THE REPUBLIC OF UGANDA
MINISTRY OF HEALTH

BASELINE ASSESSMENT OF DISTRICT HEALTH SYSTEMS CAPACITY: USE OF THE DHSS PROGRESSION MODEL

MAKERERE UNIVERSITY
School of Public Health (MakSPH)

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ABBREVIATIONS

ANC	Antenatal Care
ART	Antiretroviral Therapy
CHWs	Community Health Workers
DHIS2	District Health Information System 2
DHSS	District Health System Strengthening
DHT	District Health Team
DLG	District Local Government
DLT	District League Table
HC	Health Centre
HFA	Health Facility Assessment
HFQAP	Health Facility Quality Assurance Program
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRIS	Human Resource Information Software
HSD	Health Sub-District
HSS	Health System Strengthening
HUMC	Health Unit Management Committee
ICCM	Integrated Community Case Management of Childhood Illnesses
ITC	Inpatient Therapeutic Care
M&E	Monitoring and Evaluation
MoH	Ministry of Health
QoC	Quality of Care
RDT	Rapid Diagnostic Test
SAM	Severe Acute Malnutrition
SARA	Service Availability and Readiness Assessment
SDG	Sustainable Development Goal
UNICEF	United Nations International Children's Emergency Fund
VHT	Village Health Team
WHO	World Health Organization

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The District Health System Strengthening (DHSS) Progression Model was developed through a highly consultative and participatory process involving key stakeholders including the Ministry of Health (MoH), United Nations Children's Fund (UNICEF), UNICEF East and Southern Africa Regional Office, World Food Program (WFP), the UK Department for International Development (DFID), IntraHealth, AVSI, Baylor Uganda and Makerere University School of Public Health. A series of stakeholder meetings were held to review and approve the model.

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EXECUTIVE SUMMARY

Background: UNICEF in Uganda is making significant investments in health system strengthening at all levels of the health care system. The strategy targets national, sub-national, and community levels of the health system with inter-related systems strengthening interventions. To be able to link health system strengthening inputs to outcomes (coverage) and impact of its interventions, UNICEF Uganda designed a Monitoring and Evaluation (M&E) framework based on the progression model for measuring the capacity of health systems using a set of indicators.

Objectives: The overall objective of the baseline assessment was to determine the capacity of the district health systems by establishing a benchmark with respect to the national and international standards upon which improvement interventions will be based. Specifically, the assessment sought to (i) document the implementation of the DHSS progression model to measure district health system capacity; (ii) obtain baseline capacities of the district health systems upon which interventions for improvement will be based; and (iii) test the assumptions that the progression model is linear, that precision targeting is possible and that capacity strengthening is directly linked to system performance.

Methods: The baseline assessment was conducted in 32 districts across five sub regions: Karamoja (9 districts); West Nile (11 districts); northern (2); east central (4 districts); and mid-western (6 districts). A cross-sectional design that involved quantitative data collection using the district health system strengthening progression model assessment tool was adopted. Data collection was based on a retrospective review of data from national health management information systems and surveys and conducting interviews with members of the district health teams. In each district, the electronic tool was administered by at least two program persons with good knowledge and understanding of district health systems. Measures were based on the six WHO health system strengthening components: (i) leadership and governance, (ii) access to essential medicines, (ii) health management information systems, (iv) health work force, (v) health financing, and (vi) service delivery. For each component, the automated tool generated scores with colour codes of dark green (>90%) for Level 4 progression (surpasses basic expectations), light green (70%-90%) for Level 3 (meets basic expectations), yellow (50%-70%) for Level 2 (needs improvement), and red (<50%) for Level 1 progression (needs urgent attention). The findings of the assessment were shared with the district health team members and action plans for addressing the identified gaps were jointly developed.

Results: The model was successfully implemented across the 32 districts. The overall mean percent score for all the districts was 63.0% (Level 2 of progression). None of the districts attained the highest level (Level 4) of progression. Only 25.0% of the districts attained Level 3 of progression, the majority 65.6% attained Level 2 and very few (9.4%) of the districts attained Level 1 of progression. Overall, the health information systems domain registered the highest score of 71.6% (Level 3). Access to essential medicines and health workforce domains registered the lowest scores of 50.9% and 57.0% (Level 2), respectively. The low level of health system capacity is attributable to gaps that cut across all the health system components. These include weak DHT organization capacity, lack of key policy documents and guidelines, inadequate access to essential medicines, commodities, basic equipment and amenities, insufficient data synthesis and use, weak human resource and community health information systems, inadequate health worker availability, non-functional community health structures, delayed remittance of primary health care funds, non-responsiveness of the health care system and low uptake of maternal health services.

Conclusions and Recommendations

- The progression model is an important and user-friendly tool for measuring capacity of district health systems in a linear fashion and for guiding accurate targeting for capacity enhancement interventions.
- None of the districts achieved the highest level of health system capacity progression.
- The low level of health system capacity is attributable to gaps that cut across all the health system components which include weak DHT organization capacity, lack of key policy documents and guidelines, inadequate access to essential medicines, commodities, basic equipment and amenities, insufficient data synthesis and use, weak human resource and community health information systems, inadequate health worker availability, mal-functional community health structures, delayed remittance of primary health care funds to the districts, client dissatisfaction with health services, and low uptake of maternal and child health services.
- The lowest levels of progression were observed in the access to essential medicines and health workforce domains of health systems.
- There is a need to revise the assessment tool to capture each of the standards as an independent entity. This will help to identify the most important specific areas that require urgent attention and inform timely and targeted interventions.

Programmatic Implications

- UNICEF and partners should support the districts to institutionalize the progression model for periodic monitoring and evaluation of district health system strengthening efforts
- There is need to develop a comprehensive capacity building plan that targets health system components with low levels of progression. This will require close collaboration between the Ministry of Health, UNICEF, PCA partners, implementing partners, and the district local governments. While there are huge capacity needs that would require further prioritization, a potential approach would be to focus on a few key issues under each of the intervention packages.
- Reinforcing good clinical and client-centred approaches as well as good data management and use practices through training, mentorship and support supervision of health service providers will be an important practical approach for improving the quality and uptake of health services.

Recommendation for Future Research

- There is need for further research to corroborate the assumption that health system capacity can be linked to improved health outcomes. This will include performing a detailed sensitivity analysis to determine the most important health system components for achieving the desired outcome.

1.0 BACKGROUND

UNICEF defines Health System Strengthening (HSS) as "actions that establish sustained improvements in the provision, utilization, quality, and efficiency of services, including both preventive and curative care, as well as the resilience of the health system. There is increasing evidence that health systems, which can deliver services equitably and efficiently are critical for achieving improved health status. However, in the absence of a sound monitoring strategy that enables decision-makers to accurately track systems capacity development, systems performance and evaluate impact, and ensure accountability at national and sub-national levels, efforts to strengthen health systems would not be sustainable. There is need to develop a monitoring and evaluation framework for regularly measuring health systems strengthening performance.

1.1 A Framework for Monitoring and Evaluation of Health System Strengthening (HSS)

A framework for M&E of HSS consists of four major indicator domains: (i) system inputs and processes, (ii) outputs, (iii) outcomes, and (v) impact. System inputs, processes and outputs reflect health systems capacity. Outcomes and impact are the results of investments and reflect health systems performance [1] (Figure 1)

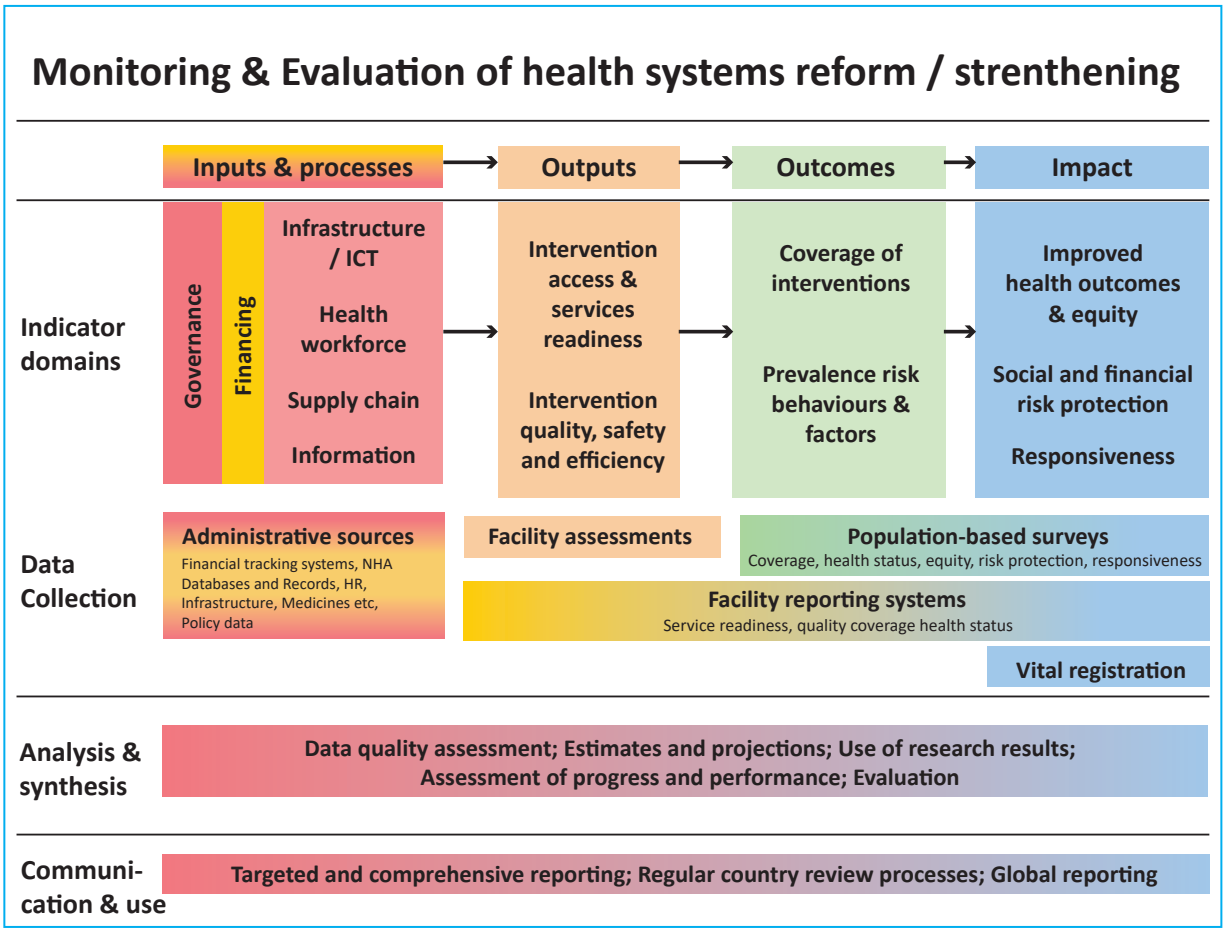


Figure 1. M&E framework for HSS

Monitoring of health system performance needs to show how inputs to the system (resources, infrastructure etc.) are reflected in outputs (such as availability of services and interventions) and eventual outcomes and impact including use of services and better health status. This results chain framework can be used to demonstrate performance of health systems and disease-specific interventions. The framework addresses the importance of dissemination, communication and use of the monitoring and evaluation results to inform policy making and programmatic decisions at all levels.

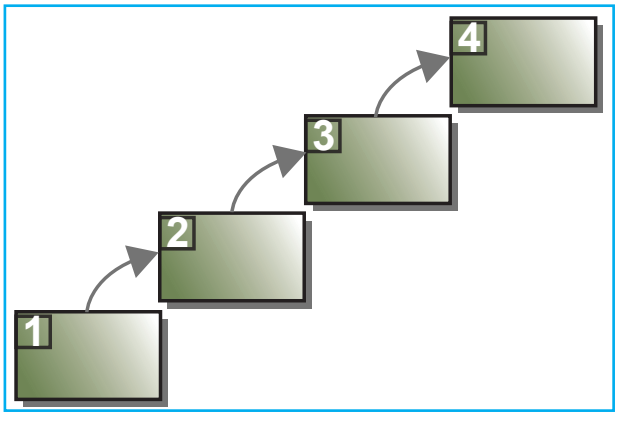
1.2 Background to UNICEF HSS Efforts

UNICEF Uganda is making substantial investments in Health System Strengthening (HSS) at all levels of the health care system. UNICEF's HSS strategy targets national, sub-national, and community levels of the health system with inter-related systems strengthening interventions. At the national level, UNICEF supports the Ministry of Health (MoH) to develop equity-focused health policies, strategies, and plans. At district level, UNICEF supports enhanced management capacity for evidence-based planning and monitoring while at community-level, it supports strengthening of community platforms as well as the integration of the platforms into the sub-national health systems. In addition, UNICEF supports MoH to strengthen information systems; procurement and supply chains; social protection and welfare; engagement of the private sector and quality of care at community and facility-levels

UNICEF Uganda developed a District Health Systems Strengthening (DHSS) approach, which aims to strengthen the capacity of District Health Management Teams (DHT) to manage the delivery of health services at the decentralized level. This includes enhancing capacity of the DHT to use data for evidence-based decision making and supporting the development and use of robust health information systems such as DHIS2 and mTrac. Further, UNICEF has supported the institutionalization of data use applications such as the scorecard, bottleneck and causality analysis applications which help to identify bottlenecks to service delivery. The application of these tools informs resource allocation for priority interventions by the DHT and programme managers. The need for information to track how health systems respond to increased inputs and improved processes, and the impact they have on improved health outcomes necessitated the development of core indicators and tools for measuring health system capacity.

1.3 Health System Strengthening Monitoring and Evaluation Framework

UNICEF Uganda designed a monitoring and evaluation framework for linking health system strengthening inputs to outcomes and impact of its interventions. The framework is premised on the theory of change, which makes the assumption that if data is available to support evidence based decision making, and that if financial and human resources are available to overcome the bottlenecks and if there is motivation, willingness, and skills to use data for decision making and if there is capacity and motivation to demand accountability from governance structures both at the community and district level, then bottlenecks to implementation of high quality interventions will be resolved, resulting into improved coverage of quality interventions and improved health outcomes [2].



The M&E framework draws on the progression model, which is a recognized tool for measuring improvements in health systems based on a set of indicators. The model is a recognized tool for stepwise and systematic development

and is used to identify the gaps between actual and desired states as well as to demonstrate an evolutionary path to achieve the improvement from a desired to an actual state. The model helps to assess the progression such as capacity and competency of a selected domain based on a set of criteria. Progression is evaluated on a four-point Likert scale with '1' representing the lowest level and '4' representing the highest level of progression [3]. The main purpose of the M&E framework is to provide information for tracking system capacity development given inputs by UNICEF and other partners working at the decentralised level. The framework augments UNICEF's support to the Ministry of Health's evidence-based planning using the Bottleneck Analysis approach, which supports diagnosis of system performance issues.

1.4 Scope of the HSS M&E Matrix

The M&E matrix covers all the six building blocks (domains) of health systems strengthening: (i) leadership and governance, (ii) access to essential medicines, (ii) health management information systems, (iv) health work force, (v) health financing, and (vi) service delivery. These are assessed at district level. Each HSS building block is divided into different subdomains: Leadership and Governance (8 subdomains); Access to Essential Medicines (6 subdomains); Health Information Systems (5 subdomains); Health Workforce (3 subdomains); Health Financing (2 subdomains); and Service Delivery (9 subdomains), making a total of 33 subdomains. Under each subdomain, there are key indicators along the progression continuum.

1.4.1 Value Addition to the Existing Health System Capacity Assessment Methodologies

Whereas the other existing health system capacity assessment methodologies such as the Health Facility Quality Assurance Program (HFQAP) [4] and the Service Availability and Readiness Assessment (SARA) [5] provide general information on the functionality and quality of care provided at health facilities, the HSS M&E matrix provides a comprehensive picture on the health system capacity at both the district and health facility level. More importantly, the HSS M&E matrix can be used to (i) measure progress in health system strengthening at both district and health facility levels in a linear approach over time, (ii) link health system capacity to outcomes, and (iii) facilitate precision targeting for health system capacity improvement. On the other hand, the District League Table (DLT) measures service delivery indicators, which are reviewed annually to assess performance of district health sector and rank districts into good and poor performers for purposes of instituting corrective measures. The drawback to the DLT is that only a few service delivery indicators limited to immunization, malaria, ART/TB, latrine coverage, antenatal care, institutional deliveries, fresh still births and submission of timely and complete HMIS reports [6] are considered.

2.0 OBJECTIVES OF THE BASELINE ASSESSMENT

2.1 General Objective

The overall objective of the baseline assessment was to determine the capacity of the district health systems by establishing a benchmark with respect to the national standards upon which improvement interventions will be based

2.2 Specific Objectives

1. To document the implementation of the DHSS progression model to measure district health system capacity
2. To obtain baseline performance of the district health systems upon which interventions for improvement will be based
3. To test the assumptions that the DHSS progression model can be linearly conceptualised, and that precision targeting for capacity improvement is possible
4. To test the assumption that system's capacity improvement is directly linked to systems performance (outcomes) as part of implementation research and learning agenda for DHSS.

3.0 METHODOLOGY

3.1 Setting

The baseline assessment was conducted in 32 districts across five regions: Karamoja (9 districts), West Nile (11 districts), northern (2), east central (4 districts) and mid-western (6 districts) regions. Data was collected in the months of September and October 2019. It is important to note that in one of the districts (Oyam), results of the pilot that was conducted in June 2019 have been considered. These districts are UNICEF 'focus' districts selected based on performance ranking on maternal and child health indicators, equity markers, and whether they were hosting refugees or not. Additional criteria used for selection includes the absolute numbers of deprived children in these districts. This selection was based on shifts recommended based on the midterm review of the UNICEF Uganda country programme which advocated for better targeting approaches based on the changing epidemiological profile (increased frequency and intensity of health emergencies) demographics and the changing nature of child poverty associated with increasing urbanisation. The mid-term review also emphasised on health systems strengthening approaches to tackle these multiple challenges. As a result, UNICEF Uganda adopted DHSS interventions, which are basic building blocks for all other interventions.

3.2 Design

This was a cross sectional baseline assessment that involved quantitative data collection using the DHSS Progression Model assessment tool. Data collection was based on a retrospective review of data from the National Health Management Information Systems (HMIS) including DHIS2, mTrac and IHRIS, and national reports such as the National Client Satisfaction Survey and the Health Facility Quality Assurance Program (HFQAP). In addition, interviews were held with members of the District Health Teams (DHTs).

3.3 Data collection

Data was collected by an assessment team, which comprised of program officers and district biostatisticians. At the districts, a brief meeting was held with the DHT during which the objectives of the assessment and the data collection procedures were discussed prior to data collection. An electronic DHSS Progression Model assessment tool was used to collect the data. For each subdomain, the indicators were discussed based on the findings from the respective data sources and the scores were jointly agreed upon.

3.4 Measures

Measures were based on the WHO framework that describes the health systems in terms of six core components: (i) leadership and governance, (ii) access to essential medicines, (ii) health management information systems, (iv) health work force, (v) health financing, and (vi) service delivery. Table 1 below shows the HSS domains and subdomains that were assessed and the respective data sources for each.

Table 1. Subdomains assessed in each of the health system strengthening building block

No	HSS domains	Subdomain	Data source
1.	A. Leadership and governance	A1. DHT organizational capacity	DHT, Documents
		A2. Availability of key policies and guidelines	
		A3. Planning and budgeting	
		A4. Stakeholder coordination	
		A5. Performance management	
		A6. Support supervision	
		A7. Community governance mechanisms	
		A8. Accountability for results	
2.	B. Access to essential medicines	B1. Availability of essential medicines	DHIS2, mTrac, HFQAP
		B2. Availability of essential commodities	
		B3. Availability of basic equipment	
		B4. Availability of diagnostic supplies	
		B5. Health facility density	
		B6. Health facility amenities	
3.	C. Health information systems	C1. Generation & compilation of quality data	DHIS2, mTrac, iHRIS
		C2. Community health information systems	
		C3. Data synthesis and use	
		C4. Surveillance mechanisms	
		C5. Human resources information system	
4.	D. Human resources for health	D1. Health worker availability	iHRIS
		D2. Health worker distribution	
		D3. Community health workers	
5.	E. Health financing	E1. Resource allocation	DHT
		E2. Resource expenditure	
6.	F. Service delivery	F1. Responsiveness of the health care system	CSS report DHIS2, mTrac, HFQAP,
		F2. HFQAP star rating	
		F3. Immunization coverage	
		F4. Antenatal care (ANC4) attendance	
		F5. Institutional deliveries	
		F6. Management of malnutrition in children	
		F7. Diagnosis of malaria	
		F8. ART for children	
		F9. ART for pregnant women	

3.5 Data Analysis and Reporting

For each of the HSS domain and subdomains assessed, the automated excel tool generated scores with colour codes of dark green for Level 4 progression (surpasses basic expectations), light green for Level 3 (meets basic expectations), yellow for Level 2 (needs improvement) and red for Level 1 progression (needs urgent attention) (Table 2)

Table 2. Colour coded scoring

Maturity Level	Colour code	Percentage
Level 4	Dark Green Score (Surpasses basic expectations)	>90
Level 3	Light Green Score (Meets basic expectations)	70-90
Level 2	Yellow Score (Needs improvement)	50-70
Level 1	Red Score (Needs urgent remediation)	<50

4.0 RESULTS

Objective 1: Implementation of the DHSS Progression Model

The DHSS progression model was successfully implemented across the 32 districts. Prior to the district visits, appointments with the respective DHOs were made through email and phone calls. At the districts, the excel-based tool, which has five sections (instruction sheet, information sheet, assessment sheet, dashboard, and action plan section) was administered by at least two program persons with good knowledge and understanding of health system strengthening. The tool was administered in a form of a discussion with the District Health Officer (DHO) or a representative of the DHO and other members of the District Health Team (DHT). Data was collected using a laptop. The scores for each domain and sub-domain were automatically generated for visualization and discussion with the DHT. The identified gaps were documented in the action plan section of the tool.

Data collection

The information sheet: The following data were completed in the information sheet: the date of data collection, district information (district name and region), the DHO's name and contacts, names of team members present and their contacts and the names of assessment team members and their contacts

The assessment sheet: This part contains the six health system domains, 33 subdomains, and the indicators under each subdomain along the progression continuum. These have been discussed in the previous sections of this report. The respective data sources and notes for each subdomain are indicated. During data collection, each member of the assessment team was assigned with a specific role:

- **Facilitator:** Took lead in the discussion with the DHT members, asked questions under each subdomain and collected the supporting documents for verification purposes.
- **Note-taker:** Took additional notes to ensure a complete capture of the discussions. The additional notes were triangulated with the responses captured during the discussions for consistency and accuracy. The note-taker also ensured that all the documentation and data sources for each standard were validated.

For each standard, a rating of progression levels 1-4 was provided in the dropdown box at the top right corner, which was checked according to score obtained. Colour codes of dark green for Level 4 progression (surpasses basic expectations), light green for Level 3 (meets basic expectations), yellow for level 2 (needs improvement) and red for Level 1 progression (needs urgent attention) were automatically generated.

Action plans

Based on the findings during the assessment, the identified weaknesses, action points (specific improvement activities), timelines and responsible persons (persons or organisation that will be responsible for accomplishing the tasks) were documented in the action plan section. The action plans were jointly developed between the DHT and the assessment team. The documented actions will inform development of capacity building plans.

Implementation challenges

There were few implementation challenges linked to difficulty in making appointments with the DHTs, completing some sections of the assessment and absence of key documents at some districts for verification.

Objective 2: District Baseline Performance Measurement

4.1 Overall District Performance

The overall mean percent score for all the districts was 63.0% (Level 2). There were considerable variations in percent scores across the districts and these ranged from 43.2% (Level 1) to 78.8% (Level 3). Only 8 (25.0%) districts attained Level 3, the majority 21 (65.6%) districts attained Level 2 and only 3 (9.4%) districts attained at Level 1 of progression. None of the districts attained the highest level (Level 4) of progression (Figure 2). (see Annex for details of district specific performance).

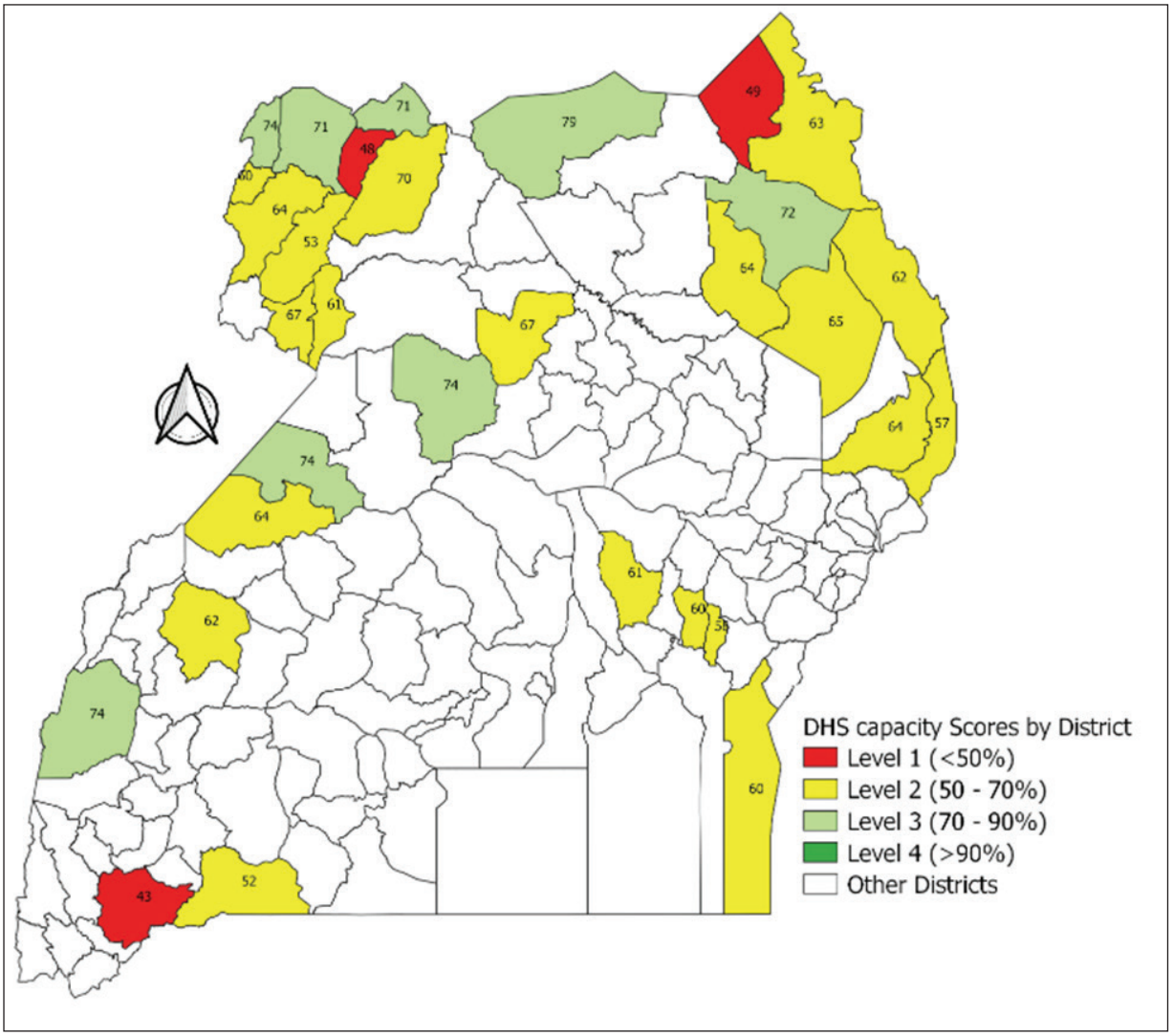


Figure 2. Health system capacity scores by district

4.1.1 Overall Performance by Subdomain

Overall, health information systems was the best performing domain at Level 3 of progression (71.6%) (Table 3)

- The overall percent score for leadership and governance was 67.6% (Level 2). Only two (6.3%) districts (Moyo and Lamwo) attained Level 4 of progression; 12 (37.5%) districts attained Level 3; most 14 (43.8%) districts attained Level 2; and four (12.5%) districts were at Level 1 of progression.
- Under access to essential medicines, the overall percent score was 50.9% (Level 2). Only one district (Kotido) attained Level 4 of progression, two (6.3%) districts (Abim and Hoima) attained Level 3, 16 (50%) districts attained Level 2, and 13 (40.6%) districts attained Level 1 of progression.
- With respect to health information systems, the overall percent score was 71.6% (level 3). Although none of the district attained Level 4, 16 (50.0%) districts attained Level 3, 15 (46.9%) attained Level 2 and only one district (Karenga) was at Level 1.

Table 3. Overall percent scores across the domains by district

No	District	**A:** Leadership and Governance	**B:** Access to Essential Medicines	**C:** Health Information Systems	**D:** Health Workforce	**E:** Health Financing	**F:** Service Delivery	Overall
1.	BUGWERI	62.5	50.0	75.0	41.7	62.5	55.6	**58.3**
2.	IGANGA	53.1	45.8	60.0	66.7	75.0	69.4	**59.8**
3.	KAMULI	81.3	45.8	70.0	33.3	75.0	52.8	**60.6**
4.	NAMAYINGO	46.9	50.0	80.0	83.3	50.0	61.1	**59.8**
5.	ABIM	62.5	70.8	70.0	50.0	62.5	63.9	**64.4**
6.	AMUDAT	62.5	45.8	80.0	33.3	50.0	55.6	**56.8**
7.	KAABONG	62.5	41.7	65.0	66.7	62.5	75.0	**62.9**
8.	KARENGA	56.3	33.3	40.0	41.7	62.5	55.6	**48.5**
9.	KOTIDO	71.9	91.7	75.0	58.3	50.0	66.7	**72.0**
10.	MOROTO	68.8	41.7	85.0	25.0	87.5	63.9	**62.1**
11.	NABIRATUK	43.8	54.2	65.0	50.0	87.5	52.8	**54.5**
12.	NAKAPIRIPIRITI	68.8	50.0	85.0	50.0	87.5	58.3	**64.4**
13.	NAPAK	65.6	54.2	80.0	41.7	87.5	66.7	**65.2**
14.	HOIMA	78.1	83.3	80.0	50.0	50.0	75.0	**74.2**
15.	KASESE	81.3	58.3	70.0	91.7	50.0	77.8	**73.5**
16.	KIKUUBE	71.9	66.7	55.0	33.3	87.5	66.7	**64.4**
17.	KIRYANDONGO	84.4	62.5	70.0	58.3	75.0	77.8	**73.5**
18.	KYENJOJO	68.8	58.3	70.0	50.0	62.5	58.3	**62.1**
19.	ISINGIRO	59.4	20.8	65.0	33.3	62.5	63.9	**52.3**
20.	NTUNGAMO	40.6	33.3	65.0	16.7	25.0	52.8	**43.2**
21.	ADJUMANI	84.4	58.3	60.0	83.3	50.0	69.4	**69.7**
22.	ARUA	71.9	50.0	75.0	50.0	75.0	61.1	**63.6**
23.	KOBOKO	87.5	54.2	75.0	66.7	87.5	72.2	**73.5**
24.	MADI-OKOLLO	43.8	45.8	65.0	33.3	62.5	72.2	**53.3**
25.	MARACHA	56.3	29.2	75.0	83.3	75.0	63.9	**59.8**
26.	MOYO	93.8	62.5	55.0	75.0	75.0	61.1	**70.5**
27.	NEBBI	71.9	33.3	80.0	91.7	87.5	66.7	**67.4**

No	District	A: Leadership and Governance	B: Access to Essential Medicines	C: Health Information Systems	D: Health Workforce	E: Health Financing	F: Service Delivery	Overall
28.	OBONGI	53.1	41.7	60.0	58.3	25.0	41.7	**47.7**
29.	PAKWACH	56.3	50.0	75.0	83.3	75.0	55.6	**61.4**
30.	YUMBE	87.5	25.0	90.0	75.0	100.0	69.4	**71.2**
31.	OYAM	75.0	62.5	90.0	83.3	37.5	50.0	66.7
32.	LAMWO	**90.6**	58.3	85.0	66.7	**100.0**	77.8	78.8
OVERALL		**67.6**	**50.9**	**71.6**	**57.0**	**67.6**	**63.5**	**63.0**

- The overall percent score for the health workforce domain was 57.0% (Level 2). Only two (6.3%) districts (Kasese and Nebbi) attained Level 4 of progression; seven (21.9%) districts attained Level 3; 13 (40.6%) attained Level 2; and the 10 (31.3%) districts were at Level 1.
- The overall percent score for health financing was 67.6% (Level 2). Only two (6.3%) districts (Yumbe and Lamwo) attained Level 4 of progression: Most districts (14) which is43.8% attained Level 3; 13 (46.0%) attained Level 2; and three (9.4%) districts were at Level 1 of progression.
- Under service delivery, the overall percent score was 63.5% (Level 2). None of the districts attained Level 4 of progression in this domain: only seven (21.9%) districts attained Level 3; the majority of the districts at 24 (75.0%) attained Level 2; and one district (Obongi) was at Level 1.

Figure 3 below is a graphic presentation of the district progression levels by health systems strengthening domain

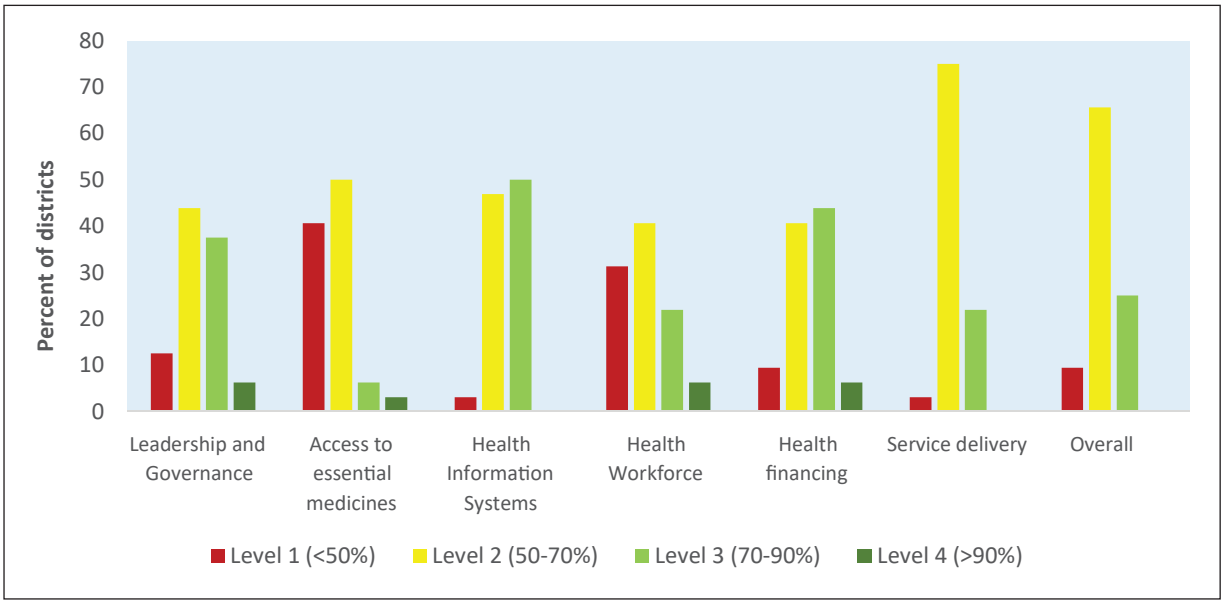


Figure 3. District progression levels by HSS domain

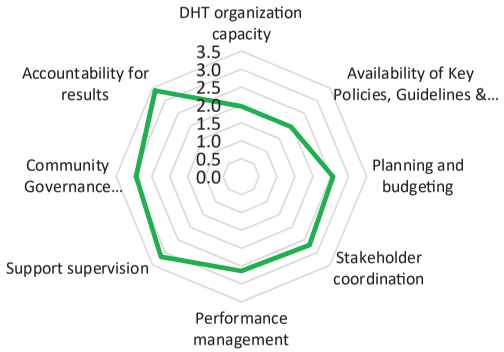
The overall performance by subdomain is summarized in the dashboards below. Under Leadership and Governance, DHT organization capacity and availability of key policies and guidelines attained Level 1 of progression. Planning and budgeting, stakeholder coordination, performance management, and community governance mechanisms attained Level 2 of progression. The best performing subdomains were support supervision and accountability for results, which attained Level 3 of progression.

Under Access to Essential Medicines domain, health facility amenities, health facility density, and availability of basic equipment and supplies for neonatal resuscitation attained Level 1 of progression.

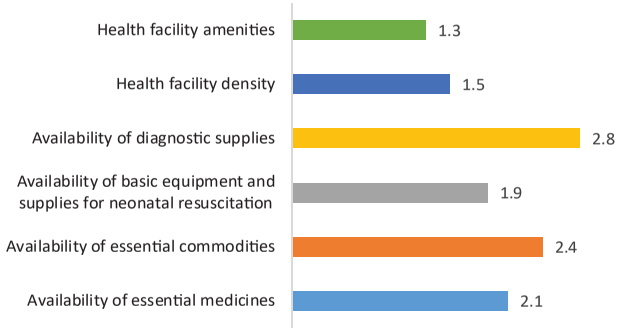
The rest of the subdomains under Access to Essential Medicines (availability of essential medicines and commodities and availability of diagnostic supplies) were at Level 2 of progression.

With respect to Health Information Systems, most of the subdomains (community health information systems, HMIS data synthesis and use and the human resource information system) attained Level 2 of progression. Generation and compilation of quality HMIS data and surveillance mechanisms were at Level 3 of progression. All the subdomains under health workforce (health worker availability and distribution by specialization and community health workers and health financing (resource allocation and expenditure) attained Level 2 of progression. Under service delivery, responsiveness of the health care system and HFQAP star rating were the most poorly performing sub domains (Level 1). Antenatal care (ANC4) attendance, health facility deliveries and management of malnutrition in children attained Level 2 of progression. Immunization coverage, diagnosis for malaria, ART for adolescents and ART for pregnant women attained Level 3 of progression.

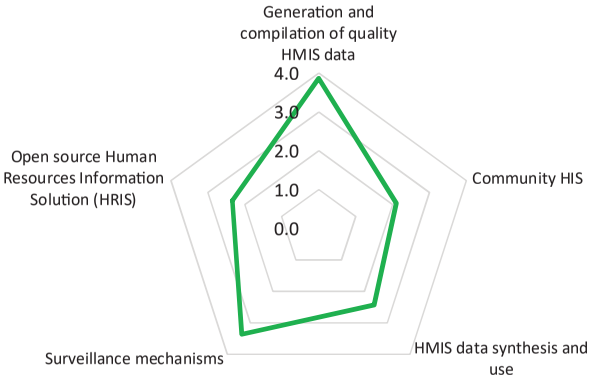
Leadership and Governance



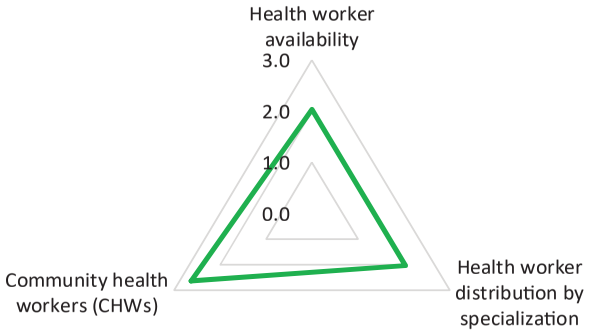
Access to Essential Medicines



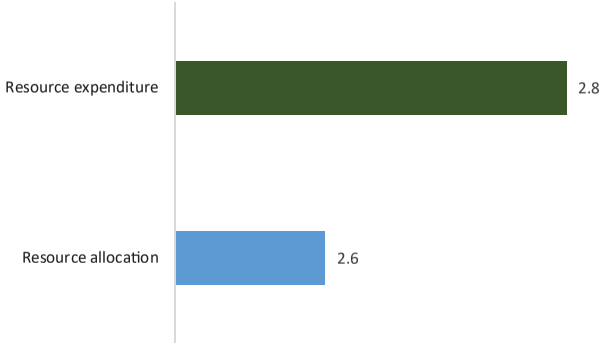
Health Information Systems



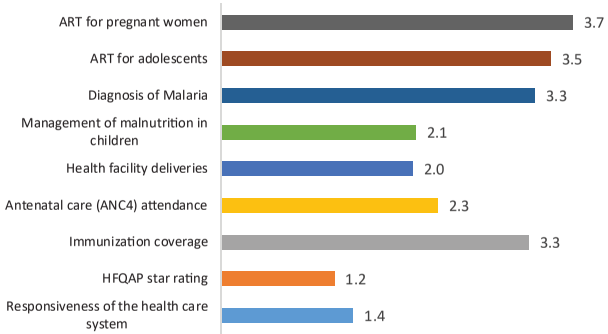
Health Workforce



Health financing



Service Delivery



4.1.2 District Performance by Subdomain

Domain A: Leadership and Governance

The majority of the districts attained Level 1 of progression with respect to DHT organization capacity (40.6%) and availability of policies and guidelines (46.9%). Accountability for results was the best performing subdomain across most (75.0%) districts, which attained Level 4 of progression. The detailed scores in each subdomain by district are indicated in Table 4 below.

Table 4. District performance in subdomains for Leadership and Governance

NO	DISTRICT	HSS Domain A: Leadership and Governance							
		DHT organization capacity **A1:**	Policies and guidelines **A2:**	Planning and budgeting **A3:**	District stakeholder coordination **A4:**	District performance management **A5:**	District support supervision **A6:**	Community governance mechanisms **A7**	Accountability for results **A8**
1.	ABIM	1	2	3	2	1	3	4	4
2.	AMUDAT	1	1	2	4	2	4	2	4
3.	MOROTO	1	2	2	2	3	4	4	4
4.	KAABONG	3	1	3	2	1	2	4	4
5.	NABILATUK	1	1	2	2	1	3	3	1
6.	KARENGA	4	1	2	2	1	1	3	4
7.	KOTIDO	2	1	3	4	3	3	3	4
8.	NAKAPRIPIRIT	3	4	2	2	3	1	3	4
9.	NAPAK	1	2	2	3	2	4	4	4
10.	ADJUMAN	3	2	3	4	4	4	3	4
11.	ARUA	2	1	2	3	4	4	3	4
12.	KIRYANDONGO	4	4	2	3	3	4	3	4
13.	KOBOKO	1	4	4	3	4	4	4	4
14.	MADI OKOLLO	1	1	1	3	1	3	3	1
15.	MARACHA	2	1	2	1	4	3	1	4
16.	MOYO	4	4	4	4	4	4	2	4
17.	NEBBI	1	2	2	2	4	4	4	4
18.	OBONGI	1	1	1	3	1	3	3	4
19.	PAKWACH	1	1	2	1	3	3	3	4
20.	YUMBE	4	3	4	3	4	3	3	4
21.	BUGWERI	1	1	2	1	4	4	4	3
22.	IGANGA	4	1	2	1	2	4	No data	3
23.	KAMULI	No data	2	4	4	4	4	4	4
24.	NAMAYINGO	1	1	3	4	2	2	1	1
25.	ISINGIRO	2	3	3	3	3	1	2	2
26.	NTUNGAMO	2	1	2	2	1	2	2	1
27.	HOIMA	2	3	4	2	2	4	4	4
28.	KASESE	3	4	4	4	2	4	1	4
29.	KUKUUBE	1	3	3	4	4	2	4	2
30.	KYENJOJO	2	1	2	3	2	4	4	4
31.	OYAM	2	3	3	3	2	3	4	4
32.	LAMWO	2	3	4	4	4	4	4	4

Domain B: Access to EssentialMedicines

Table 5 below provides a detailed analysis of the scores in each of the six sub-domain of the Access to Essential Medicines. Overall, this registered the lowest scores with most districts attaining Level 1 of progression across the sub-domains

Table 5. District performance in subdomains for Access to Essential Medicines

NO	DISTRICT	HSS Domain B: Access to essential medicines					
		Availability of essential medicines **B1:**	Availability of essential commodities **B2:**	Availability of basic equipment **B3**:	Availability of diagnostic supplies **B4:**	Health facility density **B5:**	Health facility amenities **B6:**
1.	ABIM	3	1	4	4	4	1
2.	AMUDAT	2	2	1	3	1	2
3.	MOROTO	1	3	2	1	2	1
4.	KAABONG	2	4	1	2	No data	1
5.	NABILATUK	2	4	2	2	1	2
6.	KARENGA	1	1	1	2	2	1
7.	KOTIDO	3	4	4	4	4	3
8.	NAKAPRIPIRIT	1	4	2	2	1	2
9.	NAPAK	1	1	4	1	3	3
10.	ADJUMAN	3	3	3	3	1	1
11.	ARUA	3	3	1	3	1	1
12.	KIRYANDONGO	2	4	1	2	4	2
13.	KOBOKO	3	3	2	3	1	1
14.	MADI OKOLLO	3	2	1	3	1	1
15.	MARACHA	2	1	1	1	1	1
16.	MOYO	3	3	2	3	1	3
17.	NEBBI	1	1	2	2	1	1
18.	OBONGI	3	1	1	3	1	1
19.	PAKWACH	1	2	4	3	1	1
20.	YUMBE	1	1	1	1	1	1
21.	BUGWERI	2	3	1	4	1	1
22.	IGANGA	2	1	2	4	1	1
23.	KAMULI	3	1	1	4	1	1
24.	NAMAYINGO	1	4	1	4	1	1
25.	ISINGIRO	1	1	No data	2	1	No data
26.	NTUNGAMO	1	3	No data	3	1	No data
27.	HOIMA	3	4	4	4	3	2
28.	KASESE	2	3	3	4	1	1
29.	KUKUUBE	3	4	2	3	3	1
30.	KYENJOJO	4	1	3	4	1	1
31.	OYAM	4	3	1	4	2	1
32.	LAMWO	3	3	2	3	1	2

Domain C: Health Information Systems

This was the best performing domain. Majority of the districts were at levels 4 (84.4%) and 3 (15.6%) of progression with regard to compilation of quality data. However, most districts registered low levels of progression with regard to community health information systems and data synthesis and use. Nine districts (28.1%) performed very poorly (Level 1) in Human Resource Information Systems (Table 6).

Table 6. District performance in subdomains for Health Information Systems

NO	DISTRICT	HSS Domain C: Health Information Systems				
		Compilation of quality data **C1:**	Community HIS **C2:**	Data synthesis and use **C3:**	Surveillance mechanisms **C4:**	Human Resource Information System **C5:**
1.	ABIM	3	4	1	3	3
2.	AMUDAT	4	1	4	4	3
3.	MOROTO	4	2	4	4	3
4.	KAABONG	4	3	2	3	1
5.	NABILATUK	4	1	2	4	2
6.	KARENGA	3	1	1	2	1
7.	KOTIDO	3	4	3	1	4
8.	NAKAPRIPIRIT	4	4	3	3	3
9.	NAPAK	4	1	4	4	3
10.	ADJUMAN	4	1	3	3	1
11.	ARUA	4	2	2	3	4
12.	KIRYANDONGO	4	1	4	3	2
13.	KOBOKO	4	1	4	4	2
14.	MADI OKOLLO	4	2	1	4	2
15.	MARACHA	4	3	1	4	3
16.	MOYO	4	1	1	4	1
17.	NEBBI	4	3	4	3	2
18.	OBONGI	4	1	3	3	1
19.	PAKWACH	4	4	2	4	1
20.	YUMBE	4	4	4	4	2
21.	BUGWERI	4	2	1	4	4
22.	IGANGA	3	1	2	2	4
23.	KAMULI	4	1	4	3	2
24.	NAMAYINGO	3	3	1	4	4
25.	ISINGIRO	4	1	2	4	2
26.	NTUNGAMO	4	4	1	3	1
27.	HOIMA	4	1	4	4	3
28.	KASESE	4	3	3	3	1
29.	KUKUUBE	4	2	1	3	1
30.	KYENJOJO	4	1	1	4	4
31.	OYAM	4	4	3	4	3
32.	LAMWO	4	4	2	4	3

Domains D and E: Health workforce and health financing

The detailed results for health workforce and health financing are indicated in Table 7 below. Most districts registered low levels of progression in health worker availability and distribution. Whereas many districts (50%) achieved Level 3 in resource allocation, more than a quarter of the districts were at Level 1 with respect to resource expenditure (Table 7)

Table 7. District performance in subdomains for health workforce and health financing

NO	DISTRICT	HSS Domain D: Health Workforce			HSS Domain E: Health financing	
		Health worker availability **D1:**	Health worker distribution **D2:**	Community health workers **D3:**	Resource allocation **E1:**	Resource expenditure **E2:**
1.	ABIM	2	1	3	4	1
2.	AMUDAT	1	1	2	3	1
3.	MOROTO	1	1	1	3	4
4.	KAABONG	2	2	4	3	2
5.	NABILATUK	1	1	4	3	4
6.	KARENGA	1	1	3	3	2
7.	KOTIDO	2	1	4	3	1
8.	NAKAPRIPIRIT	1	2	3	3	4
9.	NAPAK	1	1	3	3	4
10.	ADJUMAN	4	4	2	3	1
11.	ARUA	3	1	2	2	4
12.	KIRYANDONGO	3	2	2	3	3
13.	KOBOKO	2	4	2	3	4
14.	MADI OKOLLO	1	1	2	2	3
15.	MARACHA	3	3	4	2	4
16.	MOYO	3	4	2	2	4
17.	NEBBI	3	4	4	3	4
18.	OBONGI	3	2	2	1	1
19.	PAKWACH	2	4	4	2	4
20.	YUMBE	2	3	4	4	4
21.	BUGWERI	2	1	2	2	3
22.	IGANGA	3	4	1	2	4
23.	KAMULI	3	No data	1	4	2
24.	NAMAYINGO	2	4	4	2	2
25.	ISINGIRO	1	1	2	1	4
26.	NTUNGAMO	No data	No data	2	1	1
27.	HOIMA	2	2	2	3	1
28.	KASESE	3	4	4	3	1
29.	KUKUUBE	1	1	2	3	4
30.	KYENJOJO	3	1	2	1	4
31.	OYAM	4	2	4	2	1
32.	LAMWO	2	2	4	4	4

Domains F: Service delivery

The detailed results for service delivery are indicated in Table 8 below. Most districts registered low level of progression with regard to client satisfaction with health services (responsiveness of the health care system) and the HFQAP star rating. Similarly, there were low levels of progression registered in health facility deliveries and management of malnutrition. Most districts registered high levels of progression in diagnosis of malaria, ART for children and ART for pregnant women (Table 8).

Table 8. District performance in subdomains for service delivery

NO	DISTRICT	HSS Domain F: Service delivery								
		Client satisfaction F1:	HFQAP star rating F2:	Immunization coverage F3:	ANC4 F4:	Health facility Deliveries F5:	Malnutrition management F6:	Malaria diagnosis F7:	ART for children F8:	ART for pregnant women F9:
1.	ABIM	1	2	4	2	2	2	2	4	4
2.	AMUDAT	1	1	3	2	1	1	4	4	3
3.	MOROTO	2	1	3	2	2	3	3	3	4
4.	KAABONG	3	3	4	2	2	3	2	4	4
5.	NABILATUK	1	3	4	3	2	1	3	1	1
6.	KARENGA	1	1	2	2	1	2	3	4	4
7.	KOTIDO	1	1	3	3	2	4	2	4	4
8.	NAKAPRIPIRIT	1	1	4	3	2	1	3	2	4
9.	NAPAK	2	1	4	3	3	1	2	4	4
10.	ADJUMAN	1	1	4	3	4	1	4	3	4
11.	ARUA	1	1	4	2	2	2	3	3	4
12.	KIRYANDONGO	2	3	4	3	2	3	3	4	4
13.	KOBOKO	1	1	3	3	2	4	4	4	4
14.	MADI OKOLLO	1	1	4	2	2	4	4	4	4
15.	MARACHA	1	1	3	3	2	1	4	4	4
16.	MOYO	1	1	2	2	2	3	3	4	4
17.	NEBBI	1	1	3	3	3	1	4	4	4
18.	OBONGI	No data	No data	1	2	1	1	3	4	3
19.	PAKWACH	No data	1	3	2	2	1	4	3	4
20.	YUMBE	1	1	3	2	2	4	4	4	4
21.	BUGWERI	2	1	2	1	1	1	4	4	4
22.	IGANGA	3	1	3	2	3	1	4	4	4
23.	KAMULI	1	1	3	2	2	1	4	2	3
24.	NAMAYINGO	2	1	3	2	1	1	4	4	4
25.	ISINGIRO	2	1	4	2	2	1	4	3	4
26.	NTUNGAMO	2	No data	3	2	2	1	1	4	4
27.	HOIMA	1	2	4	2	3	4	4	4	3
28.	KASESE	1	1	4	3	3	4	4	4	4
29.	KUKUUBE	4	1	3	2	1	4	3	2	4
30.	KYENJOJO	1	1	4	2	2	1	4	3	3
31.	OYAM	1	1	3	2	3	2	4	1	1
32.	LAMWO	2	1	4	3	3	3	4	4	4

Objective 3. Assumptions of the DHSS progression model

Linear measurement: Through the experience gained during the application of the DHSS progression model and the results of the assessment, it is possible to present the capacity of district health systems in a linear pattern. The progression model is a recognized tool for systematic and stepwise measurement of improvements in health systems based on a set of indicators. The tool is used to identify the gaps between actual and desired states and to demonstrate an evolutionary path to achieve the improvement [3]. In this assessment, the tool helped to measure the capacity of selected health system strengthening domains and subdomains through a linear pattern based on a four-point Likert scale with '1' representing the lowest level and '4' representing the highest level of performance (progression). The indicators used were jointly agreed upon by all the key stakeholders. Thus, the assumption that the capacity of health systems can be represented through a linear model is valid.

Linking health system capacity to improved coverage of health services): The results of this assessment show that the top performing districts (Hoima, Kasese, Kiryandongo, Koboko, Moyo, Yumbe, Kotido, and Lamwo) with enhanced capacities in leadership and governance, access to essential medicines, health information systems and health workforce have better coverage for most services such as immunization, ANC4 attendance, institutional deliveries, and ART for children and pregnant mothers. While this seems to support this assumption, a detailed analysis of this correlation needs to be undertaken to further corroborate this finding.

Precision in targeting capacity building interventions: The DHSS progression model can help to identify domains and subdomains with low levels of progression, and this facilitates district health managers to identify, in further detail, where gaps occur to inform targeted improvement efforts. Further, the inference drawn by the DHSS progression model assessment can be used by partners and the Ministry of Health in prioritizing improvement interventions to districts with domains and subdomains with critical gaps. The identified gaps can also be used to inform policy development and public health practice. Thus, the assumption that the DHSS progression model can be used to achieve precision in targeting interventions for capacity building is justified.

5.0 DISCUSSION

The results of the baseline assessment show that the DHSS progression model was successfully implemented across the 32 districts. The overall findings show that none of the districts registered Level 4 of progression across all domains of health system strengthening. A quarter of the districts attained Level 3 of progression; the majority (66%) of the districts attained Level 2 and three (9%) districts registered the lowest level of progression (Level 1). Access to essential medicines and health workforce domains registered the lowest level of progression. These findings have important programmatic and policy implications for informing district health system strengthening efforts.

Below, the findings for each domain of health system strengthening are discussed. The district-specific gaps in each health system strengthening are summarized in a separate excel sheet.

5.1 Leadership and Governance

Leadership and Governance involve ensuring that strategic policy frameworks exist and are combined with effective oversight, planning and budgeting, coalition-building, regulation, performance management, and accountability [7]. In the Uganda health care system, Leadership and Governance roles at district level are vested in the DHT under the leadership of the District Health Officer. In this assessment, only two districts (Moyo and Lamwo) attained Level 4 of progression and most (44%) of the districts attained Level 2 of progression. Many districts had weak DHT organization capacities as evidenced by inadequate DHT composition, lack of clearly defined roles and responsibilities and performance targets for DHT members. Most of the key policy documents and guidelines were missing at half of the districts assessed. Many districts have not yet adopted the Bottleneck Analysis (BNA) approach for planning and not all stakeholders in the districts are involved in the planning process. There were strong support supervision systems, community governance and accountability mechanisms at the majority of the districts although critical gaps were evident in a few districts including Karenga, Nakapriprit, Nabitulak, Namayingo, and Isingiro among others.

5.2 Access to Essential Medicines

A well-functioning health system ensures equitable access to essential medical products, vaccines, and technologies of assured quality, safety, efficacy and their cost-effective use. According to WHO, access to medicines is defined as “having medicines continuously available and affordable at public or private health facilities that are within a 5km radius from the population. The lack of essential medicines, commodities, basic equipment, and diagnostic supplies in some the districts is partly responsible for the poor performance of these subdomains. With respect to health facility density, most (70%) of the districts attained Level 1 of progression. This is because, according to the district health system structure, each parish should have at least one HC II, each sub county should have at least one HC III, each county should have at least one HC IV and each district should have at least one general hospital but this hierarchal structure does not exist in most districts. It is also important to note that the availability of health facility amenities could not be assessed in many districts because the Health Facility Quality Assessment Program (HFQAP), which is the main data source for this subdomain, had not been conducted in these districts at the time of the assessment. This explains why most of the districts performed poorly in these two subdomains (health facility density and amenities)

5.3 Health Information Systems

Reliable information is the foundation of decision-making across all health system building blocks. Information is essential for health system policy development and implementation, governance and regulation, health research, human resources development, health education and training, service delivery, and financing. Health information systems have four key functions: (i) data generation, (i) collation, (iii) analysis and synthesis, and (iv) communication and use. This assessment showed that majority of the districts performed well in generation and compilation of quality data, data synthesis and use, and surveillance mechanisms. However, the majority (63%) of the districts had critical gaps in community health systems, which are attributable to poor reporting of the VHT/ICCM outputs by most health facilities and this area needs to be strengthened. It was also observed that although the Human Resource Information Software (iHRIS) was functional in most districts, it was not up-to-date and was, therefore, not being used for human resource planning in most districts.

5.4 Health Workforce

The ability of a district to meet its health goals largely depends on the availability, distribution, motivation, knowledge, and skills of the people responsible for delivering health services. The health workforce refers “all people engaged in actions whose primary intent is to enhance health.” These include clinical staff such as doctors, nurses, pharmacists, laboratory technicians, etc, as well as management and support staff, i.e. those who do not deliver services directly but are essential to the performance of health systems, such as managers, store assistants, and drivers. This assessment showed that in more than half of the districts, less than 70% of the health facilities met the established staffing norms. Among the notable missing cadres were anaesthetists, dispensers, and laboratory technicians in most districts. Although most of the districts reported a high coverage of community health workers (at least 2 CHWs/village) in nearly half of the districts, these community structures are regarded as malfunctional since most do not submit monthly reports nor do they regularly meet.

5.5 Health Financing

Health Financing is fundamental to the ability of health systems to maintain and improve human health. Without the necessary funds, no health workers would be employed, no medicines would be available, and no health promotion or prevention would take place. Health systems financing should not only seek to raise enough funds for health but should also allow the population to use the needed services without the risk of severe financial hardship. In this assessment, only two key parameters were assessed; allocation and expenditure of the primary health care (PHC) non-wage. It was noted that as a standard, the primary health care (PHC) non-wage is allocated according to the level of care. However, it was reported that the PHC quarterly releases are received very late in most districts. In more than 30% of the districts, the PHC releases are not displayed on notice boards and the budgets for donor partners are not integrated into the district budgets. With respect to resource expenditure, it was noted that 40% of the districts do not spend their PHC capital development fund in time and this was attributed to the rather long procurement beaurocratic procedures at both national and district levels.

5.6 Service Delivery

Strengthening service delivery is crucial to the achievement of the Sustainable Development Goal (SDG) 3 of achieving good health and wellbeing for all at all ages, which include delivery of interventions for reducing child mortality, improving maternal health and fighting HIV/AIDS, malaria and other diseases of

public health significance. Service delivery is an immediate output of the inputs into the health system, such as the health workforce, supplies, and financing. Increased inputs should lead to improved service delivery and enhanced access to services. Ensuring availability of health services that meet a minimum quality standard and securing access to them are key functions of a health system. A recent client satisfaction survey showed that only 25% of the clients were satisfied with health services nationally, which implies that our health care system is not responsive to the client's needs. The majority (77%) of the districts were at Level 1 of progression in the HFQAP star rating because the HFQAP had not been conducted in most districts at the time of the assessment as earlier discussed. Most of the district had good coverage for immunization, malaria diagnosis, and ART for children and pregnant women. In the majority of the districts, less than 50% of the pregnant women attend the recommended four or more ANC visits; less than 70% of pregnant mothers deliver from health facilities and less than 50% of the children with severe acute malnutrition receive appropriate management.

5.7 Methodological Discussion

5.7.1 Reflexivity

Reflexivity is an awareness of the evaluator's contribution to the construction of meanings throughout the evaluation process and refers to how knowledge is shaped by the evaluator and accounted for in the evaluation process [8]. This assessment was conducted by UNICEF program officers, partners and members of the district health teams who understand and are familiar with the district health care system. However, the tool used in the assessment was developed by an external consultant and reviewed by senior UNICEF staff and partners who were not directly involved in data collection. It is also important to note that data collection in each district was led by an evaluation team that was external to the districts.

5.7.2 Social Desirability

Data on some indicators were derived from discussions with members of the district health teams. It is possible that the respondents could have provided biased and socially desirable answers. However, most of the responses provided were verified through observations. In addition, the scores attained were jointly agreed upon during discussions between the district health teams and the assessment teams. Further, a comparison with other districts in similar settings lend credibility to the findings and suggest that the baseline findings established represent a true picture of the district health system capacity.

5.7.3 Limitation of the DHSS Progression Model

There are complex interactions between multiple variables across the different domains and subdomains of the health system strengthening progression model. It is, therefore, difficult to disentangle the effects of the individual variables and to identify the most important health system component for achieving the desired outcome.

6.0 CONCLUSIONS AND RECOMMENDATIONS

- The progression model is an important and user-friendly tool for measuring capacity of district health systems in a linear fashion and for guiding accurate targeting for capacity enhancement interventions.
- None of the districts achieved the highest level of health system capacity progression.
- The low level of health system capacity is attributable to gaps that cut across all the health system components which include weak DHT organization capacity, lack of key policy documents and guidelines, inadequate access to essential medicines, commodities, basic equipment and amenities, insufficient data synthesis and use, weak human resource and community health information systems, inadequate health worker availability, mal-functional community health structures, delayed remittance of primary health care funds to the districts, client dissatisfaction with health services and low uptake of maternal and child health services.
- The lowest levels of progression were observed in the access to essential medicines and health workforce domains of health systems.
- There is a need to revise the assessment tool to capture each of the standards as an independent entity. This will help to identify the most important specific areas that require urgent attention and inform timely and targeted interventions.

6.1 Programmatic Implications

- UNICEF and partners should support the districts to institutionalize the progression model for periodic monitoring and evaluation of district health system strengthening efforts
- There is need to develop a comprehensive capacity building plan that targets health system components with low levels of progression. This will require close collaboration between the Ministry of Health, UNICEF, PCA partners, implementing partners, and the district local governments. While there are huge capacity needs that would require further prioritization, a potential approach would be to focus on a few key issues under each of the intervention packages.
- Reinforcing good clinical and client-centred approaches as well as good data management and use practices through training, mentorship and support supervision of health service providers will be an important practical approach for improving the quality and uptake of health services

6.2 Recommendation for Future Research

- There is need for further research to corroborate the assumption that health system capacity can be linked to improved health outcomes. This will include performing a detailed sensitivity analysis to determine the most important health system components for achieving the desired outcome.

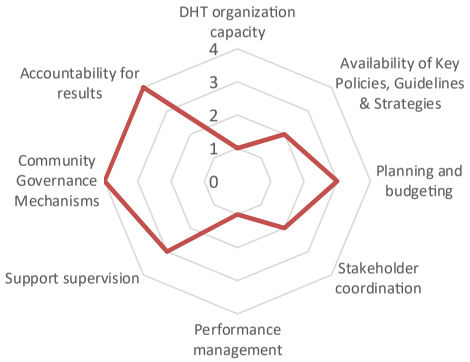
ANNEX: DISTRIICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARDS

Abim District - 2018/19

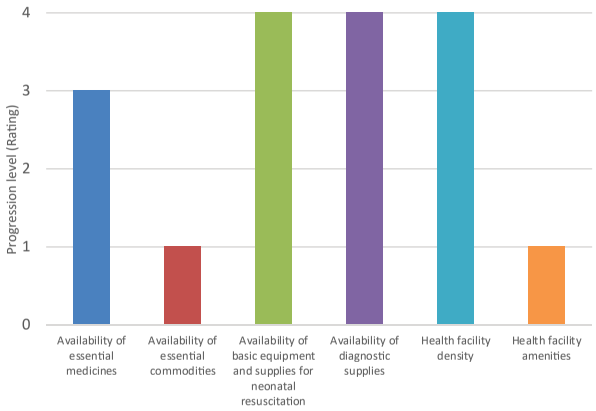
HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	62.5	70.8	70.0	50.0	62.5	63.9	64.4

Key: <50% | 50.1-70% | 70.1-90% | >90%

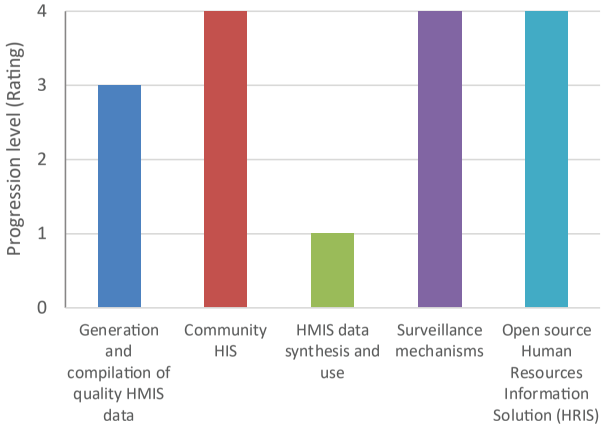
A: Leadership and Governance



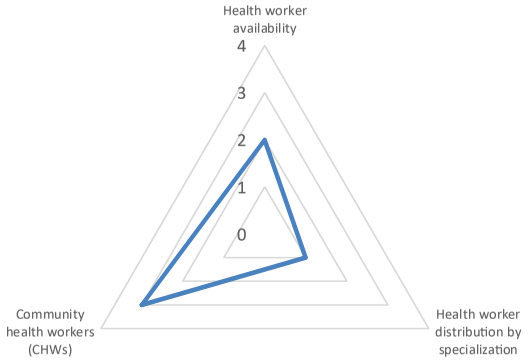
B: Access to essential medicines



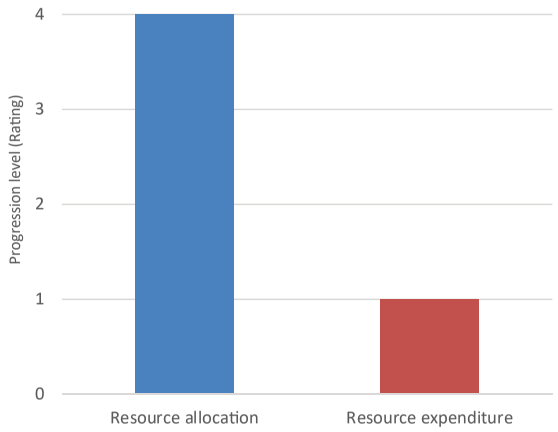
C: Health Information Systems



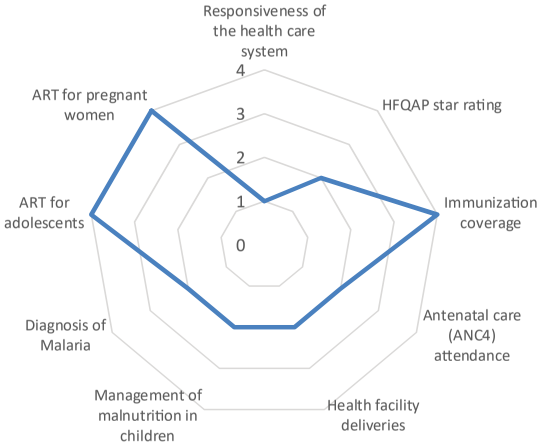
D: Health Workforce



E: Health financing



F: Service delivery



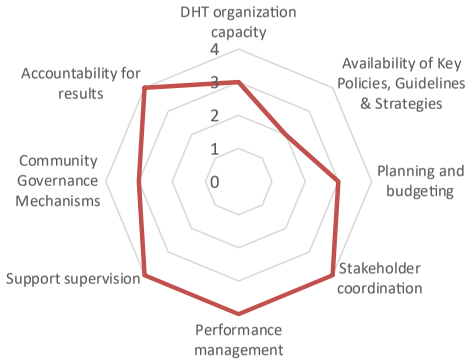
DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

Adjumani District - 2018/19

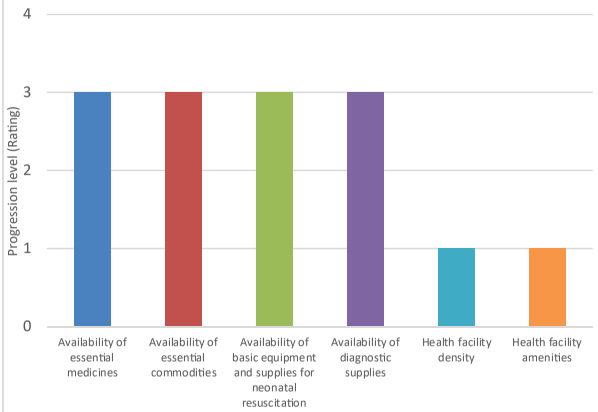
HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	84.4	58.3	60.0	83.3	50.0	69.4	69.7

Key: <50% | 50.1-70% | 70.1-90% | >90%

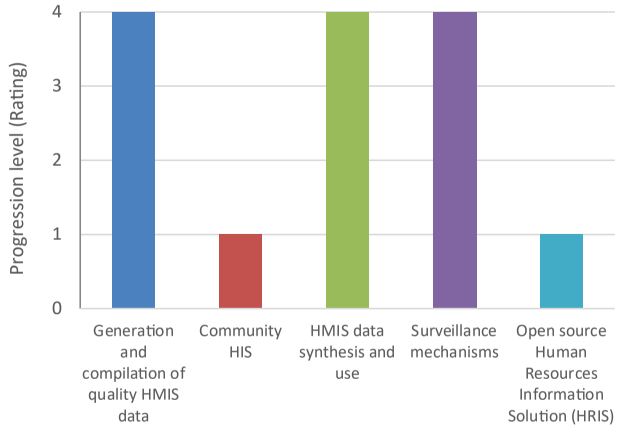
A: Leadership and Governance



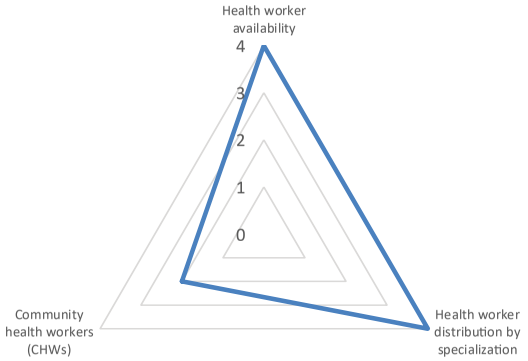
B: Access to essential medicines



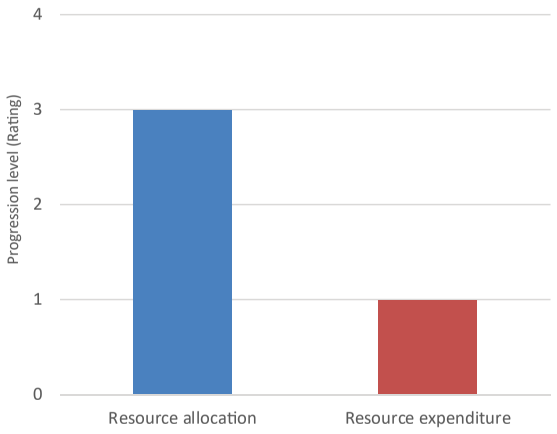
C: Health Information Systems



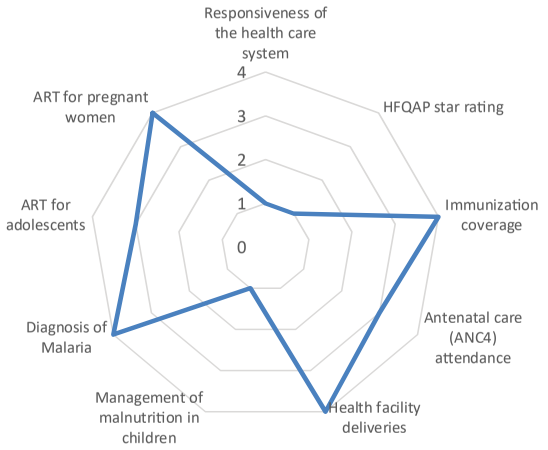
D: Health Workforce



E: Health financing



F: Service delivery



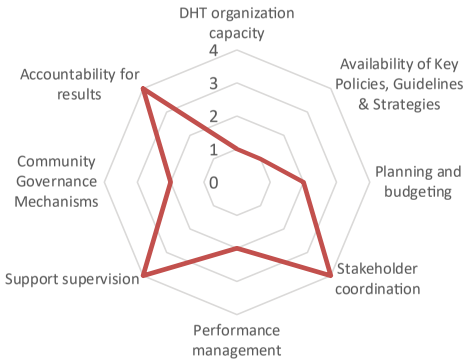
DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

Amudat District - 2018/19

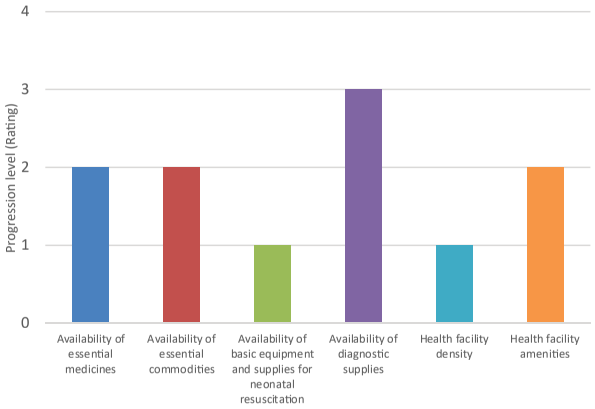
HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	62.5	45.8	80.0	33.3	50.0	55.6	56.8

Key: <50% | 50.1-70% | 70.1-90% | >90%

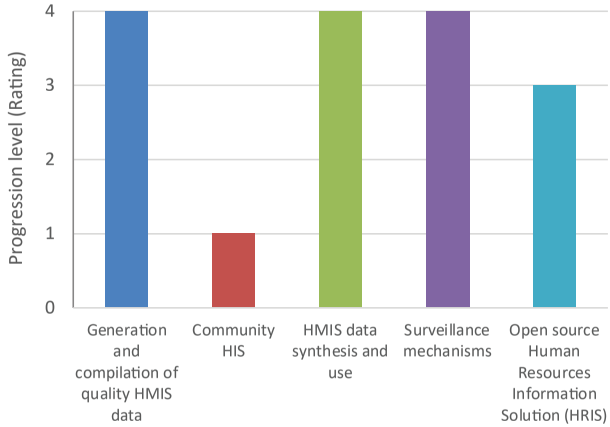
A: Leadership and Governance



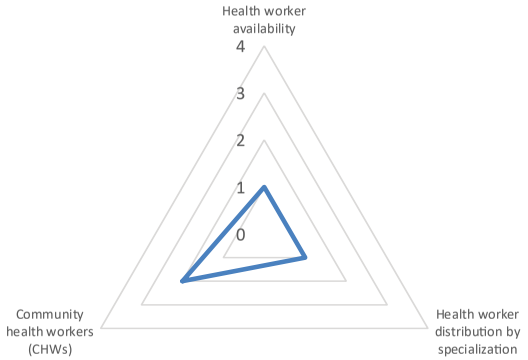
B: Access to essential medicines



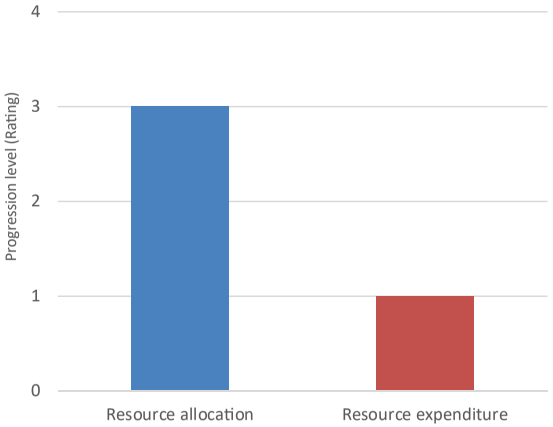
C: Health Information Systems



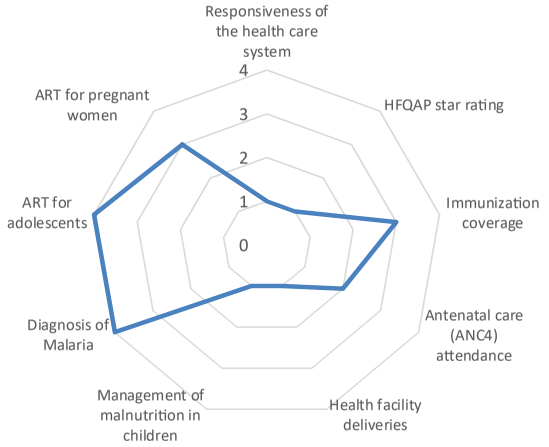
D: Health Workforce



E: Health financing



F: Service delivery



DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

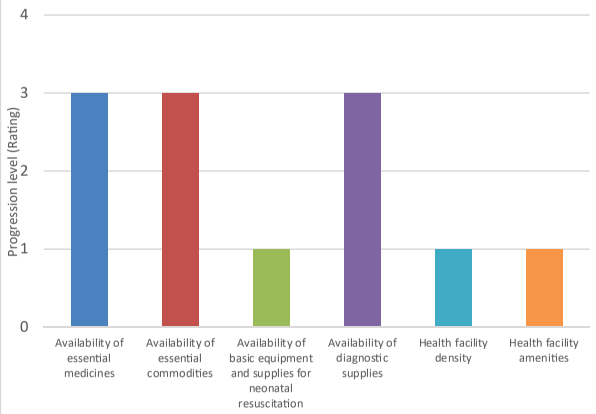
Arua District - 2018/19

HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	71.9	50.0	75.0	50.0	75.0	61.1	63.6

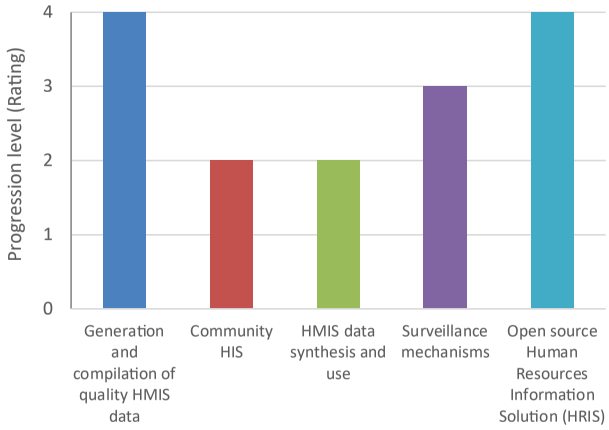
Key: <50% | 50.1-70% | 70.1-90% | >90%

A: Leadership and Governance

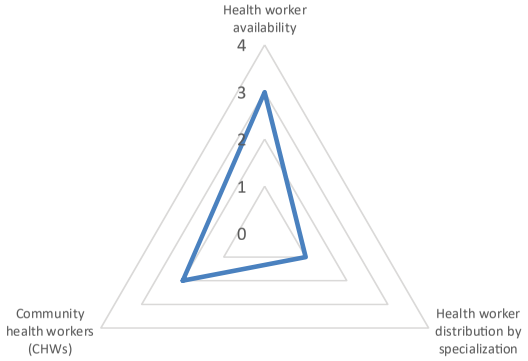
B: Access to essential medicines



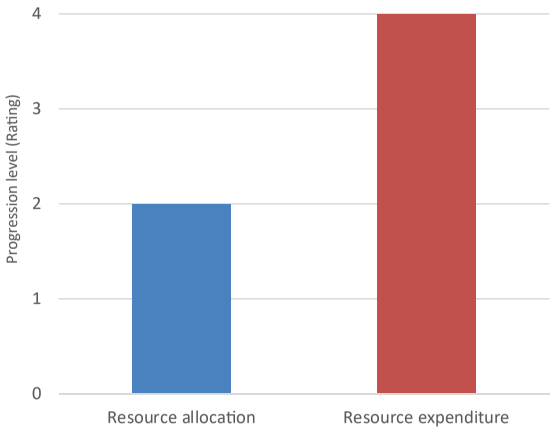
C: Health Information Systems



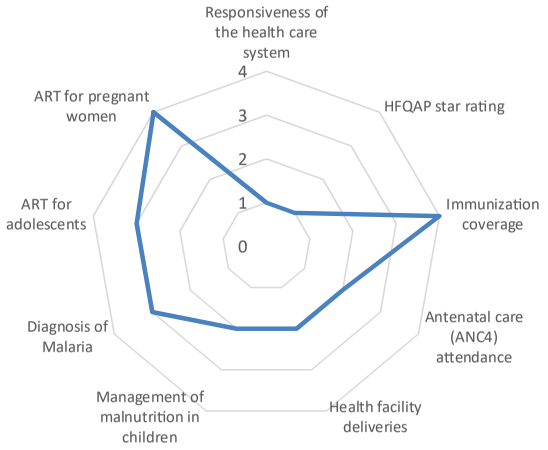
D: Health Workforce



E: Health financing



F: Service delivery



DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

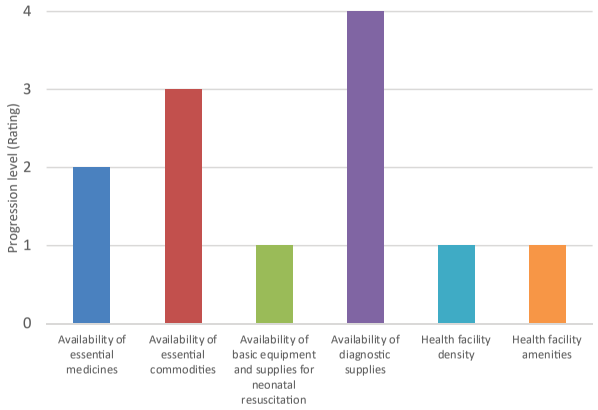
Bugweri District - 2018/19

HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	62.5	50.0	75.0	41.7	62.5	55.6	58.3

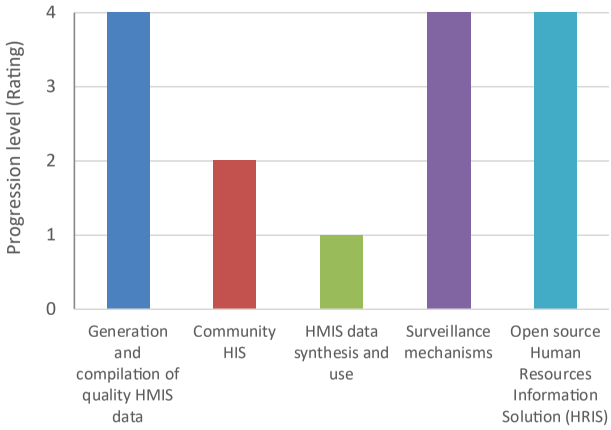
Key: <50% | 50.1-70% | 70.1-90% | >90%

A: Leadership and Governance

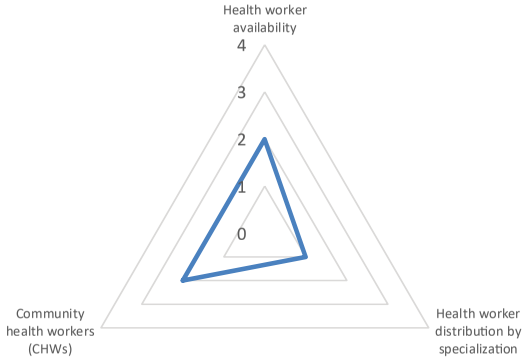
B: Access to essential medicines



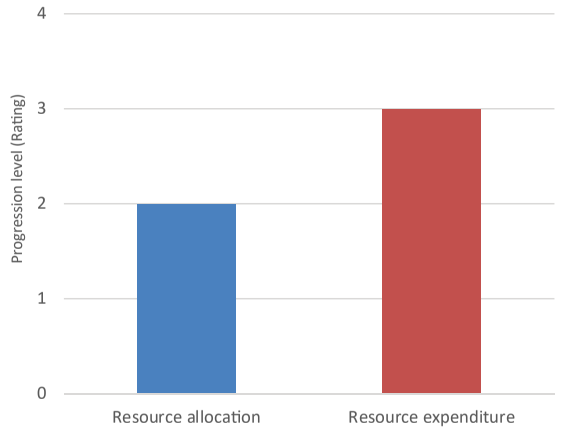
C: Health Information Systems



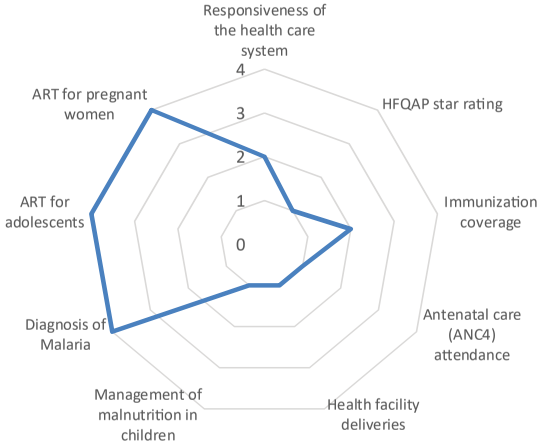
D: Health Workforce



E: Health financing



F: Service delivery



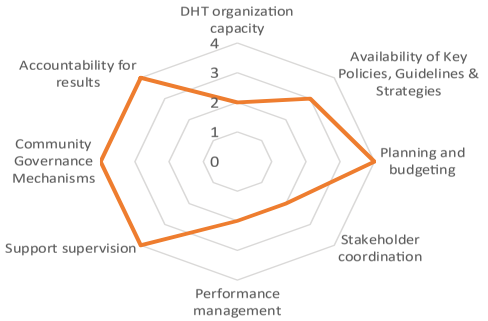
DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

Hoima District - 2018/19

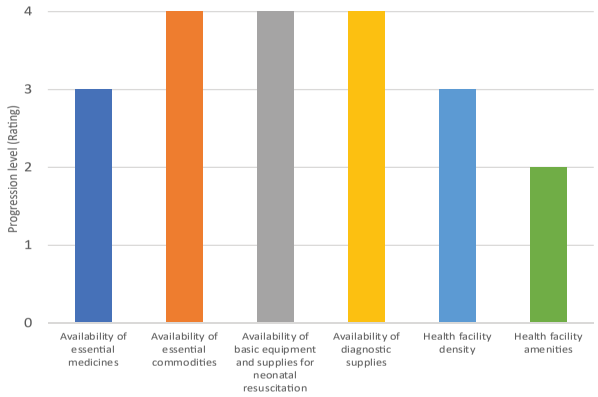
HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	78.1	83.3	80.0	50.0	50.0	75.0	74.2

Key: <50% | 50.1-70% | 70.1-90% | >90%

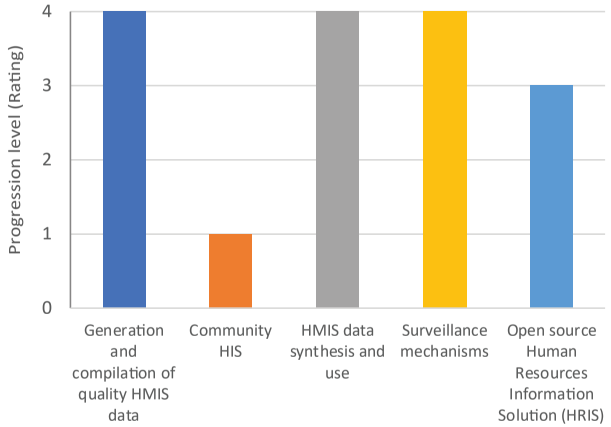
A: Leadership and Governance



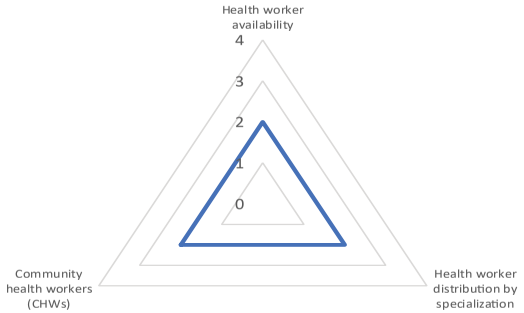
B: Access to essential medicines



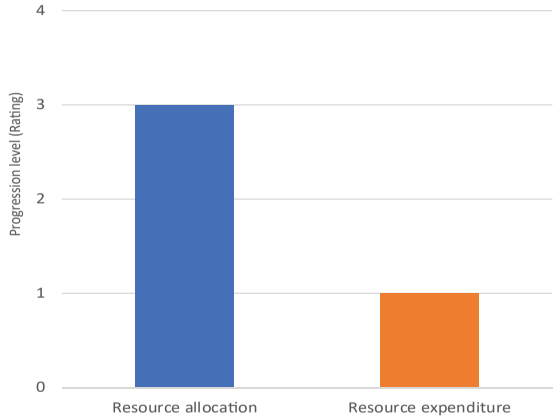
C: Health Information Systems



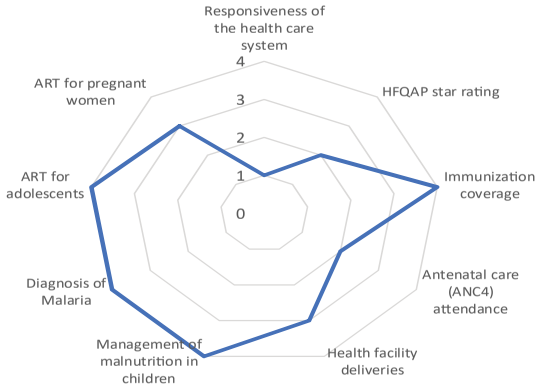
D: Health Workforce



E: Health financing



F: Service delivery



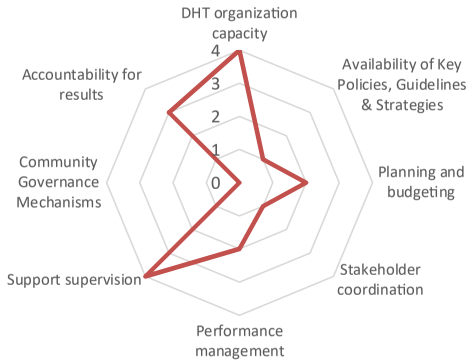
DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

Iganga District - 2018/19

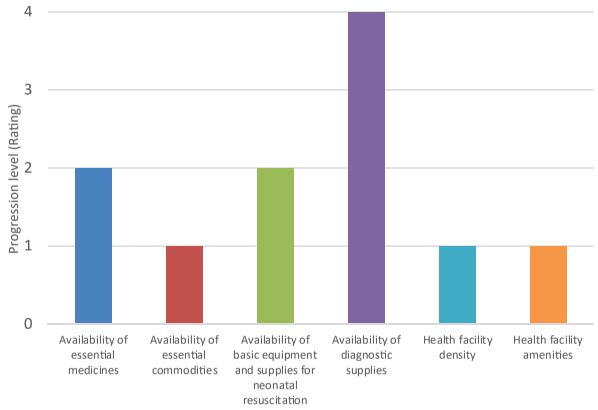
HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	53.1	45.8	60.0	66.7	75.0	69.4	59.8

Key: <50% | 50.1-70% | 70.1-90% | >90%

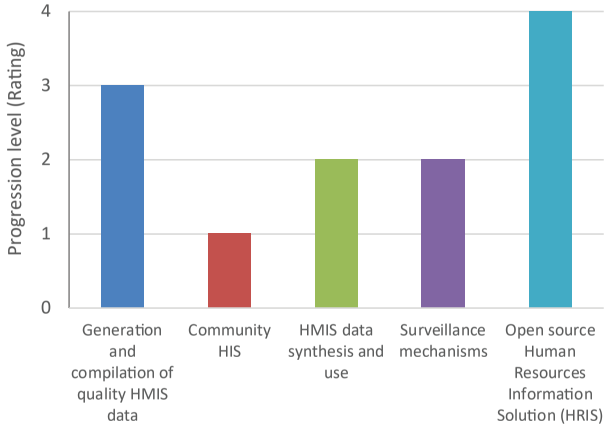
A: Leadership and Governance



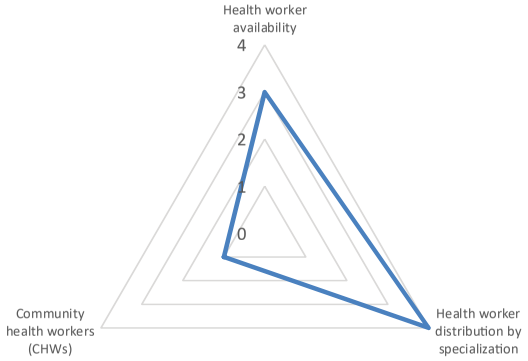
B: Access to essential medicines



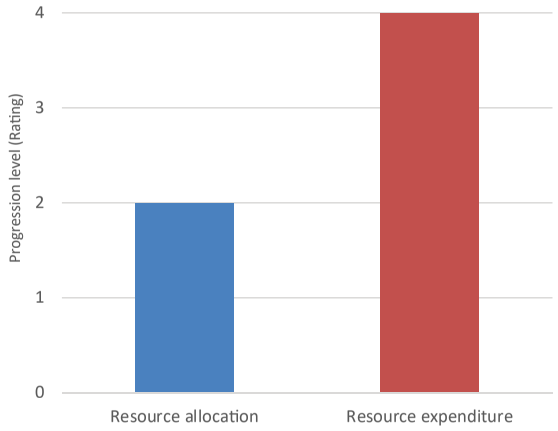
C: Health Information Systems



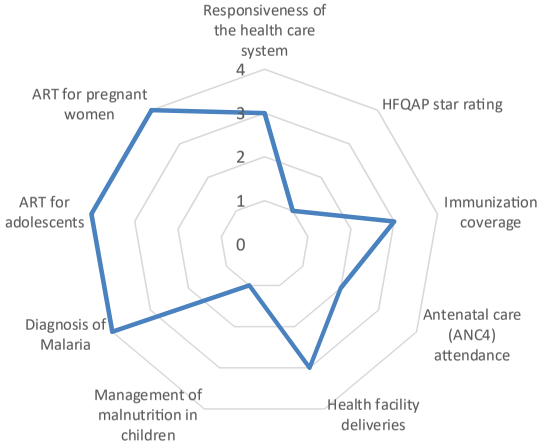
D: Health Workforce



E: Health financing



F: Service delivery



DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

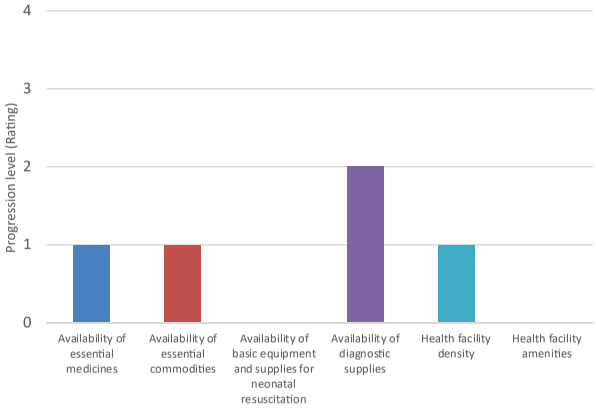
Isingiro District - 2018/19

HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	59.4	20.8	65.0	33.3	62.5	63.9	52.3

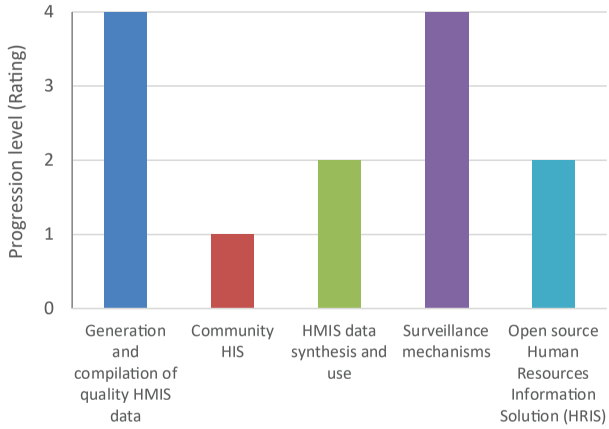
Key: <50% | 50.1-70% | 70.1-90% | >90%

A: Leadership and Governance

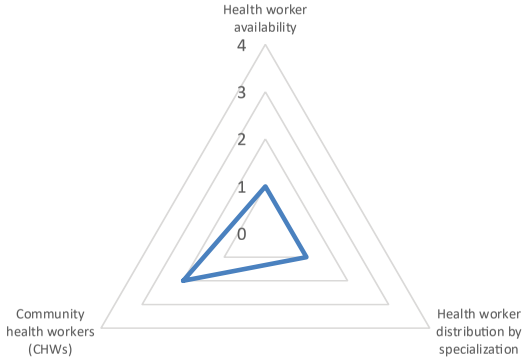
B: Access to essential medicines



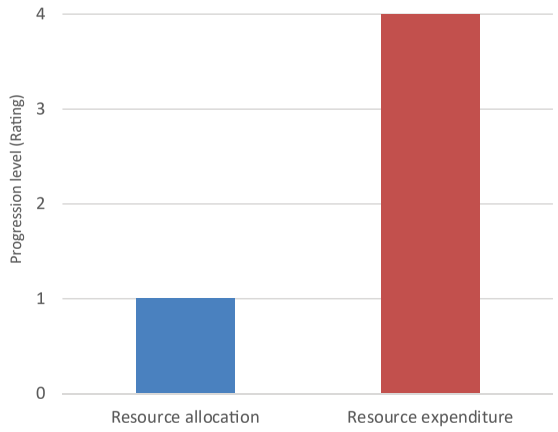
C: Health Information Systems



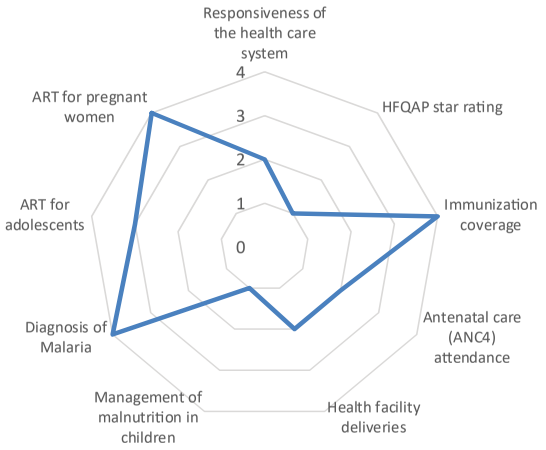
D: Health Workforce



E: Health financing



F: Service delivery



DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

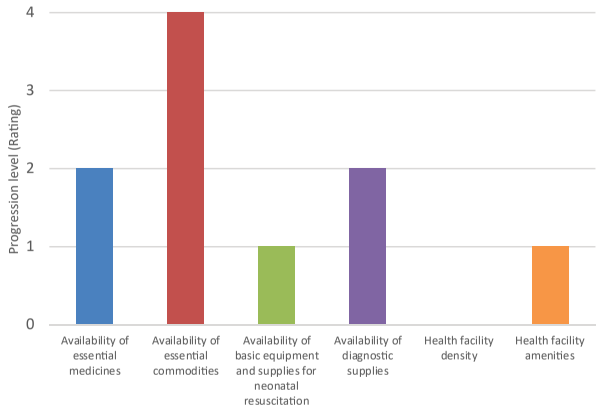
Kabong District - 2018/19

HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	62.5	41.7	65.0	66.7	62.5	75.0	62.9

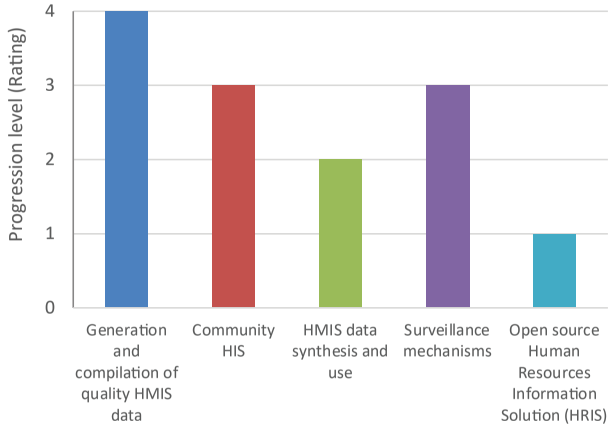
Key: <50% | 50.1-70% | 70.1-90% | >90%

A: Leadership and Governance

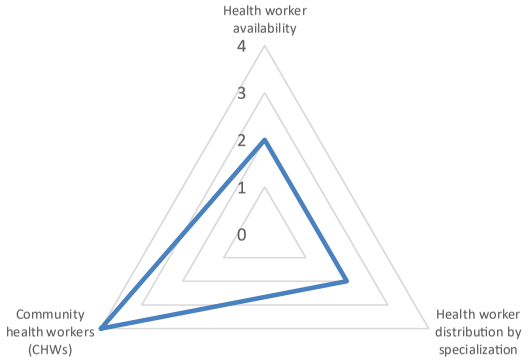
B: Access to essential medicines



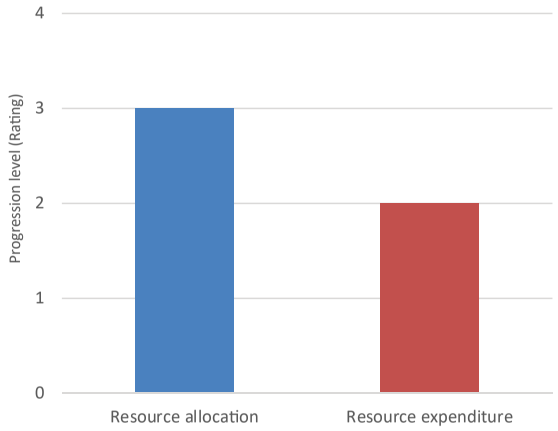
C: Health Information Systems



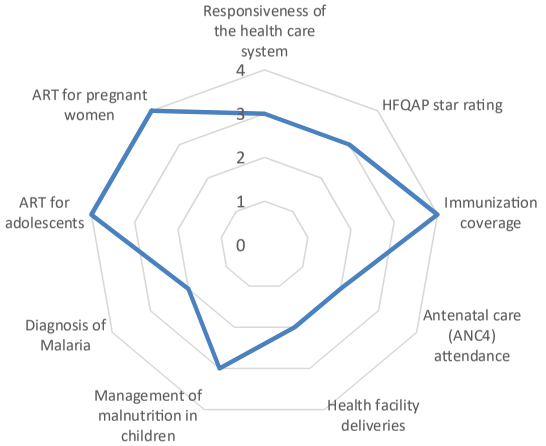
D: Health Workforce



E: Health financing



F: Service delivery



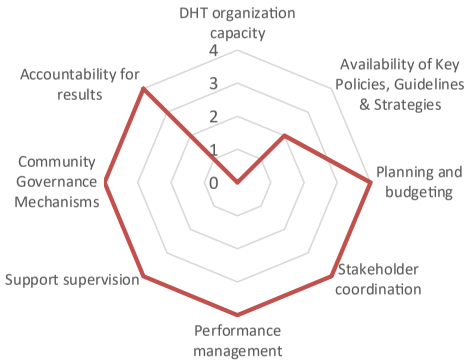
DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

Kamuli District - 2018/19

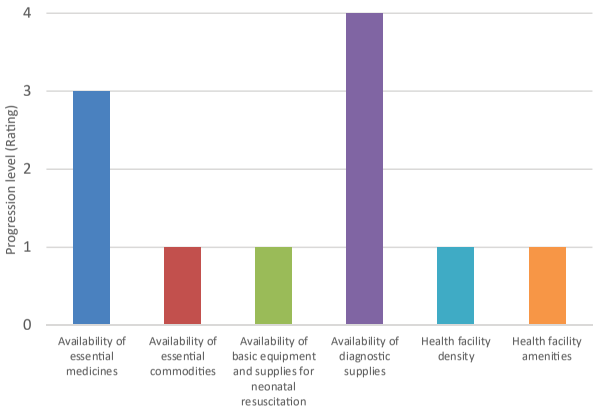
HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	81.3	45.8	70.0	33.3	75.0	52.8	60.6

Key: <50% | 50.1-70% | 70.1-90% | >90%

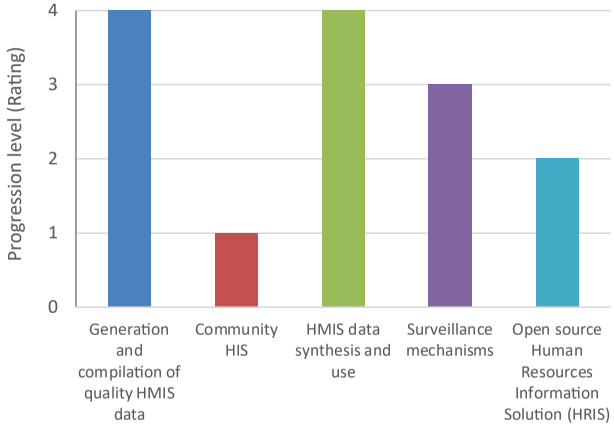
A: Leadership and Governance



B: Access to essential medicines

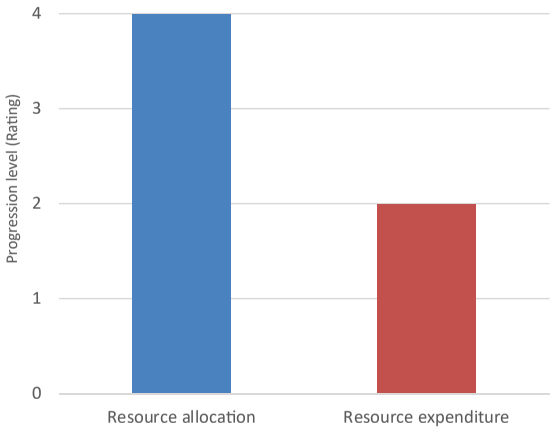


C: Health Information Systems

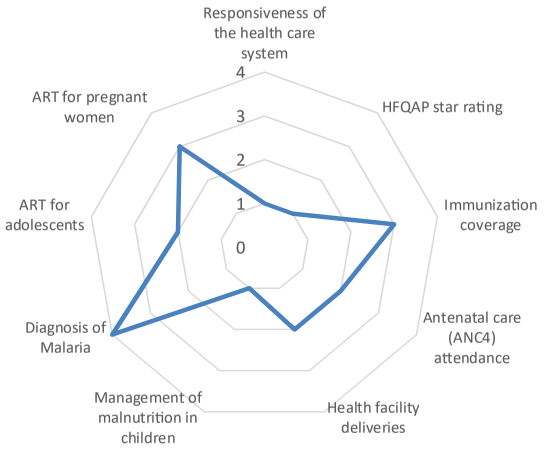


D: Health Workforce

E: Health financing



F: Service delivery



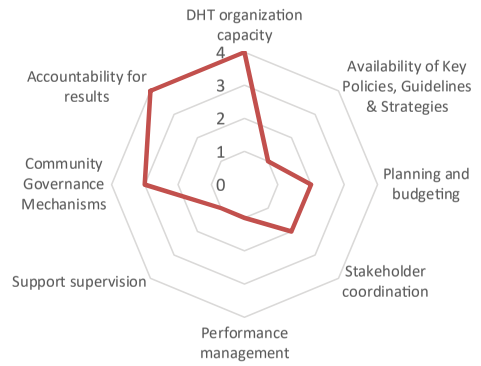
DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

Karenga District - 2018/19

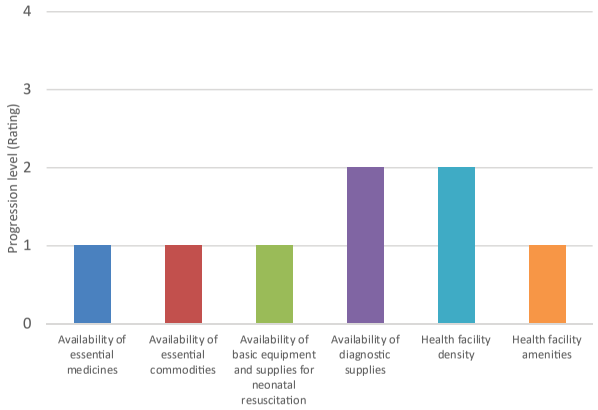
HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	56.3	33.3	40.0	41.7	62.5	55.6	48.5

Key: <50% | 50.1-70% | 70.1-90% | >90%

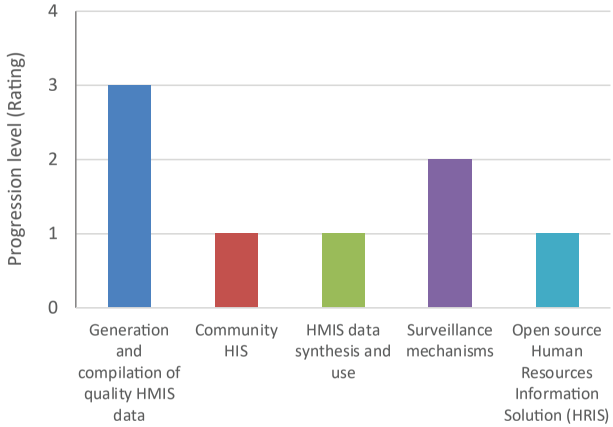
A: Leadership and Governance



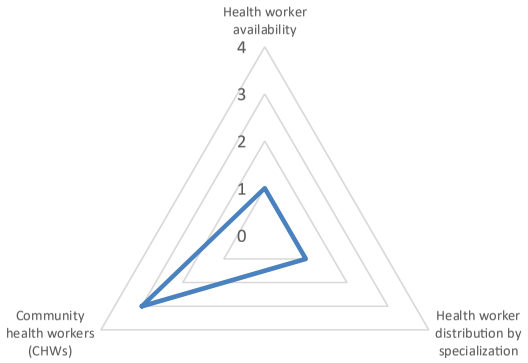
B: Access to essential medicines



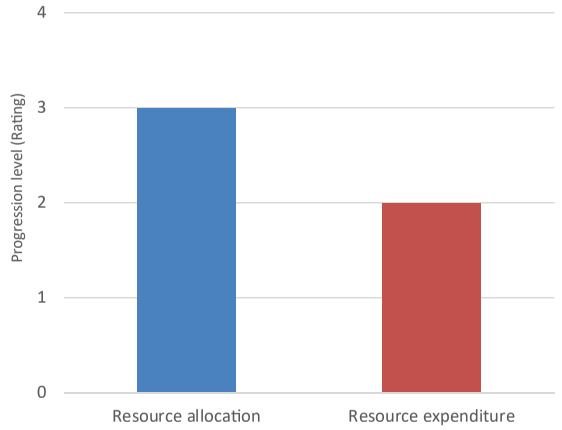
C: Health Information Systems



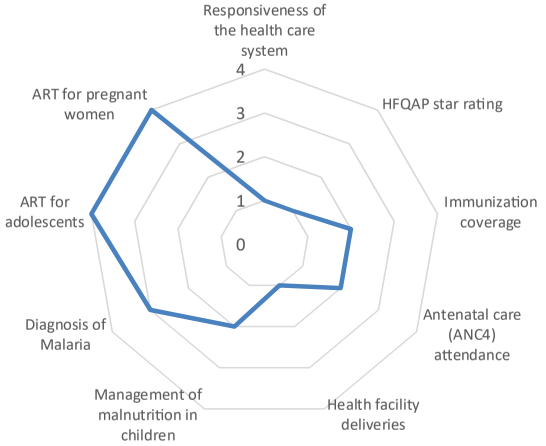
D: Health Workforce



E: Health financing



F: Service delivery



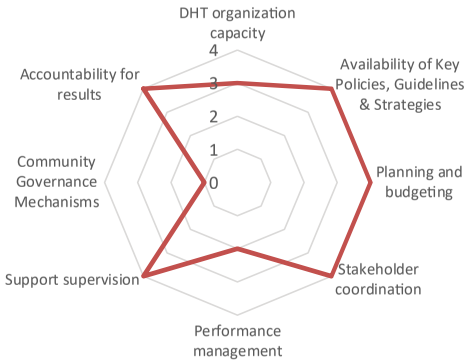
DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

Kasese District - 2018/19

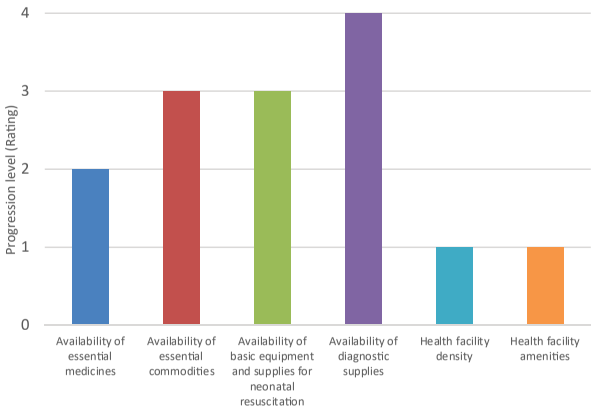
HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	81.3	58.3	70.0	91.7	50.0	77.8	73.5

Key: <50% | 50.1-70% | 70.1-90% | >90%

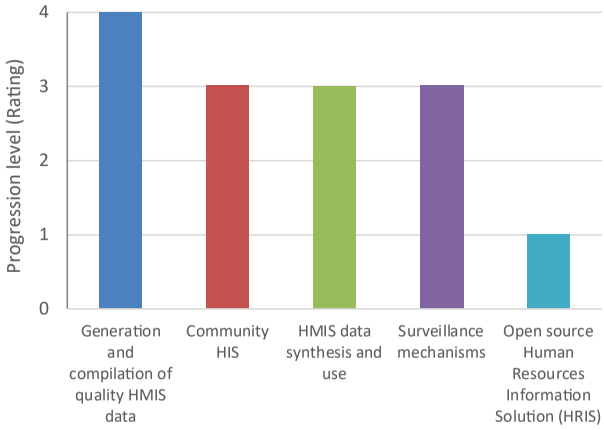
A: Leadership and Governance



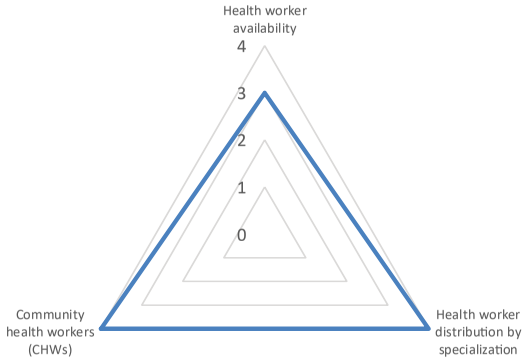
B: Access to essential medicines



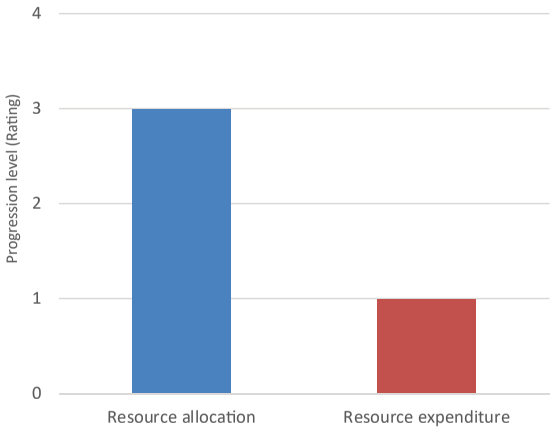
C: Health Information Systems



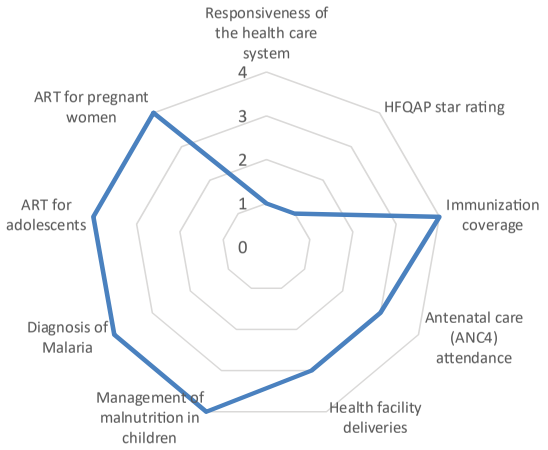
D: Health Workforce



E: Health financing



F: Service delivery



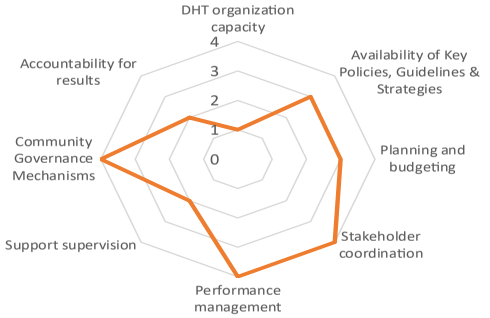
DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

Kikuube District - 2018/19

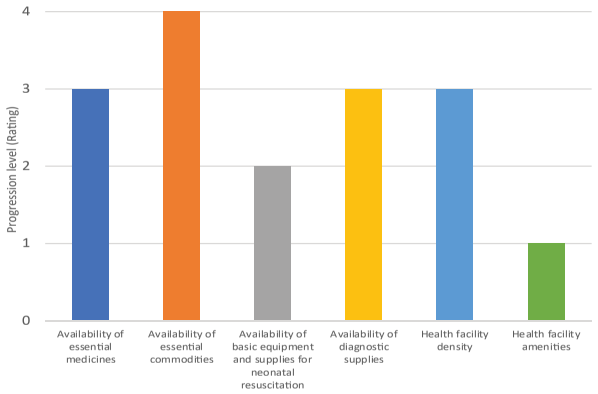
HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	71.9	66.7	55.0	33.3	87.5	66.7	64.4

Key: <50% | 50.1-70% | 70.1-90% | >90%

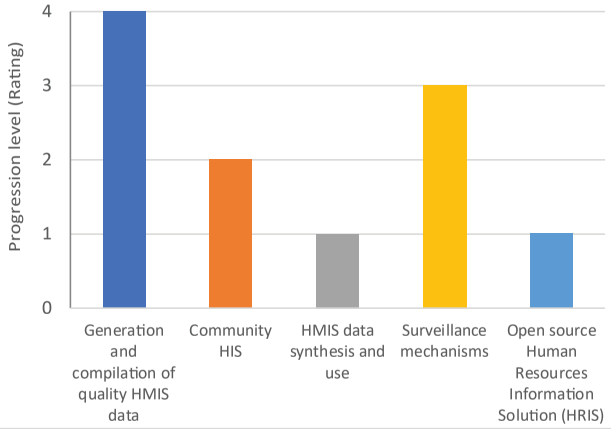
A: Leadership and Governance



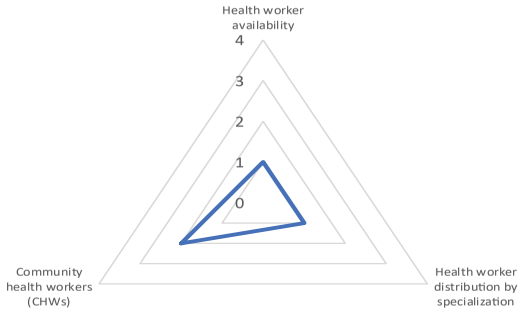
B: Access to essential medicines



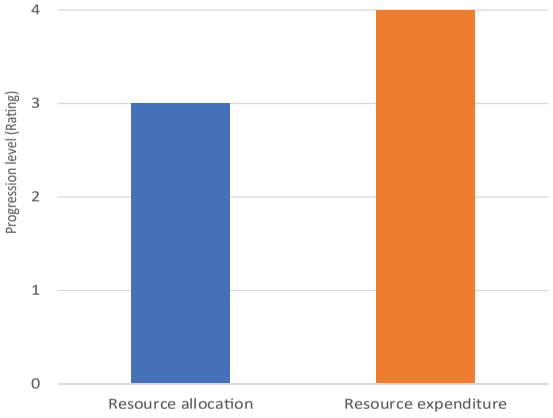
C: Health Information Systems



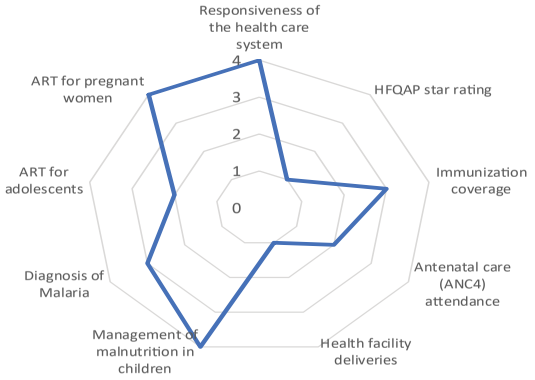
D: Health Workforce



E: Health financing



F: Service delivery



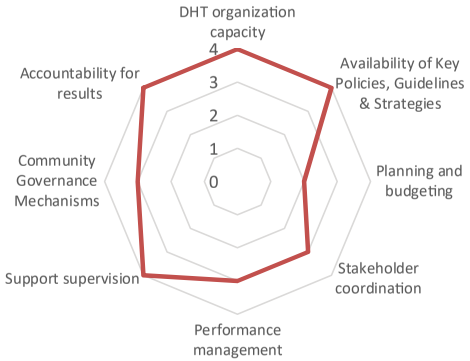
DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

Kiryandongo District - 2018/19

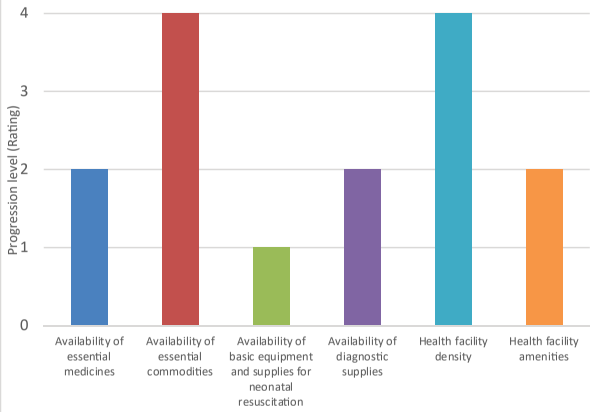
HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D:Health Workforce	E: Health financing	F: Service delivery	Overall
	84.4	62.5	70.0	58.3	75.0	77.8	73.5

Key: <50% | 50.1-70% | 70.1-90% | >90%

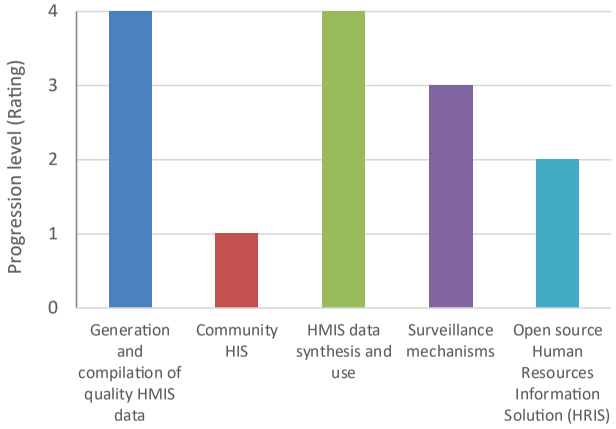
A: Leadership and Governance



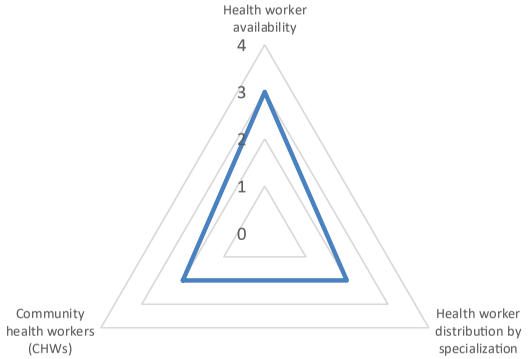
B: Access to essential medicines



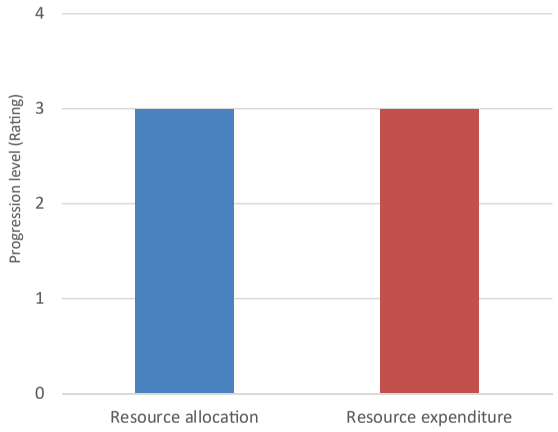
C: Health Information Systems



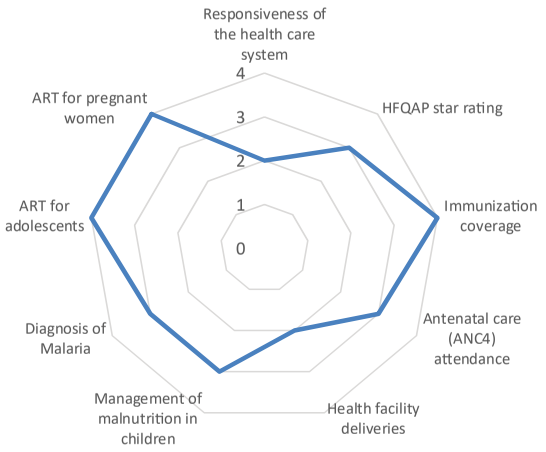
D: Health Workforce



E: Health financing



F: Service delivery



DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

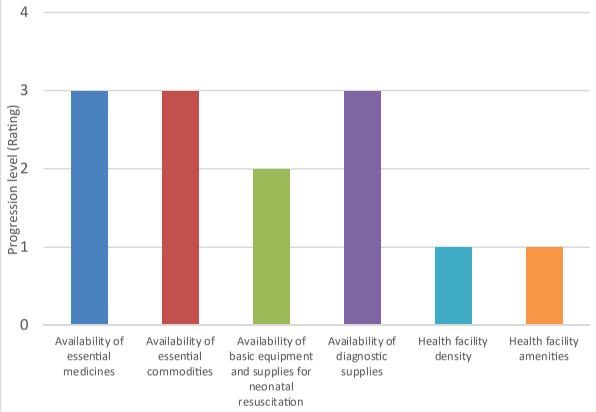
Koboko District - 2018/19

HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	87.5	54.2	75.0	66.7	87.5	72.2	73.5

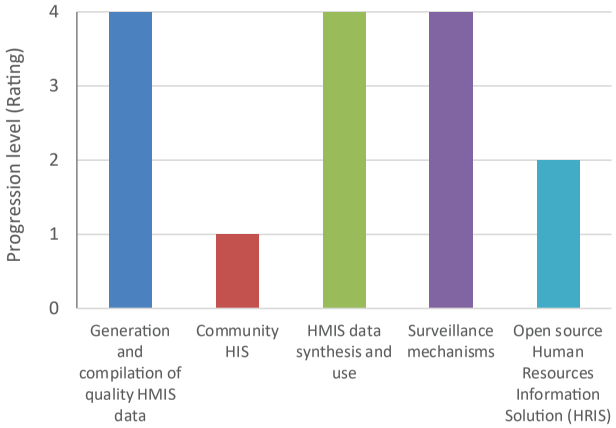
Key: <50% | 50.1-70% | 70.1-90% | >90%

A: Leadership and Governance

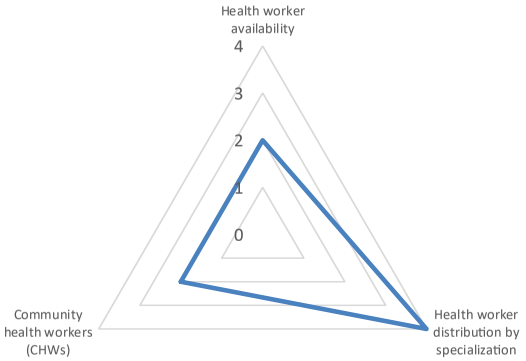
B: Access to essential medicines



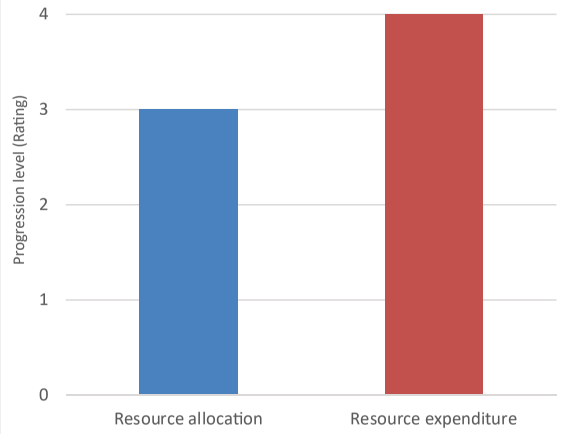
C: Health Information Systems



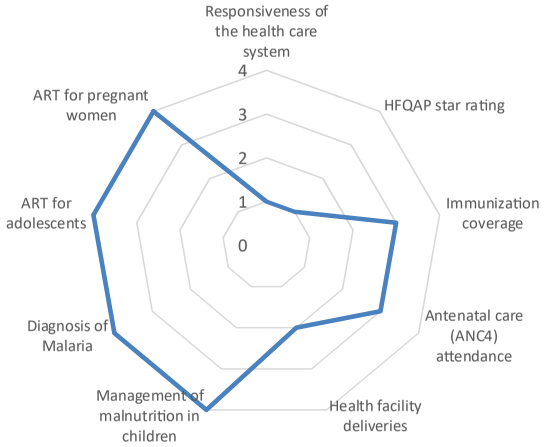
D: Health Workforce



E: Health financing



F: Service delivery



DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

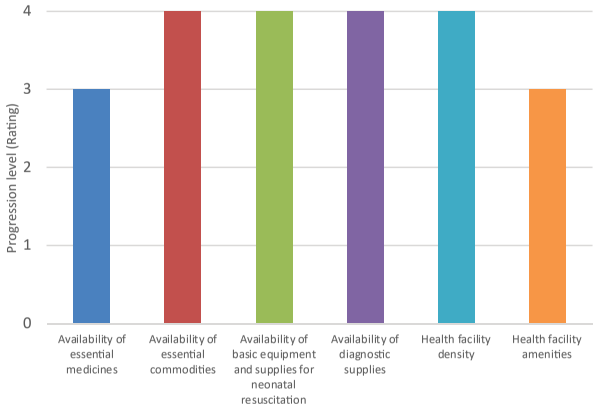
Kotido District - 2018/19

HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	71.9	91.7	75.0	58.3	50.0	66.7	72.0

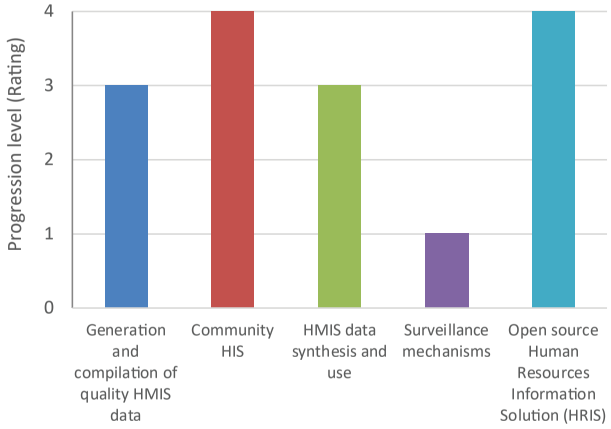
Key: <50% | 50.1-70% | 70.1-90% | >90%

A: Leadership and Governance

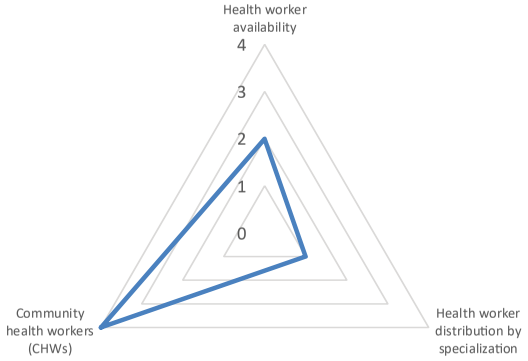
B: Access to essential medicines



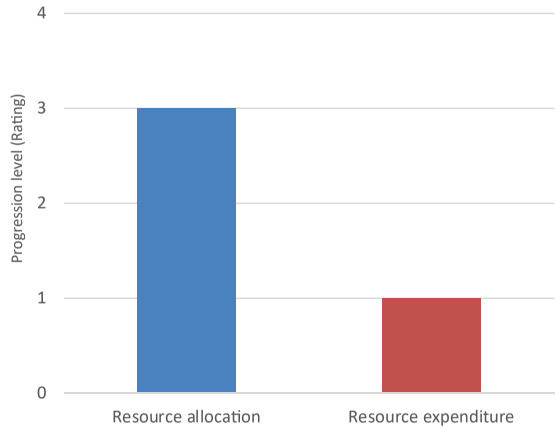
C: Health Information Systems



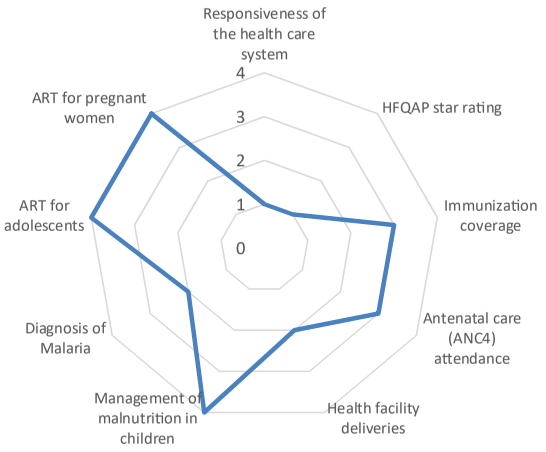
D: Health Workforce



E: Health financing



F: Service delivery



DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

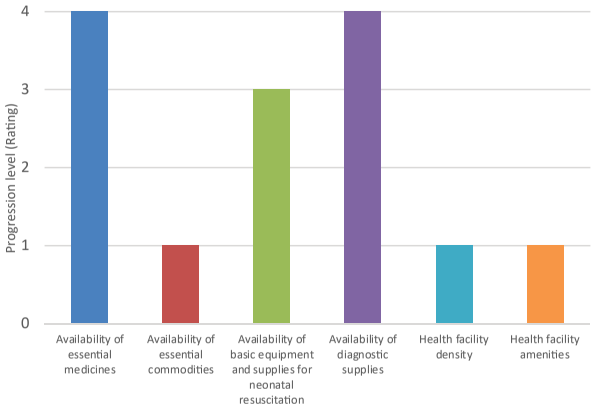
Kyenjojo District - 2018/19

HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	68.8	58.3	70.0	50.0	62.5	58.3	62.1

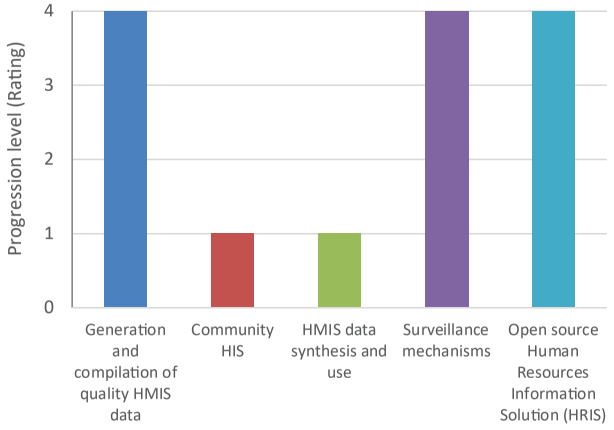
Key: <50% | 50.1-70% | 70.1-90% | >90%

A: Leadership and Governance

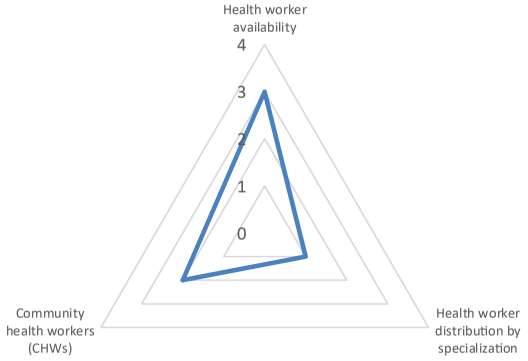
B: Access to essential medicines



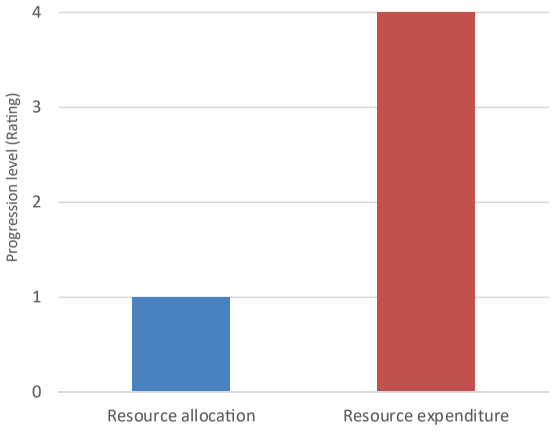
C: Health Information Systems



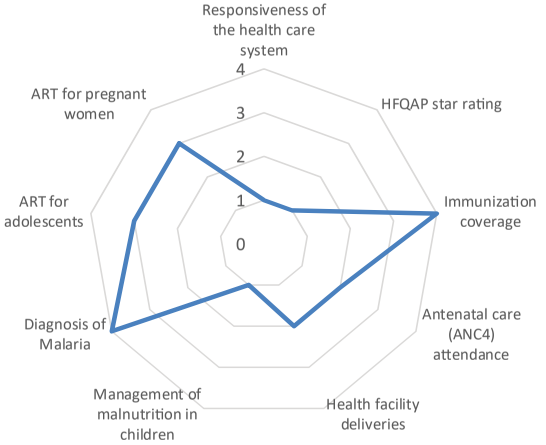
D: Health Workforce



E: Health financing



F: Service delivery



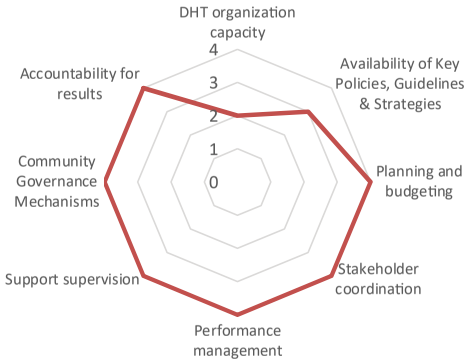
DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

Lamwo District - 2018/19

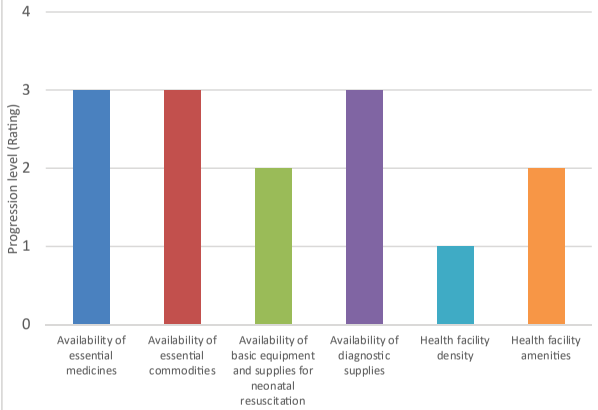
HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	90.6	58.3	85.0	66.7	100.0	77.8	78.8

Key: <50% | 50.1-70% | 70.1-90% | >90%

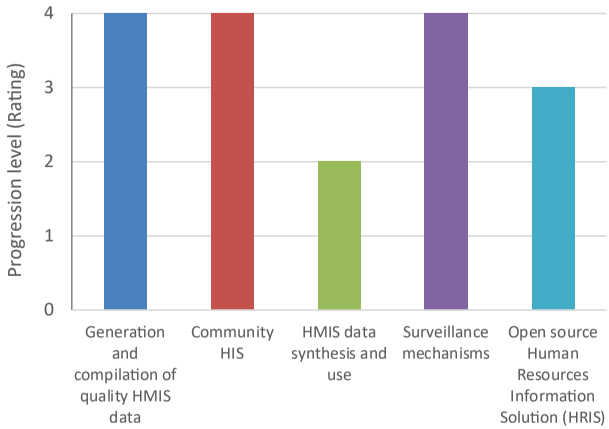
A: Leadership and Governance



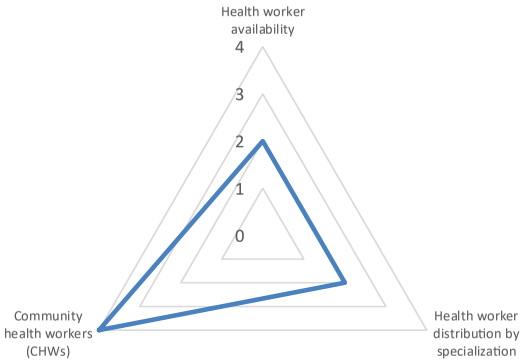
B: Access to essential medicines



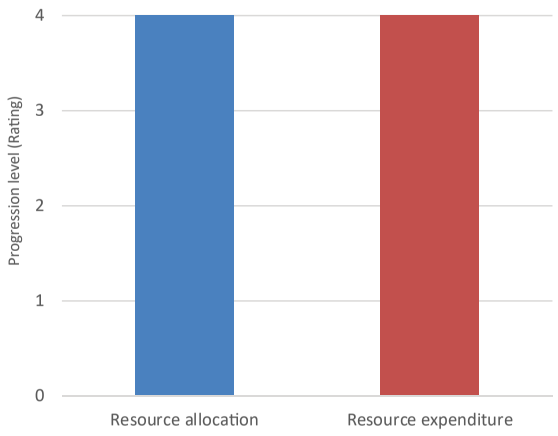
C: Health Information Systems



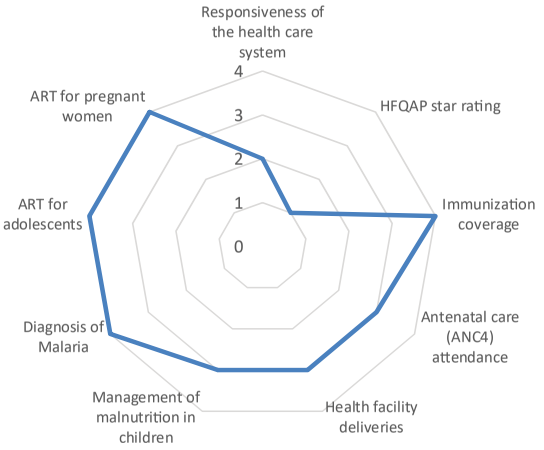
D: Health Workforce



E: Health financing



F: Service delivery



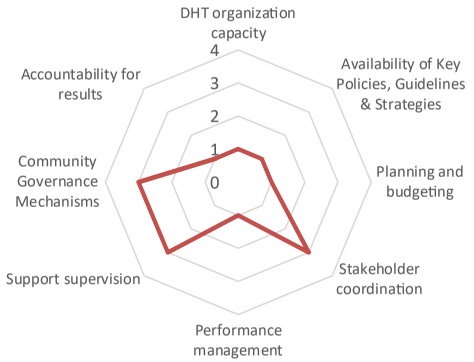
DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

Madi Okollo District - 2018/19

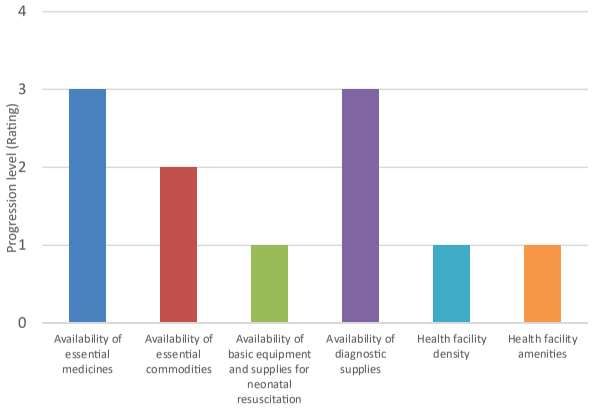
HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	43.8	45.8	65.0	33.3	62.5	72.2	55.3

Key: <50% | 50.1-70% | 70.1-90% | >90%

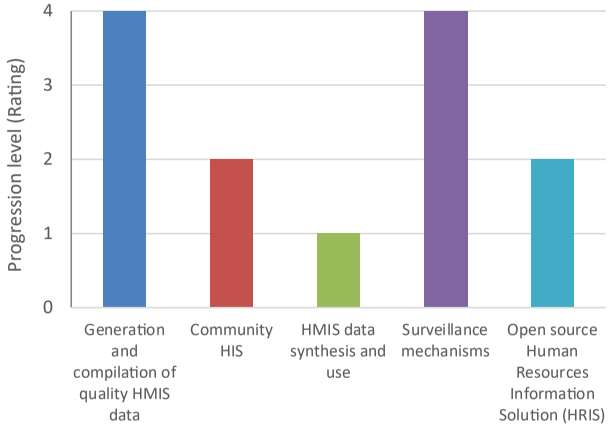
A: Leadership and Governance



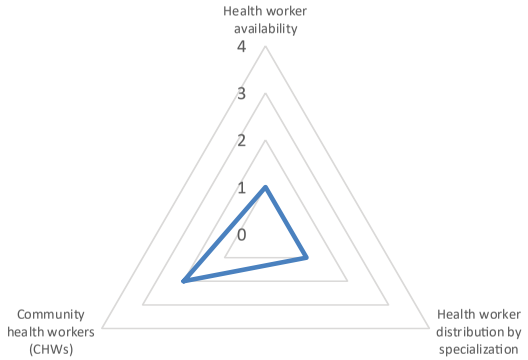
B: Access to essential medicines



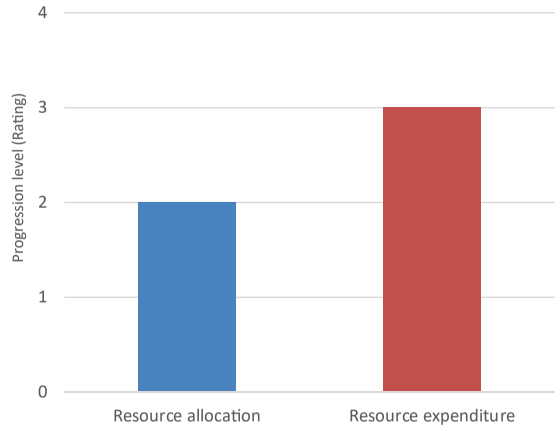
C: Health Information Systems



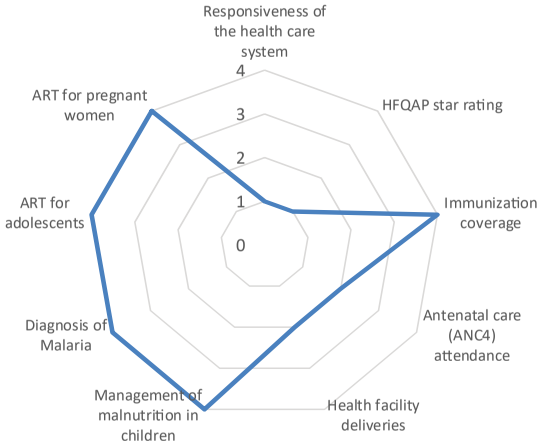
D: Health Workforce



E: Health financing



F: Service delivery



DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

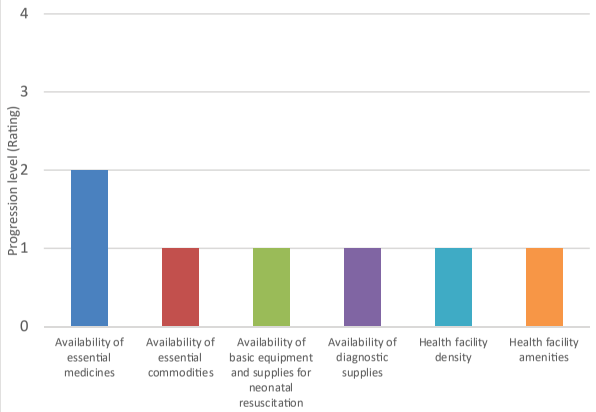
Maracha District - 2018/19

HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	56.3	29.2	75.0	83.3	75.0	63.9	59.8

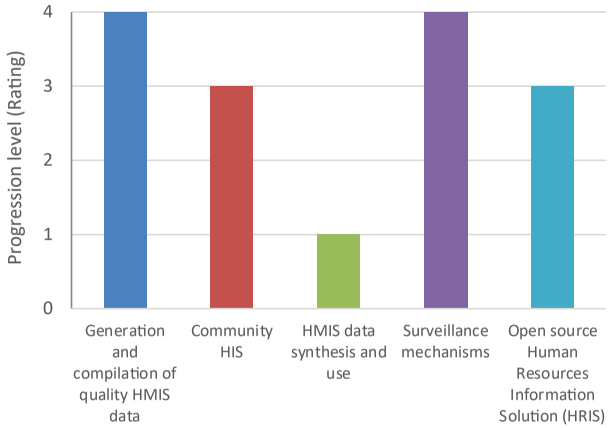
Key: <50% | 50.1-70% | 70.1-90% | >90%

A: Leadership and Governance

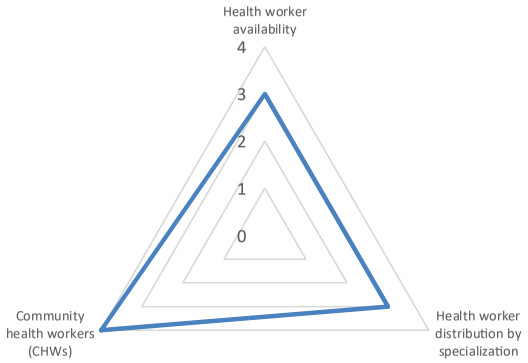
B: Access to essential medicines



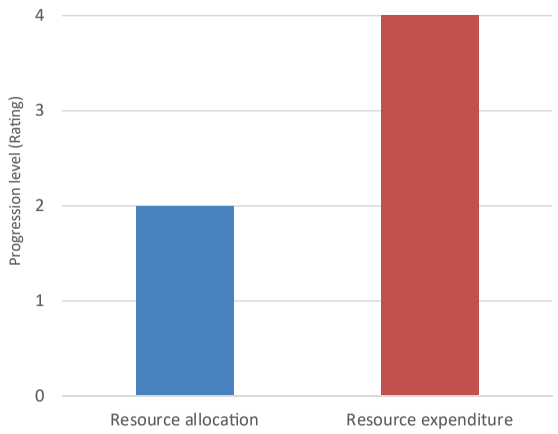
C: Health Information Systems



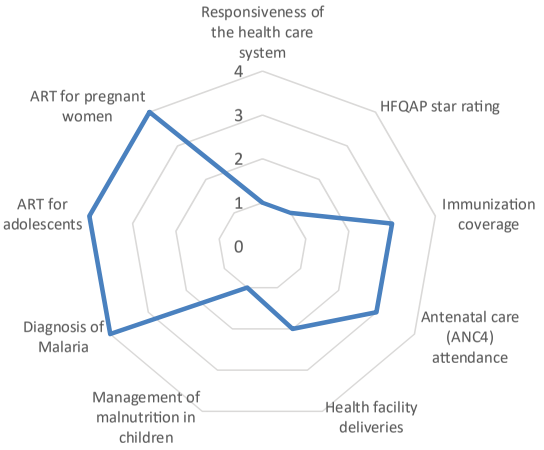
D: Health Workforce



E: Health financing



F: Service delivery



DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

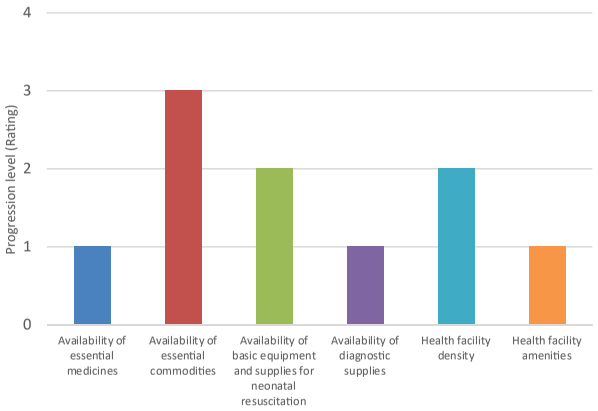
Moroto District - 2018/19

HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	68.8	41.7	85.0	25.0	87.5	63.9	62.1

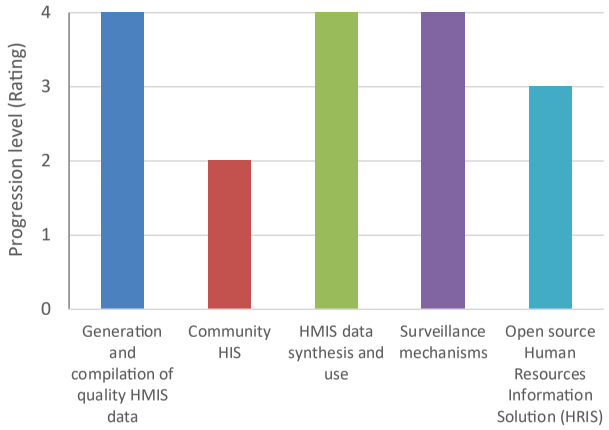
Key: <50% | 50.1-70% | 70.1-90% | >90%

A: Leadership and Governance

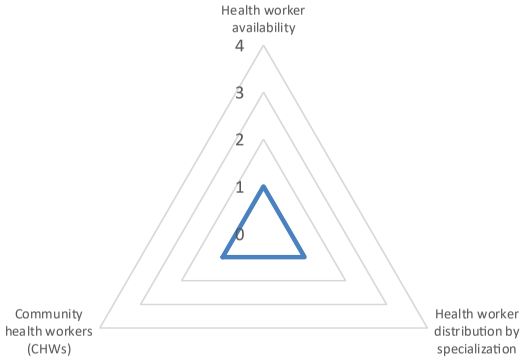
B: Access to essential medicines



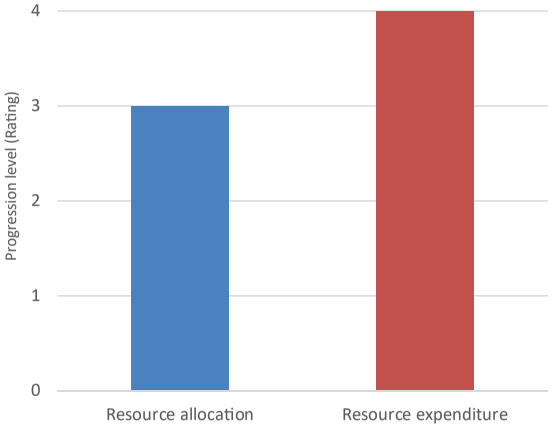
C: Health Information Systems



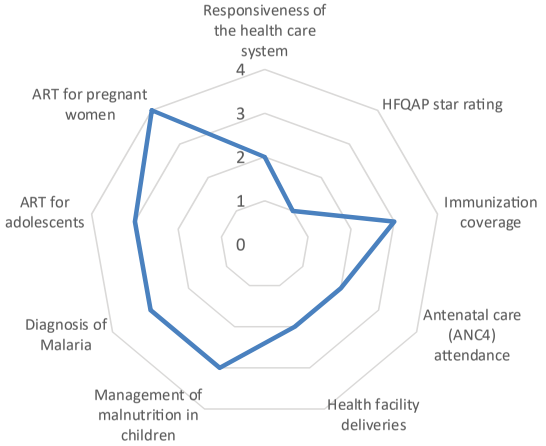
D: Health Workforce



E: Health financing



F: Service delivery



DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

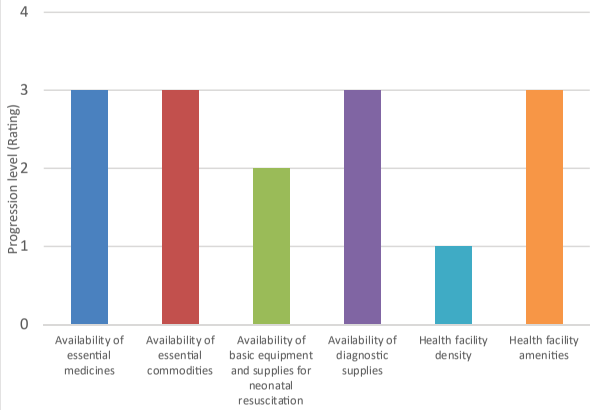
Moyo District - 2018/19

HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	93.8	62.5	55.0	75.0	75.0	61.1	70.5

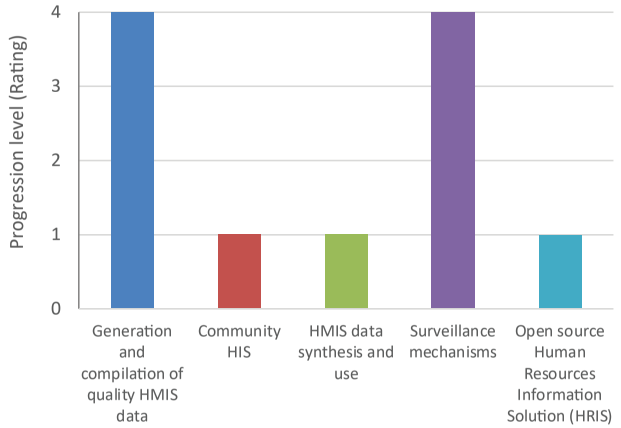
Key: <50% | 50.1-70% | 70.1-90% | >90%

A: Leadership and Governance

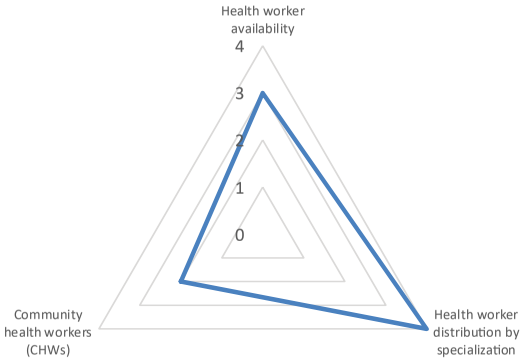
B: Access to essential medicines



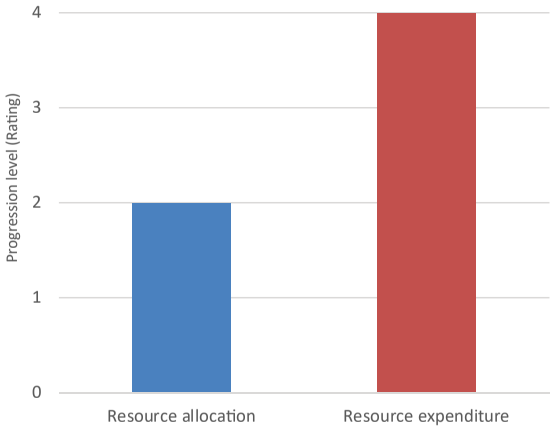
C: Health Information Systems



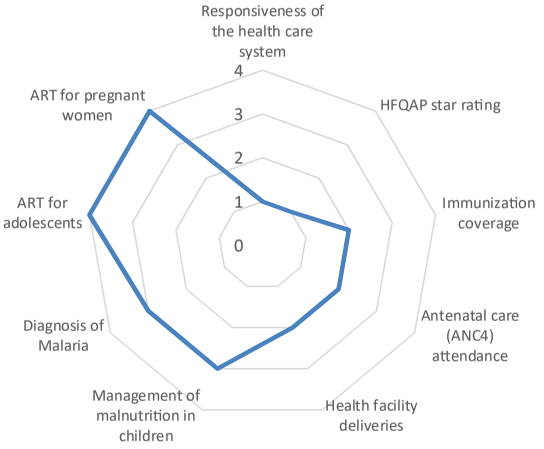
D: Health Workforce



E: Health financing



F: Service delivery



DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

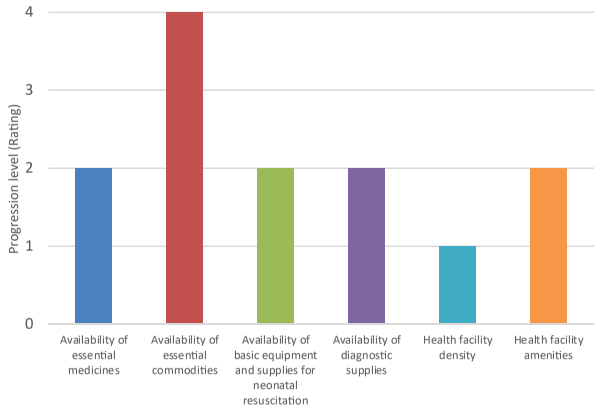
Nabilatuk District - 2018/19

HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	43.8	54.2	65.0	50.0	87.5	52.8	54.5

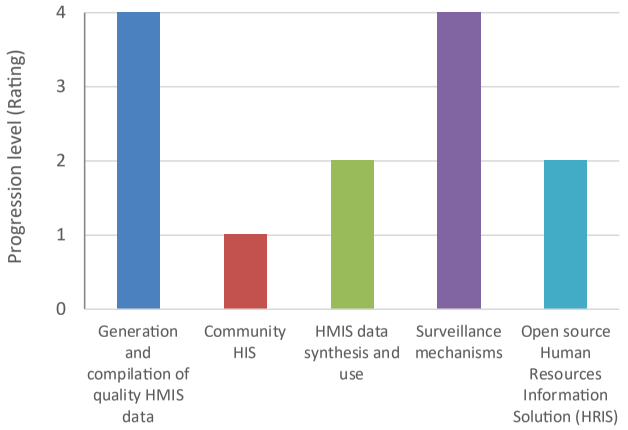
Key: <50% | 50.1-70% | 70.1-90% | >90%

A: Leadership and Governance

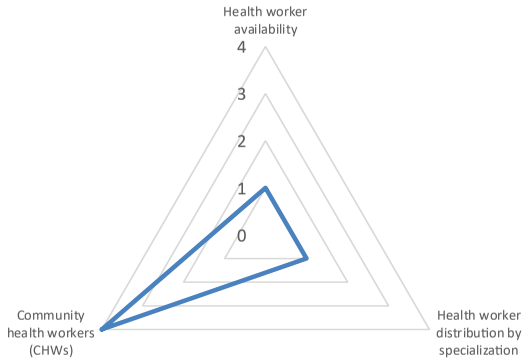
B: Access to essential medicines



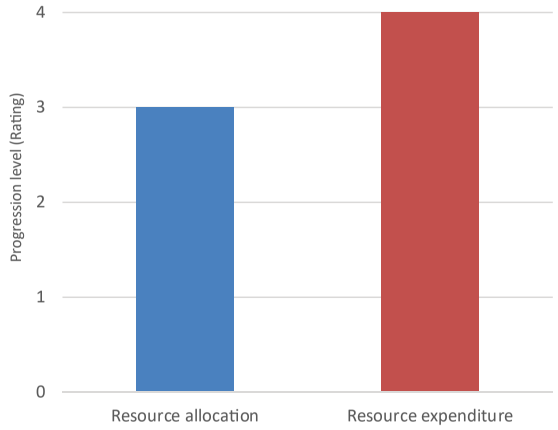
C: Health Information Systems



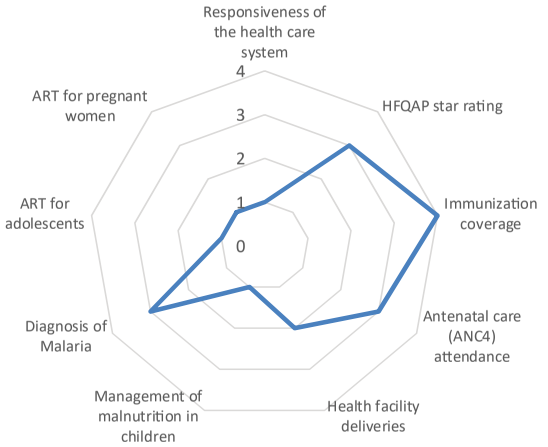
D: Health Workforce



E: Health financing



F: Service delivery



DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

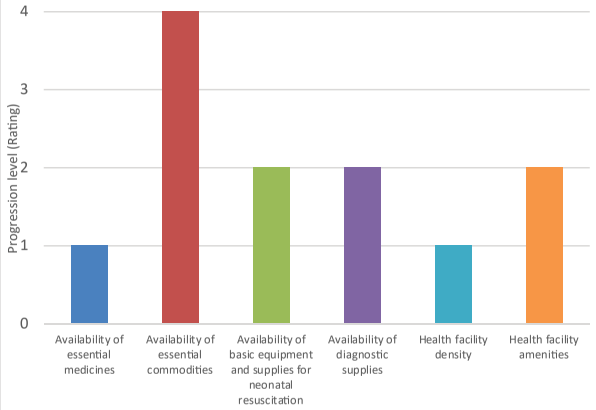
Nakapiripirit District - 2018/19

HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	68.8	50.0	85.0	50.0	87.5	58.3	64.4

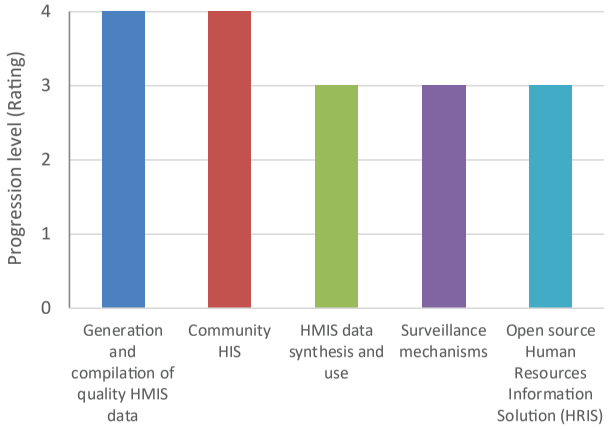
Key: <50% | 50.1-70% | 70.1-90% | >90%

A: Leadership and Governance

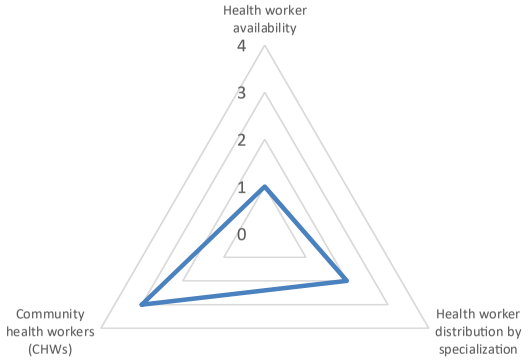
B: Access to essential medicines



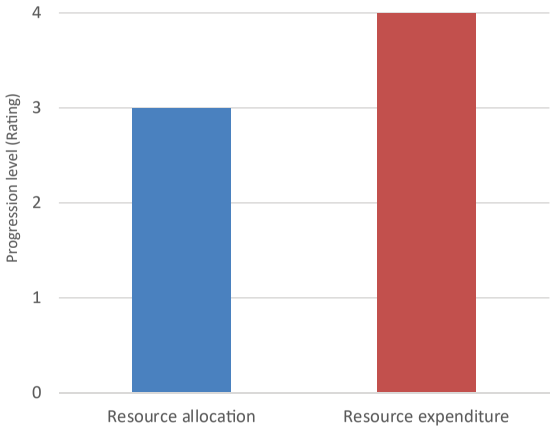
C: Health Information Systems



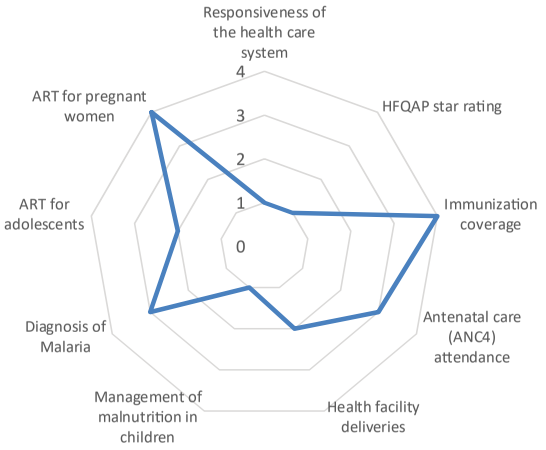
D: Health Workforce



E: Health financing



F: Service delivery



DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

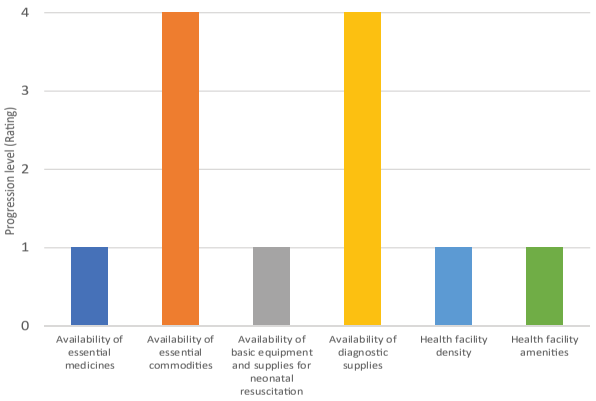
Namayingo District - 2018/19

HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	46.9	50.0	80.0	83.3	50.0	61.1	59.8

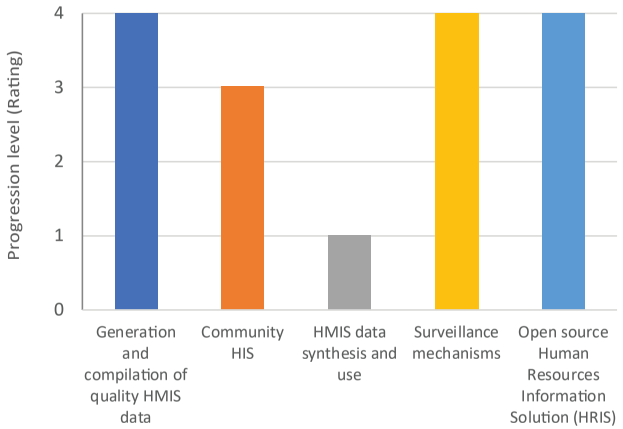
Key: <50% | 50.1-70% | 70.1-90% | >90%

A: Leadership and Governance

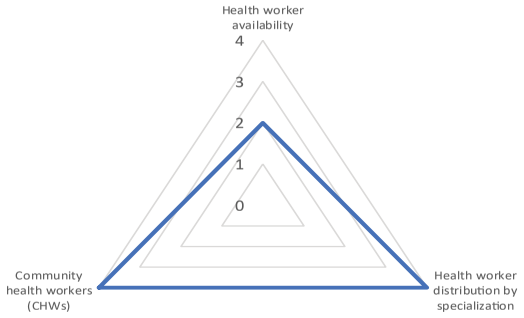
B: Access to essential medicines



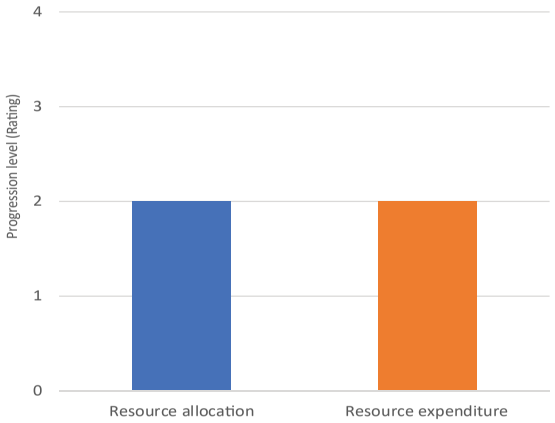
C: Health Information Systems



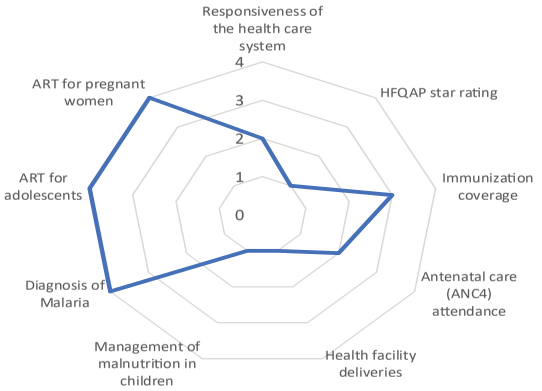
D: Health Workforce



E: Health financing



F: Service delivery



DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

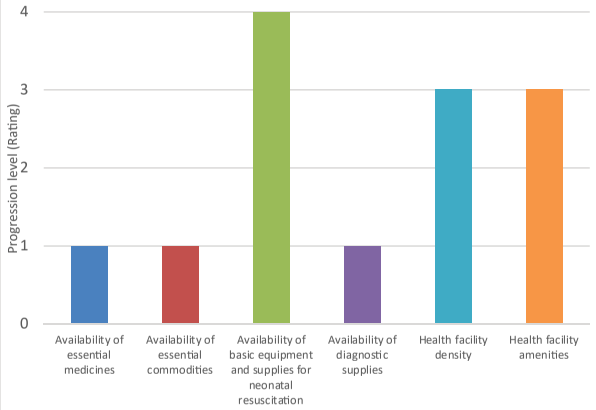
Napak District - 2018/19

HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	65.6	54.2	80.0	41.7	87.5	66.7	65.2

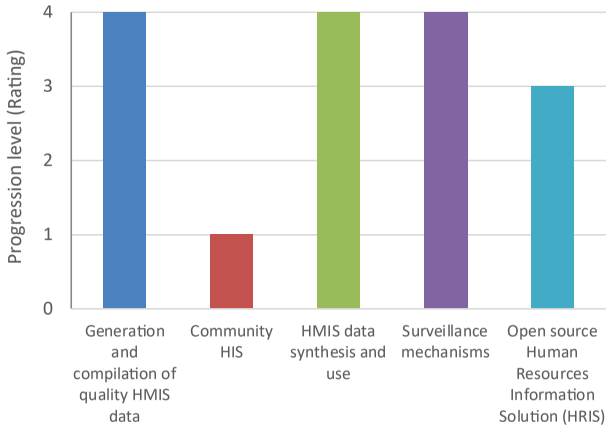
Key: <50% | 50.1-70% | 70.1-90% | >90%

A: Leadership and Governance

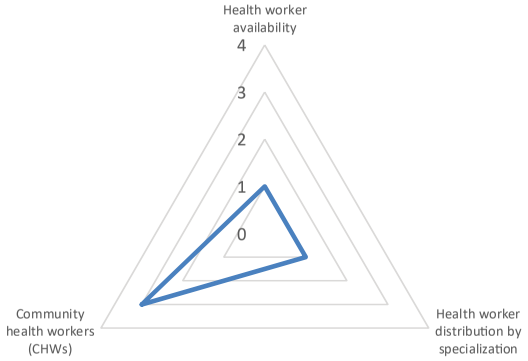
B: Access to essential medicines



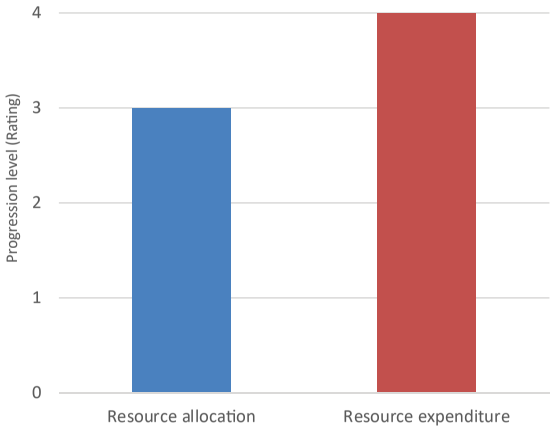
C: Health Information Systems



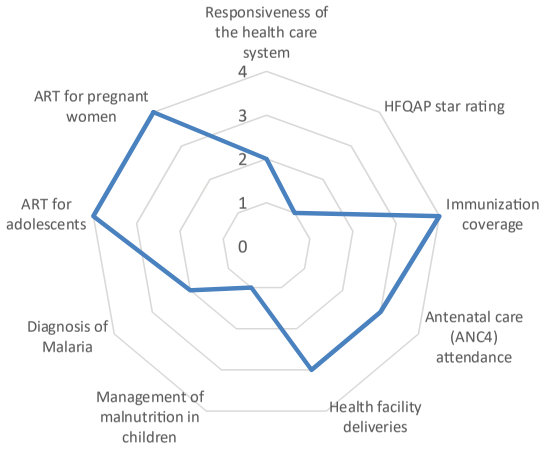
D: Health Workforce



E: Health financing



F: Service delivery



DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

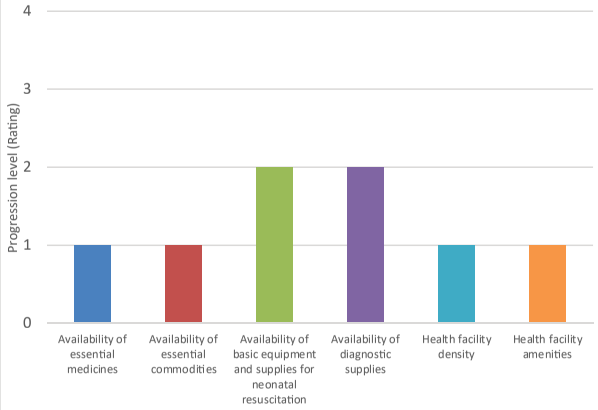
Nebbi District - 2018/19

HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	71.9	33.3	80.0	91.7	87.5	66.7	67.4

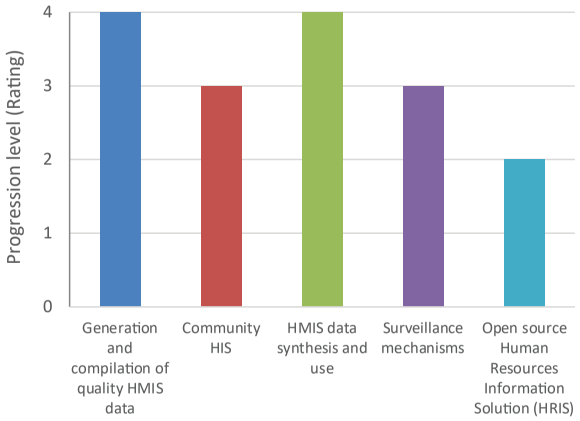
Key: <50% | 50.1-70% | 70.1-90% | >90%

A: Leadership and Governance

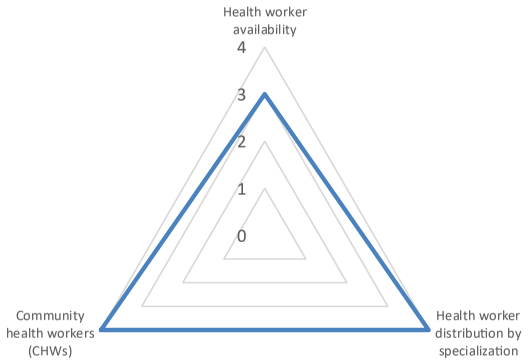
B: Access to essential medicines



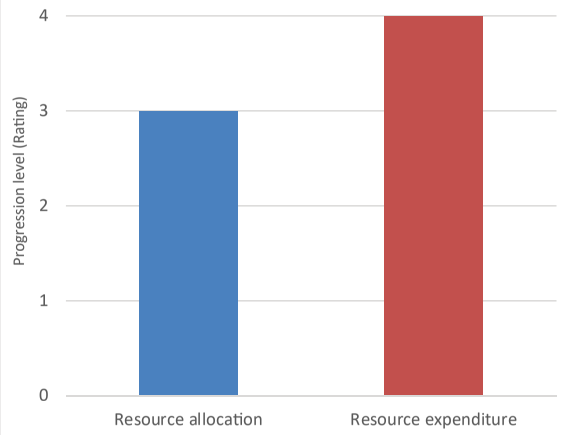
C: Health Information Systems



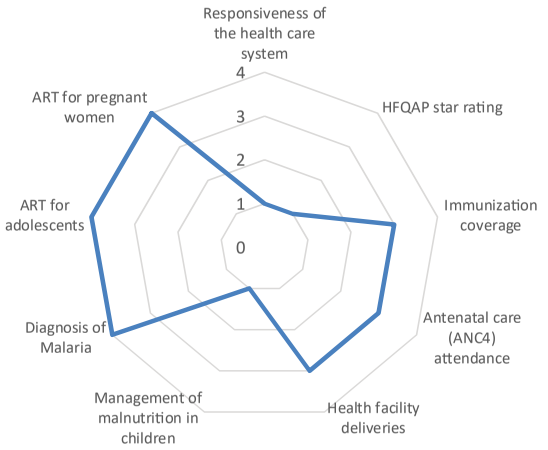
D: Health Workforce



E: Health financing



F: Service delivery



DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

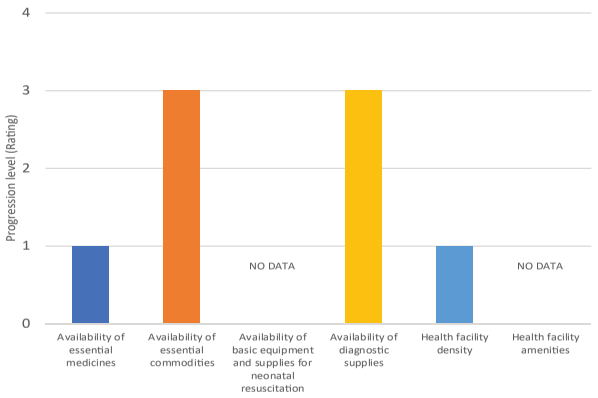
Ntungamo District - 2018/19

HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	40.6	33.3	65.0	16.7	25.0	52.8	43.2

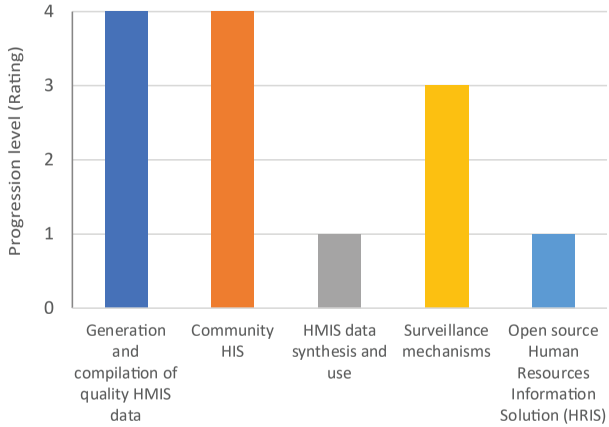
Key: <50% | 50.1-70% | 70.1-90% | >90%

A: Leadership and Governance

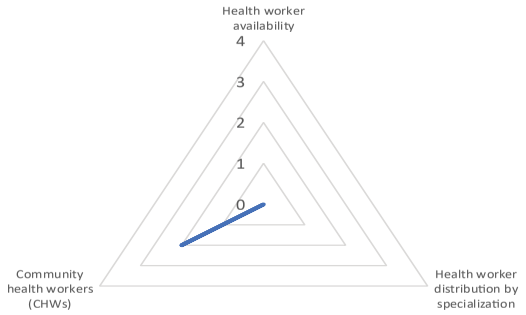
B: Access to essential medicines



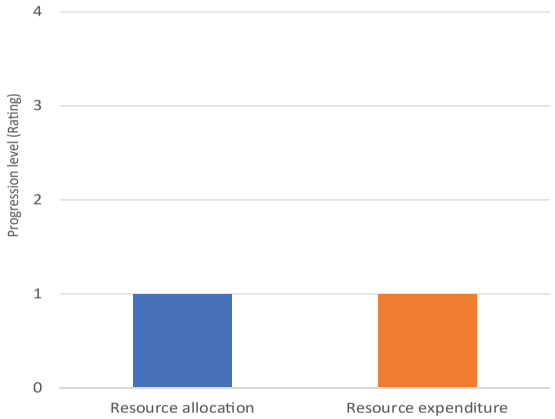
C: Health Information Systems



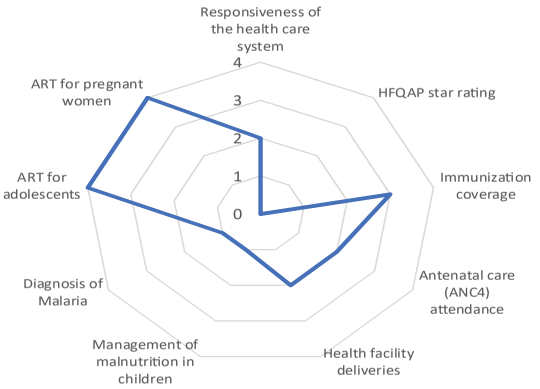
D: Health Workforce



E: Health financing



F: Service delivery



DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

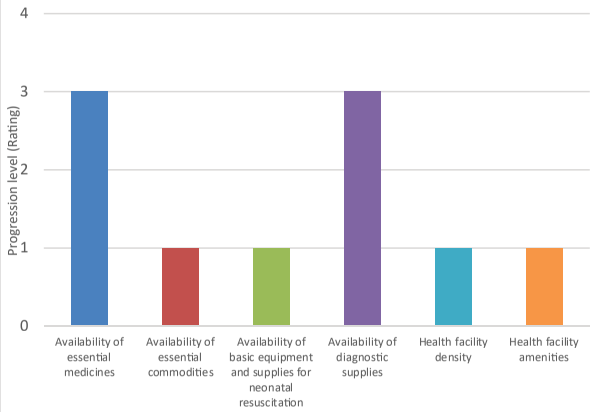
Obongi District - 2018/19

HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D:Health Workforce	E: Health financing	F: Service delivery	Overall
	53.1	41.7	60.0	58.3	25.0	41.7	47.7

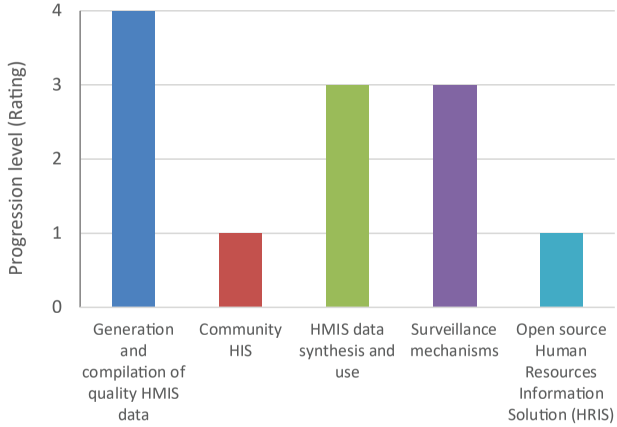
Key: <50% | 50.1-70% | 70.1-90% | >90%

A: Leadership and Governance

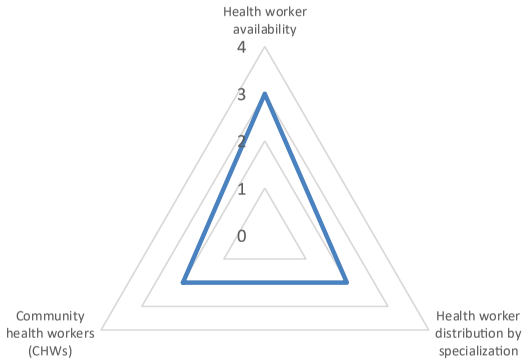
B: Access to essential medicines



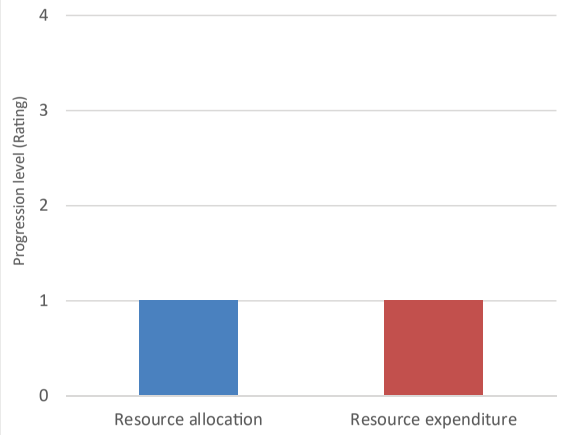
C: Health Information Systems



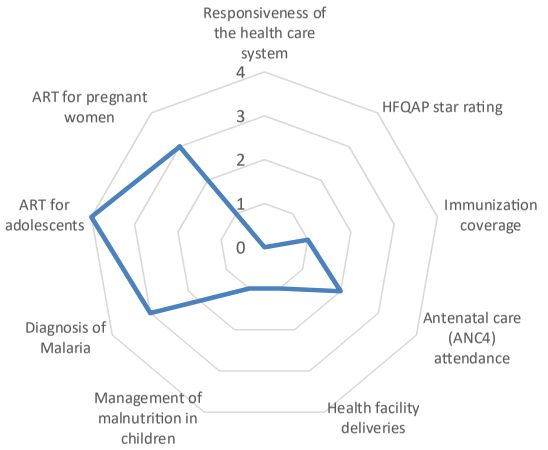
D: Health Workforce



E: Health financing



F: Service delivery



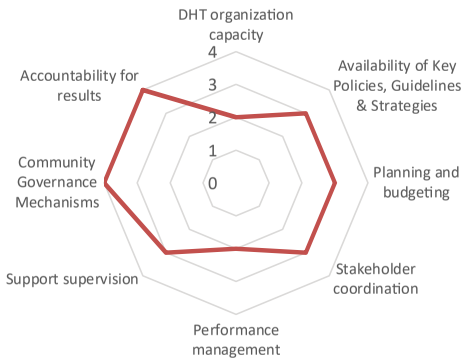
DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

Oyam District - 2018/19

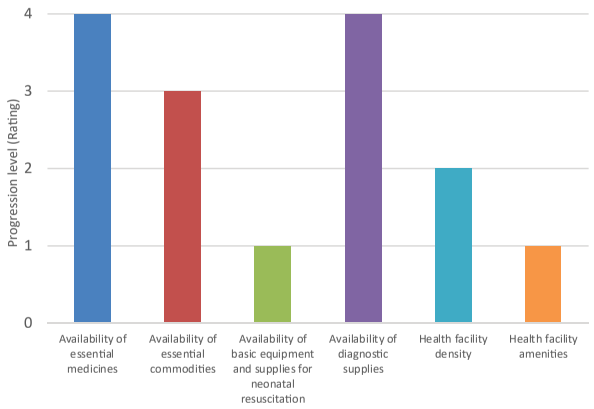
HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D:Health Workforce	E: Health financing	F: Service delivery	Overall
	75.0	62.5	90.0	83.3	37.5	50.0	66.7

Key: <50% | 50.1-70% | 70.1-90% | >90%

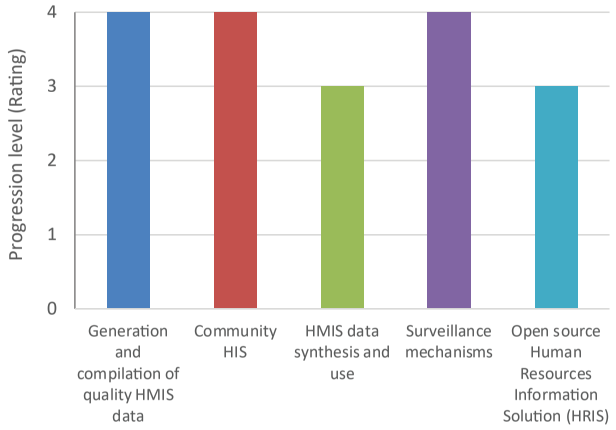
A: Leadership and Governance



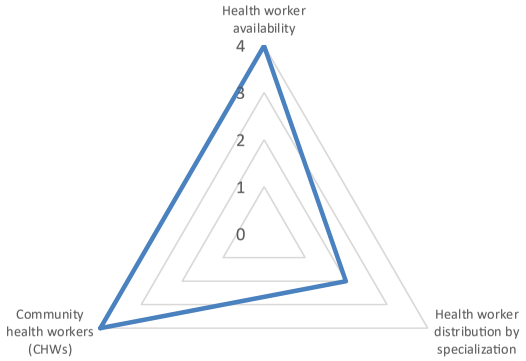
B: Access to essential medicines



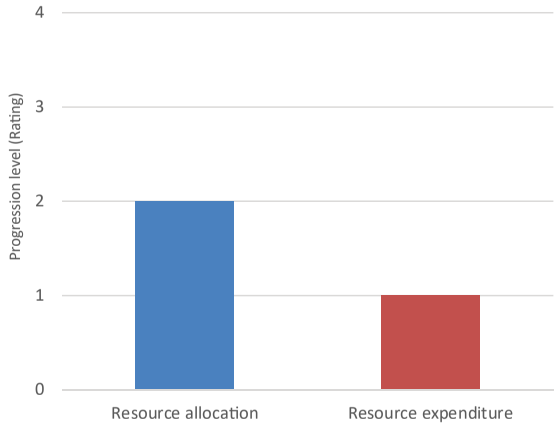
C: Health Information Systems



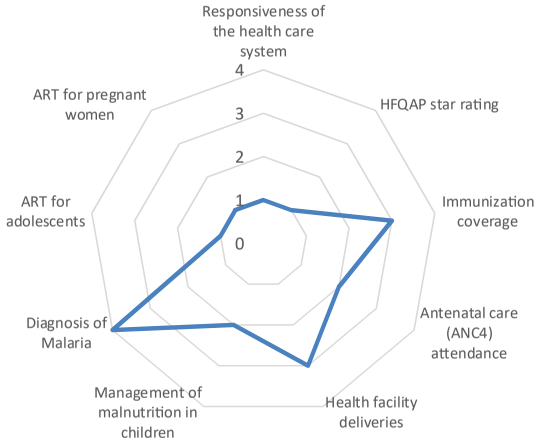
D: Health Workforce



E: Health financing



F: Service delivery



DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

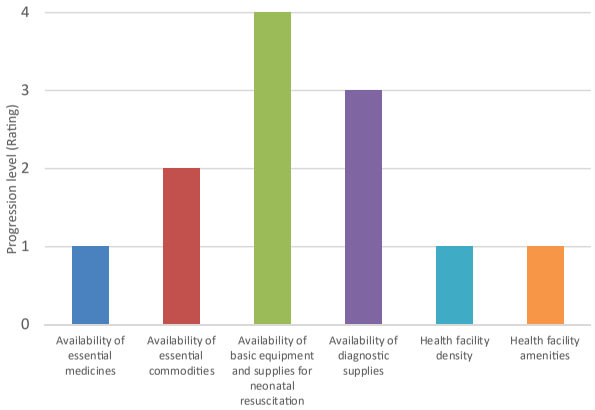
Pakwach District - 2018/19

HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	56.3	50.0	75.0	83.3	75.0	55.6	61.4

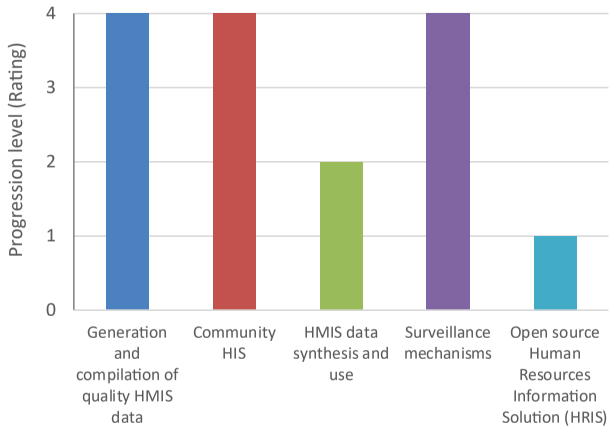
Key: <50% | 50.1-70% | 70.1-90% | >90%

A: Leadership and Governance

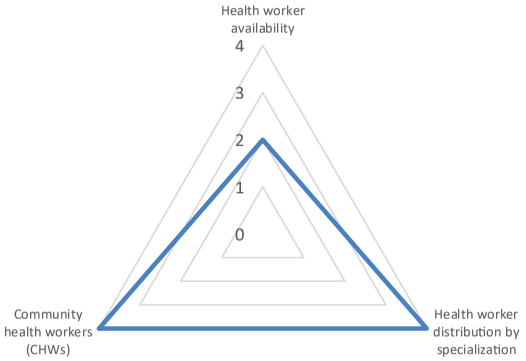
B: Access to essential medicines



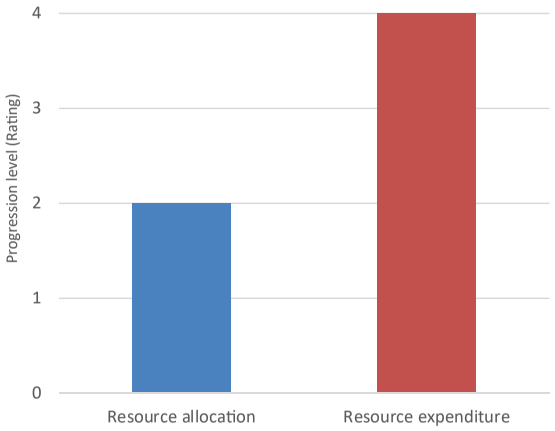
C: Health Information Systems



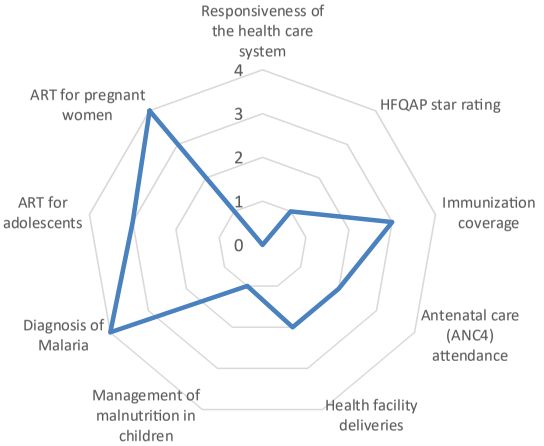
D: Health Workforce



E: Health financing



F: Service delivery



DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

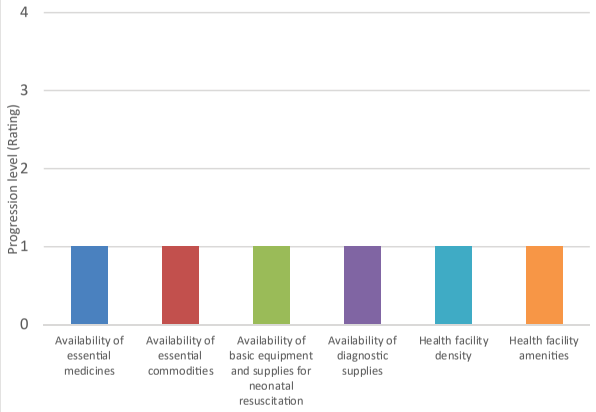
Yumbe District - 2018/19

HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D:Health Workforce	E: Health financing	F: Service delivery	Overall
	87.5	25.0	90.0	75.0	100.0	69.4	71.2

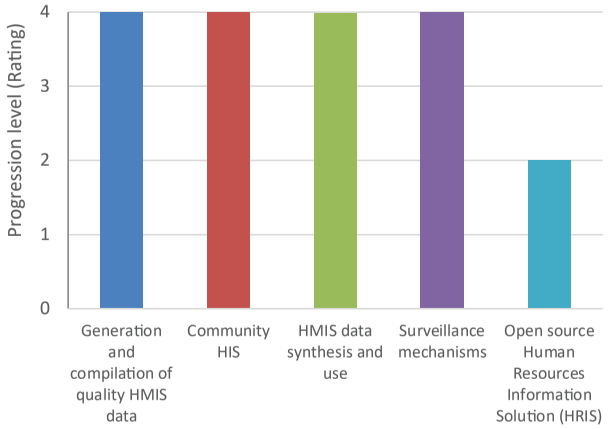
Key: <50% | 50.1-70% | 70.1-90% | >90%

A: Leadership and Governance

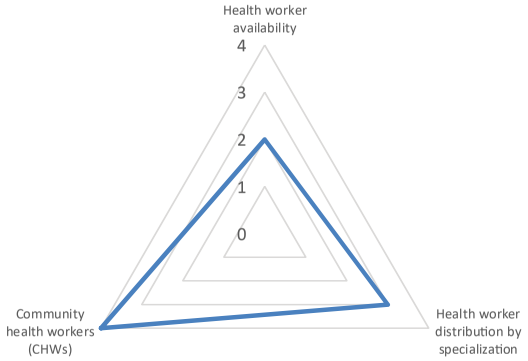
B: Access to essential medicines



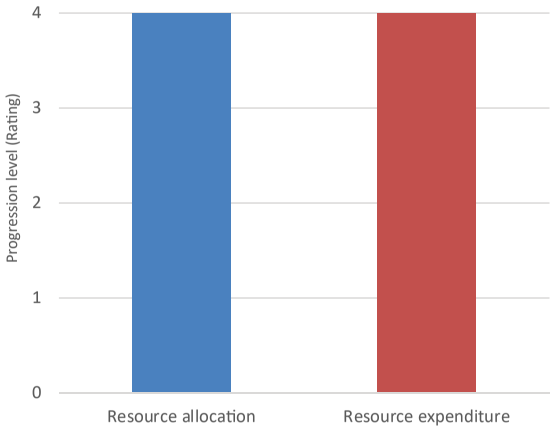
C: Health Information Systems



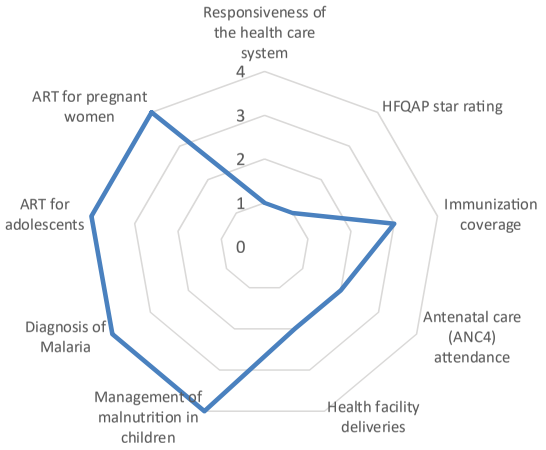
D: Health Workforce



E: Health financing



F: Service delivery



DISTRICT HEALTH SYSTEMS PROGRESSION MONITORING (DHSPM) DASHBOARD

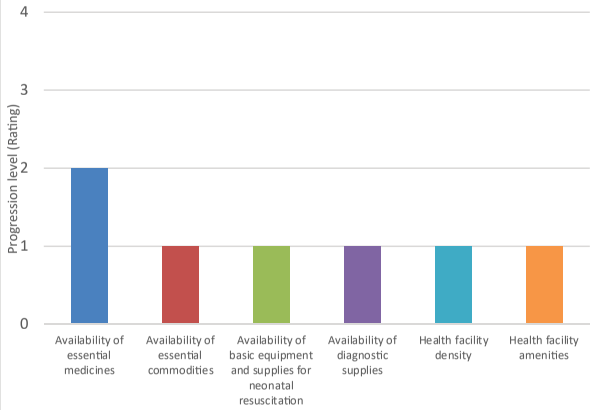
Zombo District - 2018/19

HSS Domain	A: Leadership and Governance	B: Access to essential medicines	C: Health Information Systems	D: Health Workforce	E: Health financing	F: Service delivery	Overall
	71.9	29.2	80.0	50.0	62.5	63.9	60.6

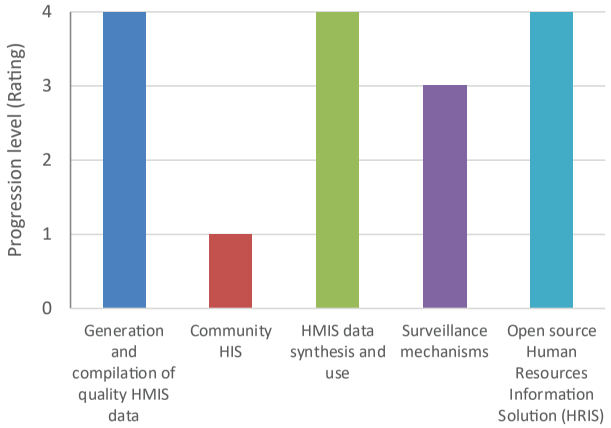
Key: <50% | 50.1-70% | 70.1-90% | >90%

A: Leadership and Governance

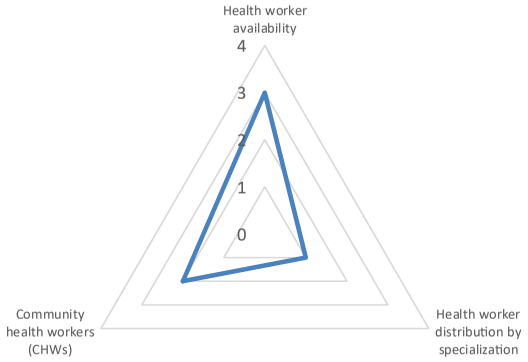
B: Access to essential medicines



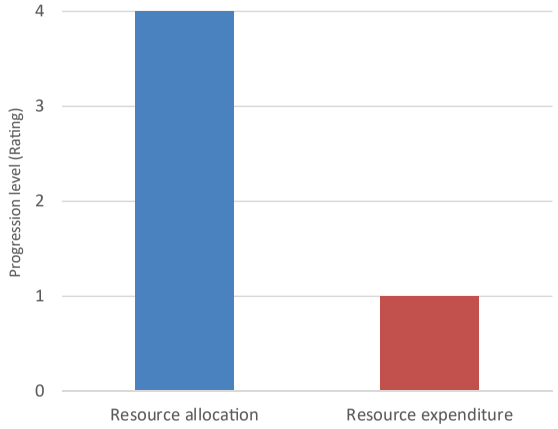
C: Health Information Systems



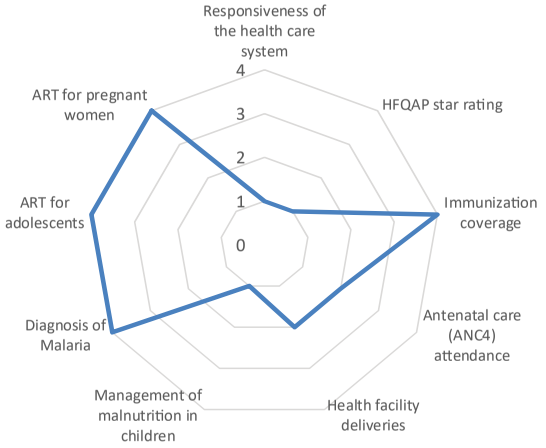
D: Health Workforce



E: Health financing



F: Service delivery



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