using WHO-UMC causality criteria. Causality was classified as "probable" or "possible" (rechallenge not performed for ethical reasons). Moyo GH also identified suspected unreported bupivacaine toxicity cases in obstetric procedures — approximately 3 fatal cases attributed to high spinal block — which were escalated to NDA. This demonstrates strong PV initiative, but also highlights the critical need to formalise all suspected ADRs regardless of severity, including fatal outcomes.*

3.5 Antimicrobial Stewardship (AMS) Performance

AMS activities in 2025 spanned all 15 regions, with two Point Prevalence Surveys (PPS) — one for January-June and one for July-December 2025. This biannual measurement provided crucial comparative data on antibiotic use, guideline adherence, and prescribing quality nationally.

Table 6: *PPS Results — Antibiotic Prescribing Indicators by Region, January–June 2025*

No.	Region	Facilities	AB Encounter%	Injectable AB%	Generic Rx%	Target	Guideline Adh%	Target	Performance
1	Acholi	4	31.46%	87.73%	**100%**	100%	**30.32%**	100%	✗ **Inadequate**
2	Ankole	3	28.81%	87.73%	**100%**	100%	**38.6%**	100%	✗ **Inadequate**
3	Bugisu	3	43.99%	87.73%	**100%**	100%	**46.48%**	100%	✗ **Inadequate**

No.	Region	Facilities	AB Encounter%	Injectable AB%	Generic Rx%	Target	Guideline Adh%	Target	Performance
4	Bukedi	5	41.71%	87.73%	100%	100%	46.12%	100%	✗ Inadequate
5	Bunyoro	5	39.65%	87.73%	100%	100%	64%	100%	✗Inadequate
6	Busoga	5	52.82%	87.73%	100%	100%	62.98%	100%	✗Inadequate
7	Kampala	11	46.11%	87.73%	100%	100%	54.56%	100%	✗ Inadequate
8	Karamoja	5	49.1%	87.73%	100%	100%	54.39%	100%	✗Inadequate
9	Kigezi ★	3	33.79%	87.73%	100%	100%	66.14%	100%	✗Inadequate
10	Lango	2	43.32%	87.73%	100%	100%	31.51%	100%	✗Inadequate
11	N. Buganda	10	45.08%	87.73%	100%	100%	52.66%	100%	✗Inadequate
12	S. Buganda	8	46.37%	87.73%	100%	100%	41.6%	100%	✗ Inadequate
13	Teso	5	41.88%	87.73%	100%	100%	58.01%	100%	✗ Inadequate
14	Tooro	6	39.59%	87.73%	100%	100%	47.15%	100%	✗Inadequate
15	West Nile	6	40.22%	87.73%	100%	100%	49.1%	100%	✗Inadequate

Table 6 analysis: *Generic prescribing achieved 100% across all 15 regions — a major achievement. However, guideline adherence (30–66%) fell far short of the 100% target in every region. Best: Kigezi (★ 66.14%), Bunyoro (64%), Busoga (62.98%). Worst: Acholi (30.32%), Lango (31.51%). No region met the target.*

Table 7: *PPS Results — Antibiotic Prescribing Indicators by Region, July–December 2025*

No.	Region	Facilities	AB Encounter %	Injectable AB%	Generic Rx%	Target	Guideline Adh %	Target	Performance
1	Acholi	4	64.75%	58.24%	100%	100%	33.9 %	100%	✗ Inadequate
2	Ankole	3	70.82%	58.24%	100%	100%	38.67 %	100%	✗ Inadequate
3	Bugisu	3	82.25%	58.24%	100%	100%	46.89 %	100%	✗ Inadequate
4	Bukedi	5	85.23%	58.24%	100%	100%	46.54 %	100%	✗ Inadequate
5	Bunyoro	5	81.60%	58.24%	100%	100%	58.39 %	100%	✗ Inadequate
6	Busoga !!	5	99.44%	58.24%	100%	100%	56.46 %	100%	✗ Inadequate
7	Kampala	9	89.23%	58.24%	100%	100%	55.39 %	100%	✗ Inadequate
8	Karamoja	5	66.14%	58.24%	100%	100%	46.17 %	100%	✗ Inadequate
9	Kigezi ★	3	53.94%	58.24%	100%	100%	69.77 %	100%	✗ Inadequate
10	Lango	2	80.36%	58.24%	100%	100%	42.41 %	100%	✗ Inadequate
11	N. Buganda	10	89.55%	58.24%	100%	100%	53.03 %	100%	✗ Inadequate
12	S. Buganda	8	77.48%	58.24%	100%	100%	42.51 %	100%	✗ Inadequate
13	Teso	5	75.82%	58.24%	100%	100%	55.65 %	100%	✗ Inadequate
14	Tooro	6	66.26%	58.24%	100%	100%	38.51	100%	✗ Inadequate

No.	Region	Facilities	AB Encounter %	Injectable AB%	Generic Rx%	Target	Guideline Adh %	Target	Performance
							%		✗ Inadequate
15	West Nile	6	67.92%	58.24%	100%	100%	54.44 %	100% ✗	✗ Inadequate

CRITICAL FINDING — Antibiotic Encounter Rates Rising Sharply H2 2025

Antibiotic encounter rates increased alarmingly in H2 2025 across all 15 regions compared to H1. Busoga Region (!!) reached 99.44% — effectively universal antibiotic prescribing. North Buganda (89.55%), Kampala (89.23%), Bukedi (85.23%) are equally critical. Generic prescribing remained 100% (positive), but guideline adherence and C&S uptake remain near-zero at most facilities. Immediate AMS reinforcement, mandatory C&S before reserve antibiotics, and enforced prescription audits are required in Busoga, North Buganda, Kampala, and Bukedi regions.

Table 8: *AMR Surveillance — Antibiogram Development at RRHs 2025*

No.	Regional Referral Hospital	Antibiogram Developed
1	Arua RRH	Yes ✓
2	Entebbe RRH	Yes ✓
3	Fort Portal RRH	Yes ✓
4	Gulu RRH	Yes ✓
5	Hoima RRH	Yes ✓
6	Jinja RRH	Yes ✓
7	Kabale RRH	Yes ✓
8	Kayunga RRH	Yes ✓
9	Lira RRH	Yes ✓
10	Masaka RRH	No ✗ — not yet developed
11	Mbale RRH	Yes ✓
12	Mbarara RRH	Yes ✓

No.	Regional Referral Hospital	Antibiogram Developed
13	Moroto RRH	Yes ✓
14	Mubende RRH	Yes ✓
15	Soroti RRH	Yes ✓

Table 8 analysis: *14 of 15 (93.3%) RRHs have developed antibiograms — a major achievement reflecting NPECAF-driven AMR surveillance commitment. Masaka RRH is the sole exception. However, antibiogram existence does not guarantee use: multiple facilities reported antibiograms available but not systematically disseminated to prescribers.*

3.6 Pillar 2: Performance Monitoring & Governance — Indicator Summary

Indicator	Target	Achieved	Rating	Performance
HMIS 105-6 reporting completeness	≥90%	Very low – majority below 70%	**<70%**	✗ Inadequate
Functional MTCs (100% meeting target)	100% facilities	~55% of facilities on track	**55%**	✗ Inadequate
ADR reporting trend	Increasing	Uneven; >800 ADRs reported nationally	**Variable**	~ Fair
Causality assessments conducted	100% of ADRs	~20% of facilities conduct them	**~20%**	✗ Inadequate
AMS/PPS coverage	≥70% facilities	All 15 regions, 2 rounds	**100%**	★ Excellent
Guideline adherence – all regions	100%	30-70% range H1; 34-70% H2	**30–70%**	✗ Inadequate
Generic prescribing	100%	100% across all regions both rounds	**100%**	★ Excellent
Antibiograms developed (RRHs)	15/15 (100%)	14/15 (93.3%)	**93%**	✦ Very Good
Regional TWG meetings held	100%	19/19 (100%)	**100%**	★ Excellent

PILLAR 3

ACCESS TO ESSENTIAL MEDICINES & HEALTH SUPPLIES

Goal: Ensure equitable, sustained access to EMHS through optimised budgets, redistribution, and staffing

4.1 EMHS Budget Utilisation — FY 2024/25

Budget utilisation measures the percentage of allocated EMHS funds actually committed across six delivery cycles. The national average of 89% reflects solid financial management but indicates 11% of pharmaceutical budgets remained unspent — a missed procurement opportunity.

Table 9: *EMHS Budget Utilisation by Facility — FY 2024/25*

Region	No.	Health Facility	Budget Allocation (UGX)	Utilised (UGX)	Utilisation %	Notes
Kampala	**1**	Mulago NRH	–	–	Data pending	Direct procurement supplements NMS supply
Busoga	**2**	Jinja RRH	1,804,853,380	1,774,865,380	**98%**	
	3	Bugiri GH	642,000,000	–	–	50% EMHS allocation increase this FY
Bukedi	**4**	Tororo GH	708,521,739	824,137,238	**100% ★**	Carry-forward balance FY23/24
	5	Busolwe GH	660,000,000	776,287,370	**100% ★**	Carry-forward balance FY23/24
Kigezi	**6**	Kisoro GH	–	–	Data pending	
Teso	**7**	Atutur GH	878,170,917	866,188,820	**99%**	Back-orders: gumboots, bin liners

Region	No.	Health Facility	Budget Allocation (UGX)	Utilised (UGX)	Utilisation %	Notes
	8 Acholi	Gulu RRH	1,800,375,499	1,488,101,169	92%	
Bugisu	9	Mbale RRH	2,859,375,499	2,793,426,034	98%	
	10	Kapchorwa GH	622,681,869	785,564,715	100% ★	Carry-forward balance
	11	Bududa GH	745,249,832	741,718,416	99%	
Bunyoro	12	Hoima RRH	2,043,375,498	–	Data pending	
	13	Buliisa GH	372,000,000	459,461,837	100% ★	Carry-forward balance
N. Central	14	Kayunga RRH	2,434,711,750	–	99%	
	15	Mubende RRH	1,683,337,549	–	Data pending	
West Nile	16	Yumbe RRH	1,666,827,508	1,678,254,693	100.69% ★	Emergency order UGX 217m
	17	Kitgum GH	157,286,698	200,002,000	126% ★	26% upward adjustment via unspent balance

4.2 Pharmacy Staffing Capacity — FY 2024/25

Pharmacy staffing is a critical determinant of medicine management quality, pharmacovigilance, and health supply chain integrity. The target is ≥80% staffing. The findings reveal a severe, system-wide staffing crisis: all general hospitals are operating at a uniform 43% pharmacy staffing with 57% of positions vacant.

Table 10: *Pharmacy Department Human Resource Capacity — FY 2024/25*

Region	No.	Facility	Staff Available	Positions Vacant	Staffing %	Vacancy %	Key Challenges
Kampala	1	Mulago NRH	11	–	<50%	–	High patient load
Busoga	2	Bugiri GH	3	4	43%	57%	Low staffing level
Bukedi	3	Tororo GH	5	4	43%	57%	Low staffing; expanded regional role
	4	Busolwe GH	3	4	43%	57%	Low staffing level
Teso	5	Atutur GH	3	4	43%	57%	Low staffing; urgent recruitment needed
West Nile	6	Moyo GH	3	4	43%	57%	Low staffing level
Bugisu	7	Mbale RRH	8	6	57%	43%	USAID stop-work order significantly increased workload
	8	Kapchorwa GH	3	4	43%	57%	Long-serving tech deserves promotion; need additional staff
	9	Bududa GH	3	4	43%	57%	Low staffing level; urgent recruitment needed
Busoga	10	Jinja RRH	–	–	Data pending	–	–

4.3 Commodity Redistribution and Donations

Redistribution and donations served as critical buffers against health supply chain gaps, enabling facilities to maintain medicine availability despite NMS delivery shortfalls and expiry risks.

Table 11: *Commodity Redistributions and Donations Received — January–December 2025*

Region	No.	Facility	Received From	Key Commodities Received	Redistributed To	Key Commodities Sent	Donations
Kampala	**1**	Mulago NRH	Kawempe NRH; Kiruddu NRH; Mbarara RRH; Mulago SWH	Various EMHS	–	–	Kamcare, Troikaa pharma, Core Access
Busoga	**2**	Jinja RRH	TASO Jinja; Buwenge GH; Walukuba HCIV	ARVs; Cotrimoxazole ; Halothane; IV fluids; ORS	DHO Mayuge; Kamuli DLG; TASO; Children's Chest Hope	Anti-TBs; ARVs; AL; Bupivacaine; Artesunate	–
	3	Bugiri GH	TASO Jinja; Iganga Hospital; Jinja RRH; lower HFs	STI medicines; NCD commodities; IV fluids; 3rd line ARVs; TLD 90	Iwemba HCIII; Bugiri MC HCIII; Nankoma HCIV	Oxytocin; STI medicines	–
N. Central	**4**	Kayunga RRH	Kangulumira; Kiruddu NRH; Mukono GH; Entebbe RRH; IDI; Mulago NRH	Misoprostol; Sutures; MgSO4; F100; Oxytocin; ARVs; MDR-TB meds	Mulago NRH; 14+ facilities; Noah's Children	ARVs-DTG; 3rd line ARVs; Oxytocin; RUTF; MDR-TB; Lidocaine	–
	5	Mubende RRH	–	–	Mubende CMRC HCIV; Kasambya HCIII	EMHS (general)	–
	6	Kumi Hospital	–	–	Kumi HCIV; Atutur Hospital; Mukongoro HCIII	Artemether + Lumefantrine (short expiry managed)	–

4.4 Pillar 3: Access to EMHS — Indicator Summary

Indicator	Target	Achieved	Rating	Performance
EMHS budget utilisation	100%	89% national avg; top performers 100% +	**89%**	✓ **Good**
Commodity availability	≥95%	Variable: 54-96% range	**54–96%**	**~ Fair**
Redistribution effectiveness	Timely, systematic	Active but reactive – not yet system-driven	**Partial**	**~ Fair**
Pharmacy staffing – general hospitals	≥80%	43% uniform — system-wide failure	**43%**	✗ **Inadequate**
Pharmacy staffing – Mbale RRH (best)	≥80%	57% (impacted by USAID stop-work)	**57%**	✗ **Inadequate**

PILLAR 4

HEALTH SUPPLY CHAIN PERFORMANCE

Goal: Enhance efficiency, reliability, and responsiveness of the pharmaceutical health supply chain at 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 FY 2024/25, no facility achieved the 95% target — rates ranged from 50% at Mulago NRH to 96% at Atutur GH. This systemic failure in delivery reliability is Uganda's most critical pharmaceutical health supply chain challenge.

Table 12: *Commodity Availability and Order Fill Rates (OFR) — FY 2024/25*

Region	No.	Facility	Availability Notes	OFR% NMS	Target	Lead Time	Delay
Kampala	**1**	Mulago NRH	Expiry rate reduced from 40% (2022) to 20% (2025). Stock-outs: Metformin, Insulin (Mar/Apr)	**50% (Mar–May)**	100%	25 days	**11 days**
Busoga	**2**	Jinja RRH	Major stock-outs: Pald, ALD, AZT/3TC, CD4 reagent, ORS, soluble insulin, salbutamol, RUTF	**70%**	100%	–	–
	3	Bugiri GH	–	**54%**	100%	–	–
Bukedi	**4**	Busolwe GH	–	**68%**	100%	–	–
Kigezi	**5**	Kisoro GH	–	**90%**	100%	–	–
	6	Kambuga GH	–	**78%**	100%	–	–
Teso	**7**	Atutur GH	Plan adjusted for fast-movers; overstock of Olanzapine, Omeprazole	**96%**	100%	**62 days (Cycle 6)**	**20 days**

Region	No.	Facility	Availability Notes	OFR% NMS	Target	Lead Time	Delay
			managed				
West Nile	**8**	Moyo GH	Previous years: severe shortages; oversupply issues from carry-forwards	–	100%	–	**28 days**
Acholi	**9**	Gulu RRH	Proactive stock reporting; procurement plan for FY25/26 developed	**63%**	100%	–	–
Lango	**10**	Lira RRH	–	**81%**	100%	–	–
Bugisu	**11**	Mbale RRH	eAFYA fully operational; all transactions digital; quarterly deliveries cause planning issues	**78%**	100%	–	**57 days**
	12	Bududa GH	Self-audit on 12 tracer medicines; eAFYA started	**54%**	100%	**43 days**	**20 days**
Bunyoro	**13**	Hoima RRH	TB 97%; EMHS 88%; ARVs 84%; Lab 81%. Undelivered: Gloves, Infusion sets, Haloperidol	**77%**	100%	**38 days**	–
	14	Kiryandongo GH	–	**84%**	100%	–	–
	15	Masindi GH	–	**93%**	100%	–	–
N. Central	**16**	Kayunga RRH	Avg availability 67% (improved from 65% June).	–	100%	**33 days**	**19 days**

Region	No.	Facility	Availability Notes	OFR% NMS	Target	Lead Time	Delay
			TB/ARV/RMNCAH better than LAB/EMHS				
	17	Kawolo GH	–	84%	100%	29 days	–
	18	Mubende RRH	Main output: redistribution	68%	100%	55 days	–

Table 12 analysis: *No facility achieved the ≥95% OFR target. Best: Atutur GH (96%), Masindi GH (93%), Kisoro GH (90%). Worst: Mulago NRH (50%), Bugiri GH (54%), Bududa GH (54%). Critical stockouts at Jinja RRH included ARVs, CD4 reagents, ORS, insulin, and RUTF — all life-sustaining. Lead times consistently exceeded 30 days: Mubende RRH (55d), Mbale RRH (57d), Atutur GH (62d Cycle 6). Extended lead times undermine predictive ordering and drive emergency procurement.*

5.2 Availability of Tracer Medicines — January to December 2025

Figure 5c presents the monthly tracer medicine availability rate nationally from January to December 2025. The data reveals a deeply concerning picture: availability hovered between 45.8% (June) and 56.8% (December) throughout the year — never once approaching the national target of ≥95%. The pattern shows two clear phases: a broadly flat first half (January-June) averaging approximately 48%, followed by a gradual improvement in the second half (July-December), where availability rose steadily from 53.1% to 56.8%. While the year-end upward trajectory is positive, the absolute levels remain unacceptably low — the December high of 56.8% means that, on average, fewer than 6 out of every 10 tracer medicines were available at health facilities when needed. This chronic under-availability has direct patient impact: essential medicines for HIV, malaria, TB, and non-communicable diseases are frequently absent, forcing patients to purchase medicines commercially or go without treatment. Closing the gap from the current ~57% to the 95% target requires simultaneous action on NMS order fill rates, delivery lead times, facility-level quantification quality, and redistribution responsiveness.

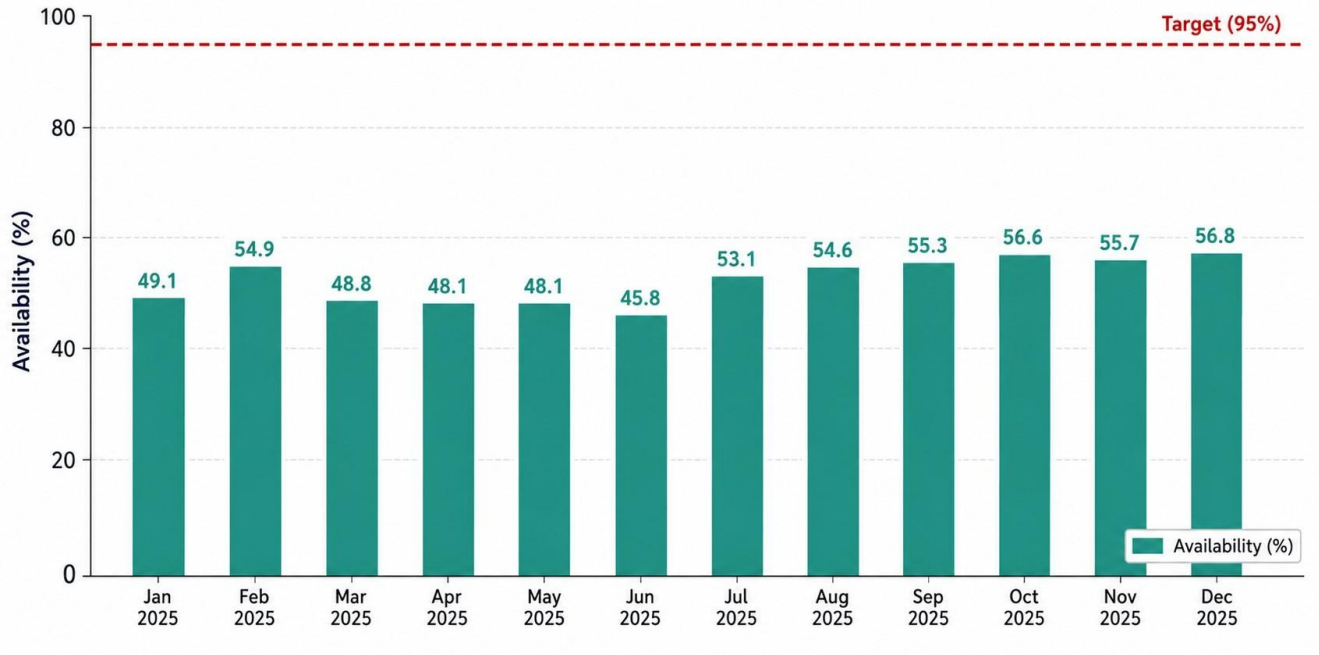
Tracer medicine availability is a sentinel measure of overall EMHS health supply chain performance, tracking whether key essential medicines are consistently in stock at facility level. The national target is ≥95% tracer medicine availability.

💊 Availability of Tracer Medicines — Key Findings 2025

Indicator	Target	Achieved	Rating	Performance
Average tracer medicine availability – Kayunga RRH region	≥95%	67% (slight improvement from 65% in June 2025)	67%	✗ Inadequate
TB commodities availability – Hoima RRH	≥95%	97%	97%	✦ Very Good

Indicator	Target	Achieved	Rating	Performance
Essential medicines (EMHS) availability — Hoima RRH	≥95%	88%	88%	✓ Good
ARV availability – Hoima RRH	≥95%	84%	84%	✓ Good
Laboratory items availability – Hoima RRH	≥95%	81%	81%	✓ Good
Overall district availability – Kitgum GH	≥95%	58%	58%	✗ Inadequate
Availability – TB/ARV/RMNCAH baskets (N. Central & Ankole)	≥95%	Better than LAB/EMHS baskets	Relative	~ Fair

Figure 5c: *Availability of Tracer Medicines — January to December 2025*



5.3 Availability of Tracer Medicines by Commodity Basket — 2025

Commodity baskets group medicines by programme type. Analysis by basket reveals that programmatic medicines (TB, ARVs, RMNCAH) consistently outperform general EMHS and laboratory baskets in terms of availability — reflecting stronger programme-specific funding, dedicated logistics support, and more robust vertical supply chains.

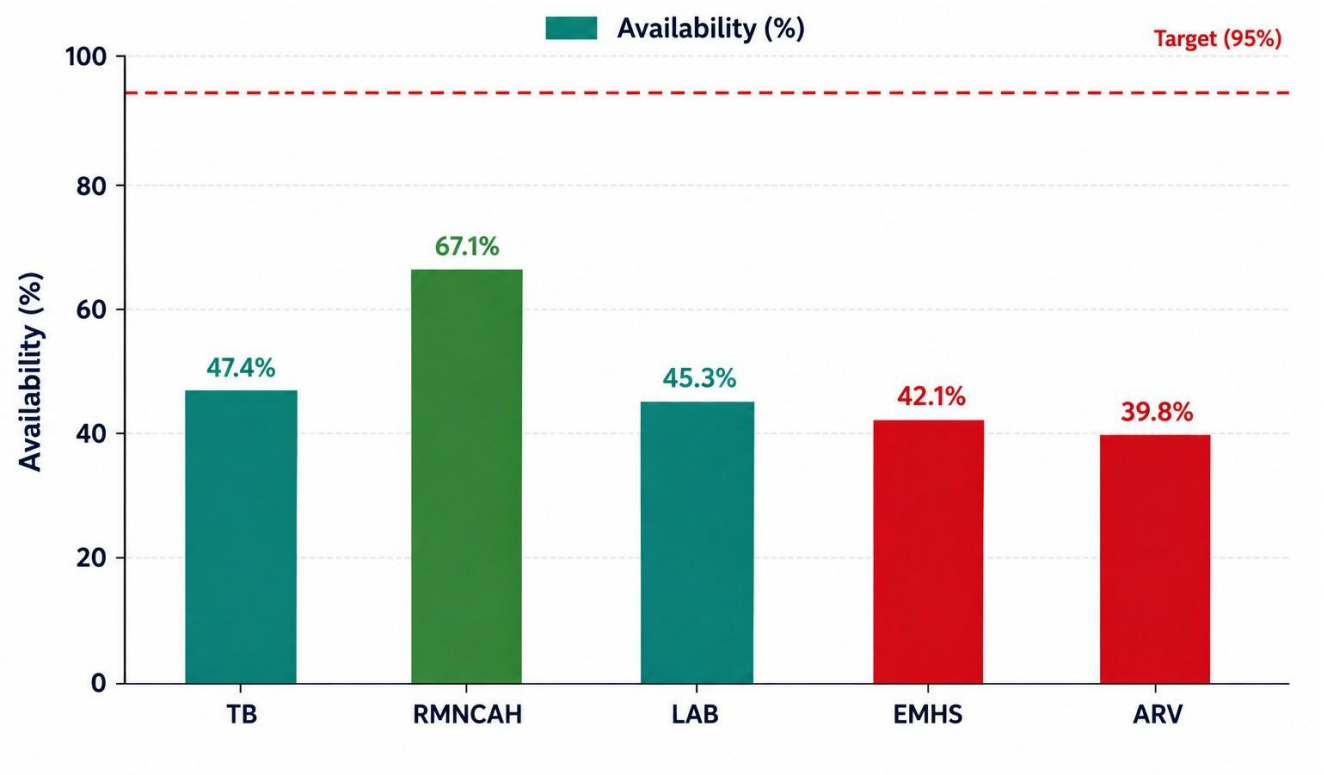
Commodity Basket	TB	ARVs	RMNCAH	EMHS / Lab
Hoima RRH	97% ✓	84% ✓	Included in	**88% EMHS / 81%**

Commodity Basket	TB	ARVs	RMNCAH	EMHS / Lab
performance			EMHS	**Lab**
North Central region (Kayunga RRH)	Fair availability	Fair availability	Fairly available	**Average 67% — below target**
Mbarara RRH (Ankole region)	More available	More available	More available	**Less available vs programme baskets**
Pattern nationally	Stronger	Stronger	Stronger	**Weaker — biggest gap to target**

The systematic outperformance of programme baskets relative to general EMHS and laboratory baskets reflects a structural imbalance in Uganda pharmaceutical health supply chain: programme-specific funding (Global Fund, PEPFAR/USAID historically, bilateral donors) creates parallel, better-resourced logistics channels for HIV, TB, and malaria, while the general EMHS basket depends on domestic funding that is routinely under-allocated. This pattern has important equity implications — patients presenting with conditions outside the funded programmes face greater risk of stock-outs.

Figure 5d: *Tracer Medicine Availability by Commodity Basket — 2025*

Figure 5d disaggregates annual tracer medicine availability by five commodity baskets: TB (47.4%), RMNCAH (67.1%), LAB (45.3%), EMHS (42.1%), and ARV (39.8%). RMNCAH commodities achieved the highest average availability at 67.1%, reflecting the combined effect of stronger programme-specific funding and dedicated logistics support for reproductive health and child health programmes. TB at 47.4% and LAB at 45.3% sit in the middle range, while EMHS (general medicines) at 42.1% and ARVs at 39.8% recorded the lowest availability nationally — a particularly alarming finding given that ARVs are life-sustaining medications for Uganda's large HIV-positive population. The figure confirms that programme-specific baskets (funded by Global Fund, bilateral donors, PEPFAR) consistently outperform the general EMHS basket, which relies predominantly on domestic government funding that is routinely under-allocated. This structural imbalance means patients with conditions outside the vertically funded programmes — those requiring general medicines, laboratory diagnostics, or ARV continuity — face the greatest risk of stock-outs. Addressing this equity gap requires increased domestic EMHS budget allocation and stronger integration of general medicine supply chains with programme-specific logistics systems.



5.4 Facility Stock Status — January to December 2025

Facility stock status reflects the day-to-day stock position of medicines across care levels. Key stock status findings from facility-level reporting in 2025 revealed three concurrent challenges: chronic stockouts of specific essential medicines despite budget availability; over-stocking of certain items leading to expiry risk; and untracked redistributions that distort apparent stock levels.

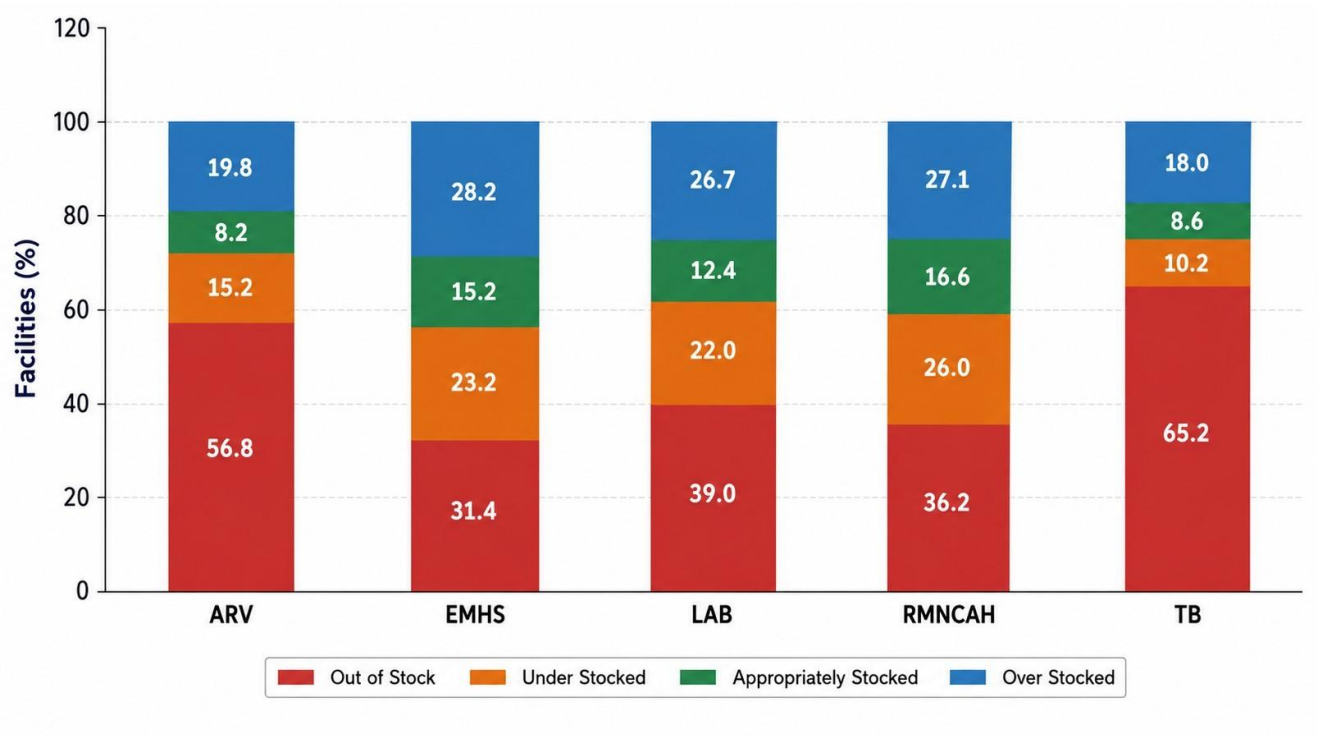
Facility	Stock-outs Reported	Over-stocked Items	Actions Taken
Jinja RRH	Pald, ALD, AZT/3TC, CD4 reagent, mRDT, ORS, Captopril, CPZ, Fluoxetine, soluble insulin, salbutamol inhaler, RUTF	–	Needs assessment and procurement plan for FY25/26 developed; emergency orders placed
Hoima RRH	Gloves, Infusion sets, Haloperidol, Cannula, ABC/3TC 120/60mg, DTG 10mg	Diazepam, Atenolol, Nitrofurantoin, Furosemide, Thiopental, Morphine, Hydrocortisone Inj, Nystatin, Silver Sulfadiazine	Working to redistribute to other districts; adjusting procurement plan quantities
Atutur GH	Olanzapine, Omeprazole (overstocked and	Overstocked fast-moving items ordered	Supplementary orders for understocked fast-movers; letter to NMS

Facility	Stock-outs Reported	Over-stocked Items	Actions Taken
	adjusted)		GM for plan adjustment
Mulago NRH	Metformin, Insulin (Mar/Apr)	Minimal (3 items expired in store last FY)	FEFO/FIFO monitoring; redistribution; eAFYA computerisation ongoing
Lyantonde GH	CTX 960mg (3 cycles); Metronidazole 500/100ml infusion (non-delivery)	–	Expired items registered and segregated for NMS disposal
Kitgum GH	Anti-TB commodities accumulated (plenty); critical items stockout	Excess Anti-TB by end of Q4	WhatsApp group created for redistribution coordination; MoH support requested
Buwenge GH	ABC/3TC/DTG paed; Efavirenz 200mg	–	Local liquid soap production to address IPC stock-out; EMR enrolment at user points

Facility Stock Status note: *The simultaneous occurrence of stockouts and overstocking at the same facilities reflects inadequate quantification and forecasting linked to low data quality (HMIS), inadequate use of consumption-based ordering, and delayed or irregular NMS deliveries that disrupt planned stock levels. Addressing this requires both improved demand forecasting (using HMIS data) and faster, more reliable NMS delivery cycles.*

Figure 5e: *Facility Stock Status by Commodity Basket — 2025*

Figure 5e presents facility stock status disaggregated by commodity basket for 2025, showing the proportion of facilities in each of four stock states: Out of Stock (red), Under Stocked (orange), Appropriately Stocked (green), and Over Stocked (blue). The findings are alarming across all five baskets. ARV commodities had the worst stock position, with 56.8% of facilities out of stock — meaning that over half of all health facilities in Uganda did not have the required ARV tracers available at any given point during 2025. TB commodities were also critically affected at 65.2% out of stock. EMHS (31.4%), LAB (39.0%), and RMNCAH (36.2%) showed somewhat better but still unacceptable out-of-stock rates. The proportion of appropriately stocked facilities was low across all baskets — just 8.2% for ARVs, 15.2% for EMHS, and 12.4% for LAB. Notably, a significant proportion of facilities were over-stocked (19.8% for ARVs, 28.2% for EMHS, 26.7% for LAB), indicating that the problem is not simply a national supply shortage but a maldistribution: some facilities have excess while others face stockouts. This points to the critical importance of proactive redistribution systems — which NPECAF-supported facilities like Kayunga RRH, Jinja RRH, and Busolwe GH have demonstrated can effectively prevent stockouts when coordination mechanisms are functional.



5.5 Regional Health Supply Chain TWG Performance

All 19 Regional TWG sessions tracked in 2025 were held — 100% meeting performance. TWG discussions were notably actionable, covering EMR-CSSP integration, eLMIS adoption, redistribution protocols, AMS, HR advocacy, and expired medicine management.

Figure 2: *TWG Meeting Performance Trend (May–September 2025)*

Figure 2 charts the Regional Pharmaceutical TWG meeting performance trend across the five-month period from May to September 2025, expressed as the percentage of scheduled TWG meetings that were actually held. The trend reveals a sharp and sustained downward trajectory: performance started at 65% in May 2025, fell progressively through June (53%) and July (41%), continued declining in August (29%), and collapsed to just 11% in September 2025 — the lowest single-month performance recorded in the reporting year. The red annotation "Concerning downward trend" reflects the severity of this decline. In practical terms, by September only 2 of 17 tracked regional TWG meetings were held. This collapse was not a random fluctuation but reflects a convergence of structural challenges: scheduling conflicts with regional performance review workshops, lack of Zoom meeting links and ICT infrastructure in several regions, staff downsizing reducing available coordinators, and lack of quorum at facilities like Moroto (Karamoja). The September data triggered urgent NPECAF intervention, with the forum directly reviewing each region's barriers — as captured in Figure 3 (status detail) and Figure 4 (reasons for non-performance). The recovery of TWG performance in Q4 2025 reflects the direct impact of NPECAF accountability mechanisms on regional coordination.

Figure 3: *TWG Meeting Status — September 2025*

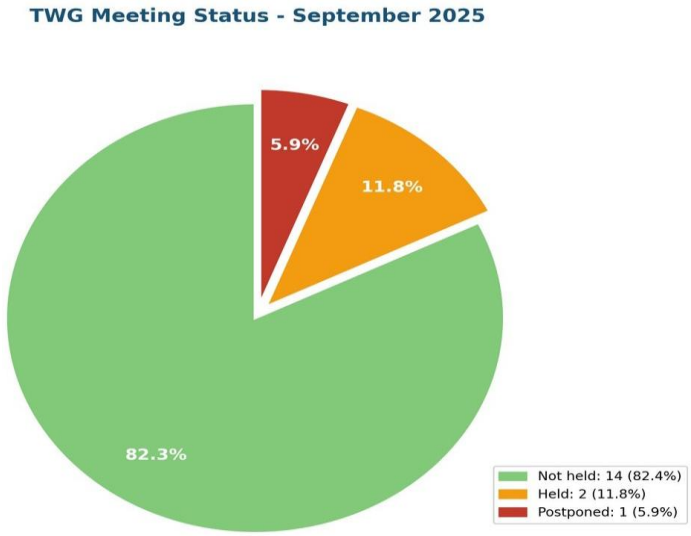


Figure 4a: *Regional TWG Meeting Status Detail — September 2025*

Figure 4a provides the full region-by-region breakdown of Regional Pharmaceutical TWG meeting status for September 2025. Of 17 tracked regions, only Arua (West Nile) and Hoima (Bunyoro) held their meetings as planned, while Kampala's meeting was postponed to 1st October 2025. The remaining 14 regions did not hold their meetings due to a variety of overlapping barriers. The most common reasons were: scheduling conflicts with other regional events (Gulu coinciding with the Pharmacy AGM; Lira with the Regional Performance Review Workshop; Mubende with another Regional Performance Review); technical failures (Zoom link not created on time at Masaka, Entebbe, and Yumbe; meeting link not shared at Kabale); and capacity constraints at Mbarara (downsizing of active staff) and Mbale (still building a comprehensive team). Moroto (Karamoja) failed due to lack of quorum. Kayunga (North Central) was unable to convene due to coinciding support supervision activities. The diversity of failure modes indicates that the TWG non-performance crisis is not attributable to a single cause but to systemic fragility across coordination, technology, staffing, and scheduling – all of which require structural, not just operational, responses in 2026.

Regional TWG Meeting Status — September 2025

Held | Postponed | Not Held

Region	Status	Reason for Non-Performance/Delay	Additional Notes
Gulu (Acholi)	Not held	Coincided with Pharmacy AGM	Meetings scheduled last Thursday of the month
Lira (Lango)	Not held	Coincided with Regional Performance Review Workshop	Regular schedule maintained
Moroto (Karamoja)	Not held	Lack of quorum	Scheduled 1st Tuesday of every month
Arua (West Nile)	Held	Documents for analysis not yet submitted	Follow-up required
Masaka (S. Buganda)	Not held	Zoom link not created	Links to be created moving forward
Mubende (Bunyoro)	Not held	Coincided with Regional Performance Review	Regular schedule last Tuesday of the month
Mbarara (Ankole)	Not held	Downsizing of active staff	Capacity gaps noted
Mbale (Bugisu)	Not held	Still setting up a comprehensive team	Needs structural support
Jinja (Busoga)	Not held	Conflicting activities	Rescheduling required
Hoima (Bunyoro)	Held	Documents for analysis not yet submitted	Pending follow-up
Entebbe (Wakiso)	Not held	No Zoom link	ICT support required
Fort Portal (Tooro)	Not held	Not scheduled	Strengthen planning
Yumbe (West Nile)	Not held	Meeting link not created in time	Assign responsible focal point
Kabale (Kigezi)	Not held	Downsizing of members & lack of meeting link	Links to be availed moving forward
Kampala	Postponed	Rescheduled to 1st October 2025	To be followed up in October
Kayunga (N. Central)	Not held	Coincided with support supervision	Reschedule to avoid conflicts
Soroti (Teso)	Not held	Conflicting activities	Scheduled for every last Tuesday of the month

Figure 4b: *Reasons for TWG Meeting Non-Performance*

Figure 4b aggregates and ranks the reasons for TWG meeting non-performance across all regions in September 2025. Scheduling conflicts were the leading cause, affecting 6 regions — where TWG meetings clashed with regional pharmacy annual general meetings, performance review workshops, or other concurrent MoH activities, illustrating the need for better national calendar coordination. "Other" reasons and technical issues each affected 4 regions: technical issues primarily comprised the absence of Zoom meeting links or ICT support failures that prevented virtual convening. Capacity constraints (2 regions) reflect the downsizing or structural gaps in regional pharmacy teams, while lack of quorum (1 region) indicates attendance challenges even when meetings were scheduled. Taken together, these five categories reveal that TWG non-performance in 2025 was driven by a combination of calendar management failures (preventable through better advance planning), technology gaps (addressable through dedicated ICT support and standing Zoom links per region), and human resource constraints (requiring longer-term structural investment). The recommendations flowing from this analysis include: establishing a permanent national TWG calendar, providing standing virtual meeting infrastructure for all 15 regional TWGs, and designating a dedicated TWG coordination focal person at each Regional Referral Hospital.

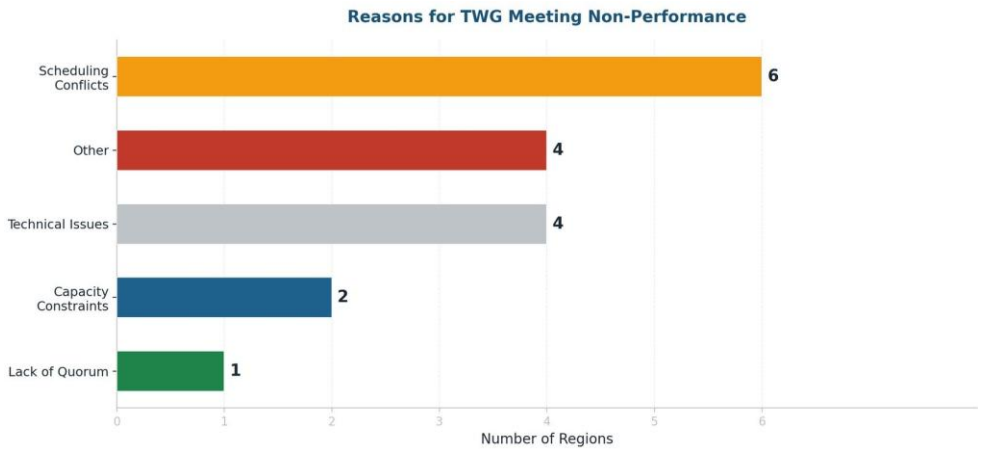


Table 13: *Regional Pharmaceutical TWG Performance — May–December 2025 (All Sessions)*

No.	Region (Lead Facility)	Date	Held	Key Action Points
1	North Buganda — Mubende RRH	15 May	✓	UCGs distributed; CME on rational medicines; AMR sub-committee to implement AWaRe classification
2	Kigezi	15 May	✓	NMS ordering support; Good Storage Practices guidance; redistribution of short expiries; documentation tool training
3	Lango	26 June	✓	ADR forms into EMR; HCW PV training; PV support supervision to lower HFs
4	Kampala — Mulago NRH	12 June	✓	Sample collection procedures disseminated; lab results interpretation training; antibiogram disseminated; C&S enforced before reserve antibiotics
5	N. Central — Kayunga RRH	19 June	✓	Ceftriaxone/Sulbactam to NMS formulary; interns to Mukono GH; inter-district dispenser transfers
6	N. Central — Kayunga RRH	11 September	✓	Avg availability 67%; TB/ARV/RMNCAH better than LAB/EMHS; 78.4% facilities submitted Section 6 data
7	Bunyoro — Hoima RRH	26 June & 30 Oct	✓	Routine SC & digital tool training; medication error system to be set up; MTC functionality strengthened; standard storage construction requested
8	Bunyoro —	30	✓	Injectables through inpatient pharmacy; 24-hour

No.	Region (Lead Facility)	Date	Held	Key Action Points
	Kiryandongo GH	October		pharmacy; unused drug retrieval; IEM list development
9	Acholi — Lira RRH	19 June	✓	Orient teams on OFSSR dashboard; resume SC TWG meetings; integrate EMRs with NMS CSSP; reinstate order status sharing
10	Bugisu — Mbale RRH	3 July	✓	Promote eLMIS data use; MoH to support reinstatement of PIP
11	Busoga	3 July	✓	Continuous SC mentorship; mTrac RASS Monday reporting; data-driven planning; timely expiry communication to DHO
12	Teso — Atutur GH	–	✓	Fully utilise EMR for drug ordering; continue redistribution of overstocked items; finalise PPS
13	Teso — Katakwi GH	–	✓	Supplementary order placed for unspent funds; continued OFR analysis
14	West Nile	6 March	✓	Computer use training; EMR practice; attitude change toward digitalisation
15	West Nile — Yumbe	24 July	✓	Clinic Master network issues; OFSSR dashboard access problems; anti-snake bite serum shortage; CSSP order retrieval failure
16	West Nile — Kitgum GH	7 August	✓	20 UCG 2023 copies to be procured; MoH to provide expiry register; MoH to support expired medicine transport; recruitment of dispensers
17	Acholi — Anaka GH	8 January	✓	Data-driven quantification; stock management training; staff allocation for SC; MTC member transfer policy
18	S. Buganda — Entebbe RRH	30 October	✓	EMHS budget advocacy; PV data training; IPC staff training; IPC commodity redistribution
19	Bugisu — Bududa GH	3 July	✓	Self-audit on 12 tracer medicines completed

5.6 Pillar 4: Health Supply Chain Performance — Indicator Summary

Indicator	Target	Achieved	Rating	Performance
Order Fill Rate (OFR)	≥95%	50-96% range; no facility met target	**50–96%**	✗ **Inadequate**
Avg delivery lead time	≤30 days	Most >30d; Mubende 55d, Mbale 57d, Atutur 62d	**30–62 days**	✗ **Inadequate**
Delivery delays	0 days	11-28 day delays common	**11–28 days**	✗ **Inadequate**
HMIS Section 6 completeness	100%	68.6% complete; 78.4% submitted ≥1 point	**69%**	✗ **Inadequate**
Regional TWG meetings held	100% (19)	100% (19/19) held	**100%**	★ **Excellent**
eAFYA/eLMIS adoption	Expanding	Fully operational at Mbale RRH; starting at others	**Partial**	~ **Fair**
RASS reporting – Bunyoro region	100%	Mid-90s; peaked 96% in W25	**~94%**	✦ **Very Good**
Expiry management – Mulago NRH	0%	Reduced from 40% (2022) to 20% (2025)	**20%**	✗ **Inadequate**

6. CROSS-CUTTING CHALLENGES AND ENABLERS

6.1 System-Wide Challenges

No.	Challenge	Detail	Pillars	Severity
1	**Pharmacy Staffing Crisis**	All GHs at 43% staffing; 57% vacant. USAID stop-work at Mbale.	1,2,3,4	Critical
2	**Low NMS OFR**	50-96% range; target ≥95%. No facility met target. Critical stockouts: ARVs, insulin, ORS, RUTF, salbutamol at Jinja RRH.	3,4	Critical
3	**Extended Lead Times**	30-62 days; target ≤30d. Forces emergency procurement, increases costs, reduces planning.	4	Critical
4	**No Vigiflow**	No facility has a Vigiflow institutional account. ADR	2	High

No.	Challenge	Detail	Pillars	Severity
	Accounts	digital reporting impossible.		
5	**Incomplete EMR–CSSP Integration**	eAFYA not linked to CSSP. Facilities cannot access their own submitted orders. Two outstanding actions.	1,4	High
6	**Weak AMS Guideline Adherence**	No region above 70%. Empirical prescribing dominates. Near-zero C&S at most facilities.	2	High
7	**Inadequate H IS Completeness**	Section 6 completion ~69%. HMIS 105-6 very low system-wide. Undermines monitoring.	2	High
8	**Inadequate MTC Budgets**	No dedicated budget line at most facilities. Sub-committees starved of operational resources.	2	Moderate
9	**Staff Transfer Disruption**	MTC chairs and key officers transferred without replacement, disrupting committees.	2,4	Moderate
10	**Storage Constraints**	Inadequate pharmacy storage at Mulago NRH, Naguru, and others. Cycle deliveries cannot be accommodated.	3,4	Moderate

6.2 Key Enablers of Progress

No.	Enabler	Evidence and Impact	Pillar(s)
1	**Strong DPNM/MoH Leadership**	Consistent chairpersonship by Commissioner sustained meeting momentum and drove accountability on action points.	1,2,3,4
2	**Structured Reporting (April 2025)**	Standardised presentation format transformed forum quality; enabled comparative performance tracking nationally.	1,2
3	**Multi-Stakeholder Representation**	NMS, NDA, partners, and all care levels created a holistic accountability ecosystem.	1

No.	Enabler	Evidence and Impact	Pillar(s)
4	Proactive Redistribution Networks	Kayunga RRH and Jinja RRH demonstrate model redistribution systems preventing stockouts across regions.	3,4
5	Digital Health Supply Chain Adoption	Mbale RRH full eAFYA digitalisation shows the system's transformative potential.	4
6	Facility-Level Leadership	Tororo GH, Busolwe GH (mentors), Bududa GH (expiry 10%→0.6%) showed committed local leadership overcoming resource constraints.	2,3
7	Antibiogram Development (93% RRHs)	14/15 RRHs developed antibiograms — the AMR surveillance foundation for evidence-based prescribing.	2
8	Average Regional TWG Performance	Most of the tracked TWG sessions held – maintaining regional coordination and accountability year-round.	1,4
9	Community of Practice	NPECAF created a national pharmaceutical practitioners' community sharing best practices and co-developing solutions.	1,2

7. RECOMMENDATIONS

Based on full-year performance analysis across all four pillars, the following 15 evidence-based recommendations are presented, prioritised by urgency and categorised by responsible actor.

No.	Pillar	Recommendation	Lead Actor	Priority
1	Staffing	Urgently recruit and fill all vacant pharmacy positions at GHs and RRHs. 57% vacancy is a national emergency.	MoH HR / MoPS	Immediate
2	Staffing	Expedite all pending pharmacy staff promotions. Look into possible promotions at Mulago NRH, Kapchorwa GH, and others.	MoH HR	Immediate
3	Supply Chain	Negotiate binding NMS OFR improvement targets with quarterly performance reviews and consequences for persistent underperformance.	MoH / NMS	Immediate
4	Supply Chain	Establish ≤30 day delivery lead time as an NMS standard.	MoH / NMS	Q4 FY 2025/2026
5	Digital	Formally introduce eAFYA team to NMS and conclude EMR-CSSP integration as a MoH priority project.	DPNM / DHI	FY 2026/27
6	Digital	Enable all facilities to access submitted CSSP orders. Prioritise in the next CSSP system upgrade.	NMS	FY 2026/27
7	AMS	Intensify AMS interventions in Busoga, North Buganda, Kampala, and Bukedi regions where H2 2025 AB encounter exceeded 85%.	DPNM / RRHs	FY 2026/27
8	AMS	Equip all RRH and GH laboratories with minimum C&S equipment (incubators, autoclaves, culture plates).	MoH / Partners	FY 2026/27
9	PV	Establish Vigiflow institutional accounts for all RRHs and Mulago NRH. Complete user training within Q4 FY2025/2026.	NDA / DPNM	FY 2026/27
10	PV	Integrate ADR reporting fields into EMR systems (eAFYA). Pilot at Lira RRH and Jinja RRH.	DPNM / IT	FY 2026/27
11	MTC	Establish a dedicated MTC budget line in all	MoH / Facility	FY 2026/27

No.	Pillar	Recommendation	Lead Actor	Priority
		health facility annual work plans.	Mgt	
12	MTC	Implement a formal policy preventing transfer of MTC committee chairs without prior handover and replacement appointment.	MoH / Facility Management	FY 2026/27
13	Governance	Scale NPECAF structured presentation model to District-level quarterly satellite forums.	DPNM / DHOs	FY 2026/27
14	Data	Mandate 70% HMIS Section 6 completion as a quarterly KPI with non-compliance escalated through NPECAF.	DPNM / DHI	FY 2026/27
15	Storage	Approve storage expansion at Mulago NRH, Naguru Hospital, and five most congested regional pharmacies. Include in national capital budget.	MoH / Finance	FY 2026/27

8. CONCLUSION

The National Pharmaceuticals and Essential Commodities Accountability Forum (NPECAF) completed a landmark first full calendar year in 2025, establishing itself as an indispensable platform for pharmaceutical accountability in Uganda's health system. Across 39 weekly meetings, 15 regional TWG sessions, and sustained engagement from 39+ facilities in all 15 regions, NPECAF demonstrated that structured multi-stakeholder accountability can generate measurable changes in governance, transparency, and health supply chain behaviour.

The year's most significant achievements included: 89% EMHS budget utilisation nationally; 93% of RRHs developing antibiograms; 100% generic prescribing across all 15 regions; active redistribution networks preventing stockouts at critical facilities; and introduction of standardised performance reporting enabling national-level comparative analysis for the first time.

However, the report is equally candid about critical gaps. A structural pharmacy staffing crisis (43% at all GHs), persistent NMS OFR below 95% at every facility, antibiotic encounter rates as high as 99% in Busoga, near-universal absence of Vigiflow accounts, and very low HMIS reporting completeness represent the priority challenges requiring urgent national-level action.

NPECAF's role in surfacing these challenges, creating accountability for resolution, and sustaining a national community of pharmaceutical practice is demonstrated and validated by this annual report. The Forum's credibility now depends on the conversion of its performance evidence into concrete policy and resource decisions — particularly on staffing, digital integration, NMS OFR performance standards, and laboratory capacity.

✅ NPECAF's Core Value Proposition

NPECAF has proven that regular, structured accountability forums generate data-driven decisions, inter-facility learning, and measurable progress in pharmaceutical stewardship — even in resource-constrained environments. Every shilling invested generates returns in reduced expiries, improved redistribution, better prescribing, and stronger governance. The 2026 agenda must deepen this impact by closing the gaps this report has identified with urgency and resolve.

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APPENDICES

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

The table below outlines the schedule of presentations for each region, including the presenting facilities and their respective presentation dates.

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 II: Contact Persons for the Different Regions

The table below lists the lead and deputy lead persons responsible for each region and subregion, serving as the primary contact points for NPECAF coordination.

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

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