



THE REPUBLIC OF UGANDA

## MINISTRY OF HEALTH

# Annual Health Sector Performance Report

Financial Year 2013/2014

October, 2014



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MINISTRY OF HEALTH

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**Financial Year 2013/2014**



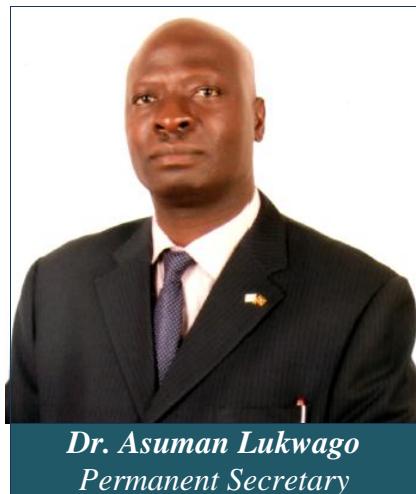
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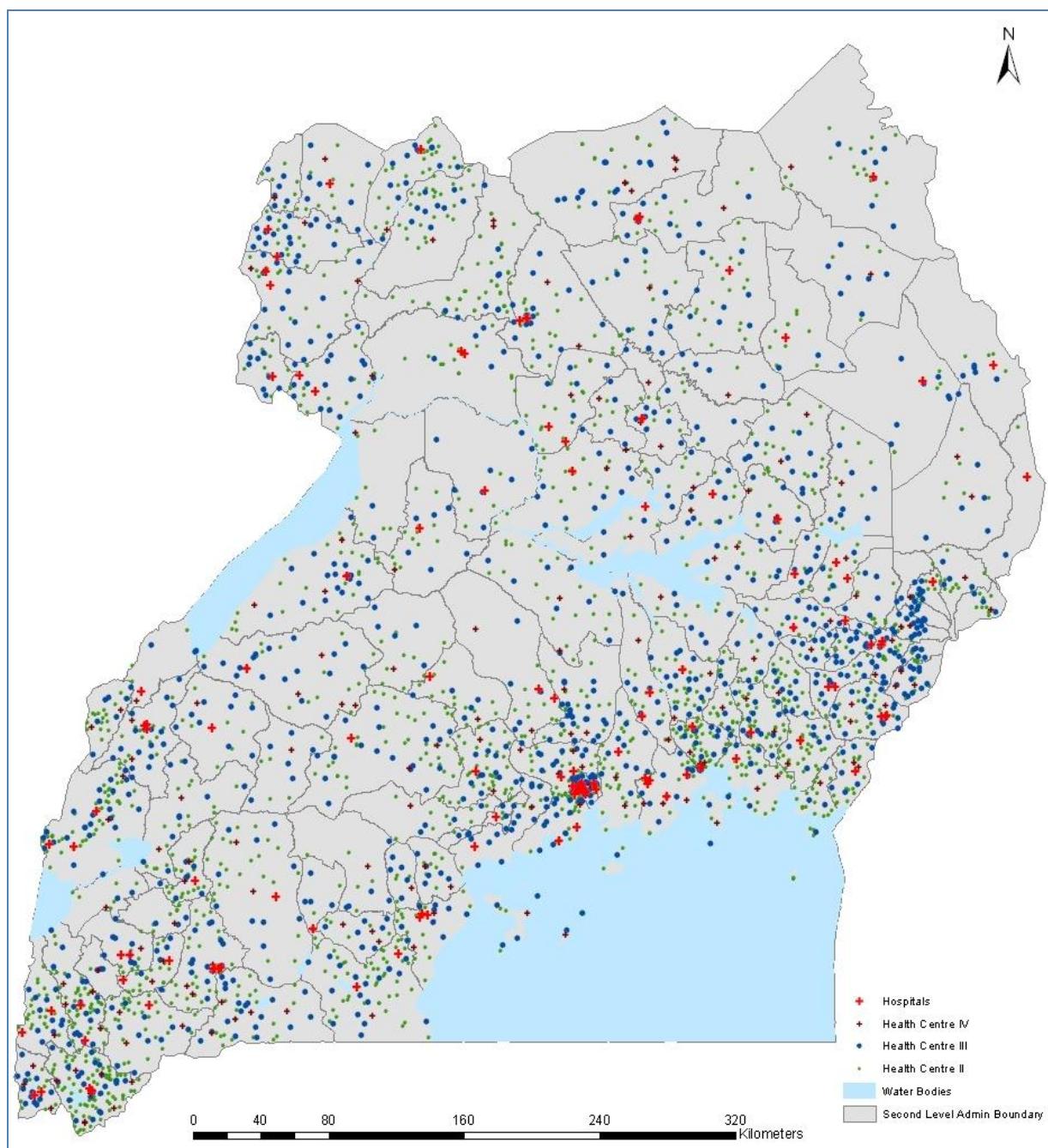
# Annual Health Sector Performance Report

**Financial Year 2013/2014**



*Printed with the support of Institutional Capacity Building Project*

## Distribution of Health facilities in Uganda



Source: Talisuna A.O et al. (2013) *An Epidemiological Profile of Malaria and its Control in Uganda*

## **FOREWORD**

The Annual Health Sector Performance Report for 2013/14 Financial Year provides analysis of health sector performance against set targets, goals and objectives for the Financial Year 2013/14 with a comparative analysis of the previous trends towards achieving the HSSIP 2010/11 – 2014/15 targets. The report is premised on an analysis of commitments in the National Development Plan, Ministerial Policy Statement, Budget Framework Paper, the HSSIP, the 19th JRM Aide Memoire and the annual sector workplans at various levels.

The report is discussed at the Annual Health Sector Joint Review Mission, and is based on the assessment of what has been achieved and what has not, and reasons why, to guide future programming. The sector is committed to refocusing priorities to interventions aimed at making positive progress towards implementing the strategies of the National Health Policy II, and achieving the National Development Plan targets and Millennium Development Goals.

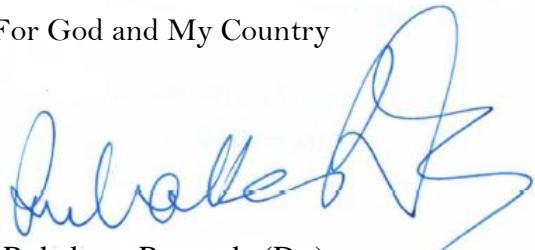
The sector continues to prioritize interventions defined in the Uganda National Minimum Health Care Package under a Sector-Wide Approach arrangement, with emphasis on recommendations of the HSSIP 2010/11 -2014/15 Mid-Term review. This is further supported by the resolutions of the World Health Assembly, the International Health Partnerships, the Paris Declaration on Harmonization and Alignment and the Accra Agenda for Action and related initiatives.

The Government of Uganda recognizes the contribution of Health Development Partners, Civil Society, the Private Sector and the community in the reported sector performance.

Sector performance cannot be improved and sustained without the dedicated efforts of all categories of health workers, working under sometimes challenging conditions, especially in the rural and hard-to-reach parts of the Country. I commend the dedicated and productive health workers, and I implore those health workers whose work ethic, behaviour and conduct hold back sector progress, to improve.

I wish to thank the Health Policy Advisory Committee members for always giving policy guidance to the sector and for their contribution in the preparation of the Joint Review Mission. Special gratitude goes to the JRM Secretariat, Task Force and Subcommittees that ensured that this annual report was compiled.

For God and My Country



Ruhakana Rugunda (Dr.)  
**MINISTER OF HEALTH**

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## **ACRONYMS**

ACT	Artemisinin Combination Therapies
AHSPR	Annual Health Sector Performance Report
AIDS	Acquired Immuno-Deficiency Syndrome
AMREF	African Medical and Research Foundation
ANC	Ante Natal Care
ART	Anti-retroviral Therapy
ARVs	Antiretroviral Drugs
BFHI	Baby Friendly Health Initiative
CAO	Chief Administrative Officer
CB-DOTS	Community Based TB Directly Observed Treatment
CCM	Country Coordinating Mechanism
CDC	Centres for Disease Control
CDD	Control of Diarrhoeal Diseases
CDP	Child Days Plus
CDR	Case Detection Rate
CEmOC	Comprehensive Emergency Obstetric Care
CPR	Contraceptive Prevalence Rate
CPT	Cotrimoxazole Prophylaxis
CSO	Civil Society Organization
CYP	Couple Years of Protection
DHO	District Health Officer
DHMT	District Health Management Team
DLT	District League Table
DOTS	Directly Observed Treatment, short course (for TB)
DPs	Development Partners
DPT	Diphtheria, Pertussis (whooping cough) and Tetanus vaccine
EAC	East African Community
ECSA-HC	East Central and Southern Africa - Health Community
EID	Early Infant Diagnosis
EMHS	Essential Medicines and Health Supplies
EmOC	Emergency Obstetric Care
FP	Family Planning
FY	Financial Year
GAVI	Global Alliance for vaccines and Immunization
GBV	Gender Based Violence
GFTAM	Global Fund to fight TB, Aids and Malaria
GH	General Hospital
GoU	Government of Uganda
HAART	Highly Active Anti-Retroviral Therapy
HC	Health Centre

HCI USAID	Health Care Improvement Project
HCT	HIV/AIDS Counselling and Testing
HDP	Health Development Partners
HIV	Human Immuno-Deficiency Virus
HMBF	Home Based Management of Fever
HMIS	Health Management Information System
HPAC	Health Policy Advisory Committee
HRH	Human Resources for Health
HSD	Health Sub-Districts
HSS	Health Systems Strengthening
HSSIP	Health Sector Strategic Investment Plan
HSSP	Health Sector Strategic Plan
ICU	Intensive Care Unit
IDSR	Integrated Disease Surveillance and Response
IEC	Information Education and Communication
IMAM	Integrated Management of Acute Malnutrition
IMCI	Integrated Management of Childhood Illness
IPT	Intermittent Presumptive Treatment for malaria
IRS	Indoor Residual Spraying
ITNs	Insecticide Treated Nets
JAF	Joint Assessment Framework
JBSF	Joint Budget Support Framework
JICA	Japan International Cooperation Agency
JMS	Joint Medical Stores
JPP	Joint Program on Population
JRM	Joint Review Mission
KDS	Kampala Declaration on Sanitation
LG	Local Government
LLINs	Long Lasting Insecticide Treated Nets
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MDR	Multi-drug Resistant
MIP	Malaria in pregnancy
MMR	Maternal Mortality Ratio
MOFPED	Ministry of Finance, Planning and Economic Development
MoGLSD	Ministry of Gender, Labour and Social Development
MOH	Ministry Of Health
MOLG	Ministry of Local Government
MOPS	Ministry of Public Service
MOU	Memorandum of Understanding
MPDR	Maternal Perinatal Death Review
MTEF	Medium Term Expenditure Framework

MTR	Mid-Term Review
NCD	Non Communicable Diseases
NCRI	National Chemotherapeutic Research Institute
NDA	National Drug Authority
NGOs	Non-Governmental Organizations
NHA	National Health Assembly
NHP	National Health Policy
NMCP	National Malaria Control Programme
NMS	National Medical Stores
NTDs	Neglected Tropical Diseases
NTLP	National Tuberculosis and Leprosy Control Program
OPD	Out Patients Department
OPM	Office of the Prime Minister
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Salt
ORT	Oral Rehydration Therapy
PHA	People with HIV/AIDS
PHAST	Participatory Hygiene and Sanitation Transformation
PHC	Primary Health Care
PLWHA	People with HIV/AIDS
PMDT	Programmatic Management of Multi-Drug Resistant TB
PMTCT	Prevention of Mother to Child Transmission
PNFP	Private Not for Profit
PPPH	Public Private Partnership for Health
PRDP	Peace Recovery and Development Plan
RH	Reproductive Health
RRH	Regional Referral Hospital
RUTF	Ready to Use Foods
SGBV	Sexual and Gender Based Violence
SHSSPP	Support to the Health Sector Strategic Plan Project
SLD	Second Line Drugs
SMC	Senior Management Committee
SMER	Supervision, Monitoring, Evaluation and Research
SP	Sulfadoxine/Pyrimethamine
STI	Sexually Transmitted Infection
SUO	Standard unit of Output
SWAP	Sector-Wide Approach
TB	Tuberculosis
TMC	Top Management Committee
TSR	Treatment Success Rate
TT	Tetanus Toxoid
TWG	Technical Working Group

UACP	Uganda Aids Control Program
UBOS	Uganda Bureau of Statistics
UBTS	Uganda Blood Transfusion Services
UCI	Uganda Cancer Institute
UDHS	Uganda Demographic and Health Survey
UGFATM	Uganda Global Fund for AIDS, TB and Malaria
UHSSP	Uganda Health Systems Strengthening Project
UHI	Uganda Heart Institute
UNEPI	Uganda Expanded Programme on Immunization
UNFPA	United Nations Fund for Population Activities
UNHRO	Uganda National Health Research Organisation
UNICEF	United Nations Children's Fund
UNMHCP	Uganda National Minimum Health Care Package
UAIS	Uganda AIDS Indicator Survey
USF	Uganda Sanitation Fund
UVRI	Uganda Virus Research Institute
VHT	Village Health Team
WHO	World Health Organisation

## **EXECUTIVE SUMMARY**

### **Background**

The annual sector performance report (AHSPR) highlights progress, challenges, lessons learnt and proposes mechanisms for improvement. The report focuses on the progress in implementation of commitments in the Ministerial Policy Statement, overall sector performance against the targets set for the FY 2013/14, and trends in performance for selected indicators over the previous FYs. The development process of the AHSPR 2013/14 was widely consultative, with involvement of all departments of the Ministry of Health (MoH), some Development Partners (DPs), Bilateral Agencies, Implementing Partners and Civil Society. The overall coordination and technical support was by the MoH JRM Task Force.

### **Data**

The report focuses on the core indicators of the Monitoring and Evaluation Plan of HSSIP, which are linked with the monitoring of the National Development Plan (NDP) and international initiatives such as the Millennium Development Goals (MDGs). The report is based on the health facility and district reports gathered as part of the Health Management Information System (HMIS), administrative sources and programme data, including both quantitative and qualitative data. Generation of output indicators for this report largely utilized data from the integrated HMIS, with completeness of reporting for the year under review standing at 94% and timeliness of 75%. Coverage estimates in the HMIS data uses the UBOS 2013 mid-year population projections to estimate the target populations.

### **Health investments**

There has been a gradual improvement in the level of investments into the health sector over the HSSIP period. The percentage of approved posts filled by health workers (Public facilities) increased just slightly from 56% in 2010/11 to 63% in 2012-13, up to 69% in 2013/14, due to the recruitment exercise by MOH and enhanced recruitment by Partners. The improved staffing level was attributed to the recruitment drive that was supported by government and development partners. Remote districts however, have not fully benefitted from the recruitment drive owing to personnel tendency to avoid areas with poor social infrastructure. The eventual absorption of workers recruited by Partners into service must be planned for by MOH. Significant investment was made in building the capacity of community health workers - 78% of the villages in the country have trained VHTs.

Among the Regional Referral Hospitals, Arua RRH is most staffed at 108%, and Moroto RRH least staffed at 41% (in comparison to the norm).

Financial investment in health by GOU was 8.7% of the overall National Budget, in 2013/14. Budget performance for the appropriated GOU budget was 99%. General Government allocation for health as percentage of the total Government budget has averaged about 8% from 2010/11 to 2013/14, which is 1.8% short of the HSSIP target of

9.8%. This translates into a government contribution of US \$ 12 per capita on health (The per capita public expenditure increased from \$9 to \$12 due to additional government, GAVI and Global Fund financing). This is still below the recommended per capita government expenditure on health of US \$ 34 per capita as per the WHO Commission of Macro Economics and Health (CMH). It is also below the HSSIP target of per capita government expenditure on health of US \$ 17.

Recurrent expenditure was 57% of the total expenditure while 43% was development expenditure (of which 36% is donor-funded, and 6% GOU funded).

The trend in allocation of funds to the health sector shows that there has been an average increase in budget allocation of 20% per annum over the past 4 years of the implementation of the HSSIP. The increment is largely attributed to the wage bill and external financing towards health.

There has been steady increase in PHC wages over the last 10 years with no significant increase in the remaining components of the non wage PHC grant. The mismatch between non wage and development allocations means that the recurrent costs cannot be optimally met, a striking example being the poor maintainance of infrastructure. In addition this situation has negatively affected outreach and supervision activities.

The level of out of pocket expenditure,as percentage of the Total Health Expenditures, has been steadily growing in the past years and it was estimated at 42% in FY 2009/10 (NHA, 2013). This out of pocket expenditure is 33% (NHA, 2014), showing a reduction, attributed to increased partner support for health, mostly through the private sector. The high out-of-pocket expenditure on health care negatively impacts on house holds incomes and affects household demand for, and access to health care. Consequently, the proportion of people facing catastrophic expenditure leading to house hold impoverishment, especially of the lower income quintiles is high. There was fiscal space to provide extra resources to the health sector but the key government priority in the year under review was energy and infrastructure.

A comprehensive health financing strategy addressing equity, catastrophic Out-Of-Pocket Payments (OOP) and other the key funding constraints should be adopted. The development and finalization of the health financing strategy is key to expanding the fiscal space for health. As part of the health financing strategy, to mitigate the high out-of-pocket expenditure, Government plans to introduce the National Health Insurance Scheme (NHIS)

There is inadequate funding for sector activities especially Primary Health Care Services. Only Ushs 41.185bn was allocated as recurrent budget to run health service delivery in 137 LGs with 56 General Hospitals, 61 PNFP Hospitals and 4,205 Lower Level Health Units. There is a challenge of the alignment of off-budget funding to sector priorities and skewed input mix in financing health facilities. There has not been comensurate funding for recurrent costs for utilities and/or maintenance arising from the construction of new buildings and equipment especially for hospitals at all levels.

Financial reporting, leadership and financial management need to be improved at all levels of the health system.

Significant progress has been made in the rehabilitation of infrastructure and supply of new equipment in the sector at various levels. Work was done at National, Regional Referral Hospitals, in KCCA, and selected General hospitals. In addition, work was done at Health centres, DHOs' office in the areas of staff houses, maternity wards, OPD and Transport among others under NUSAf II and PRDP.

Infrastructural investments in the sector have tremendously picked up, though this has created key challenges in optimal utilization of investments, against a background of sub-optimal staffing in the sector, and inadequate operational budgets.

Mapping of Health facilities in the 112 districts was also done and geo-referenced maps produced with support from UBOS, OPM, WHO and CDC. The exact location of health facilities was captured using Global Positioning System devices, commonly referred to as GPS's to enable analysis of physical accessibility. This should give the possibility to have a reliable estimate of the proportion of the Ugandan population living within 5 km of a health facility.

The percentage of health units with no stock outs of any indicator medicines in the previous six months was at 60%. Over the years government has increased funding for medicines and health supplies from 201.7 billion 2010/2011 to 219.4 billion 2013/2014 (including ARV's, ACT's, Lab Commodities, TB and Vaccines). However, this is still inadequate. Per capita government expenditure on EMHS in the FY 2013/14 was about US\$ 2.4 which is below the estimated requirement in the HSSIP of US\$ 12. This leaves a funding gap which is financed by development partners and the private sector mainly through out of pocket expenditure. Human resources inadequacies, capital investment and logistical management issues (orders versus actual supplies) are hindering the public sector mandate of providing medicines to meet the requirements for universal access.

## **Service outputs**

Most of the outcome indicators that have been measured are on track except for contraceptive prevalence rate and client satisfaction that are far below the HSSIP target. Improvements in staff recruitment and deployment contributed to improved access, quality and safety of health services. Improving medicines availability at facility level has raised community demand for facility-provided health services. The Country MDG progress report for 2013 shows commendable progress in the health-related indicators. However, the slow decline of the MMR of 438/100,000 live births raises serious concerns about the level of strength of the health system, and its effectiveness in converting inputs into desired outputs. Focussed efforts and investments in maternal and child health will be critical in the coming 350 days if the country is to make significant progress in reducing MMR and NMR by the MDG deadline.

Functionalization of HC IVs remains a key challenge for the sector, despite a significant increment in the compensation of doctors at HC IVs. This may be linked to the challenge of not having matching improvement in compensation of other cadres of staff at HC IVs who are vital to the team production process at the health centres. However, 45% of HC IVs were able to do cesarean section and 36% to perform blood transfusion during FY 2013/14. This represents an improvement, as compared to the former FY which reported 37% and 27% respectively, still insufficient to reverse the trend in MMR rates.

### **Service coverage**

The sector has demonstrated good progress in immunization of children. The percentage of children under one year immunized with 3rd dose of pentavalent vaccine now stands at 93%, from 87% in 2012/13. The percentage of one year old children immunized against measles stands at 86.5%. These achievements need to be sustained and propelled further through further strengthening existing EPI services.

Despite increase in availability of essential medicines and other health supplies, reproductive health indicators are still below the HSSIP targets. The percentage of deliveries in health facilities is still unacceptably low (increased from 41% to 44.4% in 2013-14). The percentage of pregnant women attending at least 4 ANC sessions increased only slightly from 31% to 32.4%. The Contraceptive Prevalence Rate of 30% is still below the HSSIP target of 40%. Despite improved efforts at recruitment and deployment, human resource constraints (adequacy, distributional disparities and skills) still adversely affect the delivery of quality RH services. There is need to available appropriate numbers of skilled RH providers and mobilize the community to utilize RH services.

Latrine coverage is improved from 71.2% to 74.58%.

ART coverage among those in need, at 83%, (Total 680,514; Adults- 629,212 and Children- 51,302 people on treatment out of 821,721 people in need of treatment. based on the 2010 ART Guidelines) surpassed 2014/15 target of 75% when coverage of ART is based on the 2010 guidelines. This resulted largely from increased accreditation of facilities to provide ART and scale up of Option B+. But based on these new 2013 WHO guidelines, coverage falls to 48% ( $680,514 / 1,405,268$ ), because need increases enormously from 821,721 to 1,405,268 people in need of treatment. The revised target for 2015 is 57%.

### **Health impact**

Impact is assessed using MMR, NMR, IMR, U5MR, and incidence of catastrophic household expenditure on health. Three of these impact indicators (MMR, IMR and Under 5 MR) are monitored among the MDG targets. Although the trend remains positive, with a progressive and constant reduction of all mortality indicators as compared to the past ten to fifteen years, MMR has stagnated in the past five years in Uganda. It is unlikely that Uganda will be able to meet the HSSIP Targets in 2015 as well as the MDG 5. The other three indicators, in particular IMR and U5MR are showing a more relevant decrease and, if such decrease continues at the same pace, the country could achieve the HSSIP target set

for 2015. Even the achievement of the MDG 4 appears feasible before the conclusion of the HSSIP. The Maternal Mortality Ratio stands at 438 per 100,000 (UDHS, 2011) live births [that of Kenya is 400 per 100,000 live births (WHO 2014) and Tanzania is 460 per 100,000 (World Bank 2012)]. This is below the HSSIP and MDG target of 131 per 100,000 live births (MDG country assessment report, 2013).

Facility reports show the institutional maternal death rates have dropped from 168 per 100,000 in 2012/13 to 146 per 100,000 in 2013/14. There is a general decline in average annual facility based maternal deaths from 194 per 100,000 lives (2010/11) live births to 146 per 100,000 live births in 2013/14.

Institutional maternal death rates were highest in the western region (177.6/100,000) and lowest in the eastern region (95.0/100,000).

The three classic delays (home, on the way, and at facility) must be addressed to reign in unacceptably high maternal morbidity and mortality. The top causes of maternal deaths included 1) Haemorrhage (36%), 2) Abortion related deaths (10%), 3) Pregnancy related hypertension (15%) and 4) Uterine rapture (11%).

The sector should prioritize the attraction, recruitment and retention of critical cadres to offer Maternal and Newborn care services especially in the hard to reach areas. The high burden of maternal and perinatal deaths was addressed at policy level by launching and beginning Implementation of a Reproductive health maternal, newborn and child health (RHMNCH) sharpened plan 2013 to accelerate reduction of maternal, newborn and child mortality.

### **Monitoring Implementation of the Country Compact and IHP+**

The Compact for implementation of the HSSIP is an instrument aimed at maintaining policy dialogue, promoting joint planning and ensuring implementation and monitoring of the HSSIP 2010/11 – 2014/15. The partnership in this compact is between the Government of Uganda (MoH) and all other stakeholders (HDPs, PNFP, PHP and CSOs), which are collectively referred to as health sector partners.

The HPAC serves as the overall oversight and steering body for monitoring the implementation of the Compact. Functionality of the HPAC is very crucial in monitoring implementation of the Compact and provision of advice on the implementation of the HSSIP and policies.

Attendance of HPAC meetings by the various stakeholders is varied, with the HDP representatives attending more consistently than other members. There is satisfactory presence of Private Sector Representaives and CSOs, while most concerning is the very low participation of other Line Ministeries, whose activities have a significant influence on the determinants of health, and thus on overall population health

### **Central Level – Health Systems Support**

The sector has prioritized stewardship, resource mobilization, standards and guidelines development, monitoring and supervision. Monitoring visits to implementation level were

routinely conducted by the departments. Sector monitoring needs to be harmonized. Districts are overwhelmed by different monitoring teams in verticalized monitoring mechanisms that leave them reduced time and space for activity implementation. The monitoring framework needs to be utilized to harmonize monitoring and supervision. Inter-ministerial and inter-sectoral consultations should be institutionalized to address the wider determinants of health

## **Hospital Performance**

The MoH Health Facility Inventory July, 2013 the total number of hospitals (public and private) is 155. Of these 2 are National Referral Hospitals (Mulago and Butabika), 14 are RRHs and 139 are GHs. In terms of ownership, 65 are government owned, 63 private not for profit - PNFP and 27 are Private. There are 139 GHs in the country providing; preventive, promotive outpatient curative, maternity, inpatient, emergency surgery and blood transfusion and laboratory services.

The 14 RRHs and 4 large PNFP hospitals assessed registered an increase in SUO in 2013/14 compared to 2012/13 from 8,189,908 to 8,727,279. Mbale hospital continues to lead in volume of outputs pushed by the very high number of admissions 48,754. Masaka retains the second slot despite a 19% reduction in SUO. Naguru Hospital (China-Uganda Friendship Hospital), Gulu and Lira Hospital registered the highest increases compared to the previous year 179%, 48.4% and 29.3% respectively.

Malaria remains the leading cause of mortality in hospitals (12.8%) followed by new smear positive Tuberculosis (8.6%), Pneumonia (7.5%), Anaemia (7.4%) and Perinatal Conditions in newborns (3.1%).

The total SUO for GHs has increased from 15,129,354 in 2012/13 to 15,514,147 this is generally attributed to increased number of hospitals reporting in the DHIS2 from 110 to 123. The average outputs were lower compared to the 2012/2013 for admissions, outpatients, family planning, and deliveries this is attributed to a higher number of smaller hospitals in the set. The averages were higher for antenatal, postnatal and immunization. The minimum SUO for GHs was 151 and maximum 530,729.

Hospital based deaths especially maternal deaths and fresh still births are indicators of quality of care. The total maternal deaths reported in 14 RRHs and 4 PNFP hospitals were 337 giving a mean death of 8.7 mothers per hospital per year with a minimum of 4 in Naguru RRH and maximum of 36 in Mbarara RRH. The risk of dying during delivery was highest in Mubende RRH, followed by Arua and Hoima hospitals (a mother died for every 116, 162 and 165 deliveries respectively). The risk was lowest in Naguru, Mengo and Kabale hospitals (a mother died for every 1,544, 727 and 688 deliveries respectively).

The 5 top performing (high volume) hospitals were Iganga, Bwera, Tororo, Mityana and Kawolo. Compared to the year 2012/13, Tororo and Kawolo are new entrants to the list while Busolwe and Pallisa dropped off the list. Among the PNFP the highest volume hospital is Angal St. Luke.

Maternal deaths were reported in 78 hospitals, a total of 449 deaths were recorded giving an average of 5.8 deaths per hospital. However taking the denominator as hospitals conducting deliveries 115 the average death per hospital is 3.9. The minimum is 0 and the maximum is 23 as observed in Iganga – a high volume hospital and Matany hospital in Napak district as a result of Hepatitis E outbreak that has a high case fatality rate in pregnant women.

Overall there was one maternal death for every 241 deliveries, 5 hospitals with the highest risk of a maternal death were: Matany 1 death in 46 deliveries, Kuluva 1 in 91, Nkokonjeru 1 in 108, Buluba 1 in 114 and Kaabong 1 in 123. While Matany has a clear explanation, the other hospitals have to be investigated to establish the reason for the high maternal death to deliveries ratio. 5 hospitals with the lowest risk of a maternal death were: Kitgum 1 death in 2,298 deliveries, Kawolo 1 death in 11,864, Atutur 1 death in 1,772, Entebbe 1 death in 1,682 and Bwindi community hospital 1 death in 1,294 deliveries.

### **Decentralized Responses**

Despite a general increment in the level of financing for the sector, the financing of Local Government health services is still inadequate. Recurrent budgets under the PHC grant have not improved, and, with the increasing creation of administrative units, have actually declined. Despite human resource, financial and logistic challenges, the local governments have done tremendous work to sustain, and sometimes improve service levels. There has been less emphasis and financing of primary prevention activities at district level, leaving them mainly for the CSOs and Community Based Organisation (CBOs).

42% of all HC IIs have a staffing below 40% compared to 9% of all HC IIIs, 9% of all HC IVs and 10% of all GHs. On the other hand, 91% of all HC IVs have at least 50% of established positions filled by health workers compared to 81% of all HC GHs, 84% of all HC IIIs and 41% of all HC IIs. These staffing levels are closely linked to the observed service gaps at different levels of care.

### **Public-Private Partnership in Health**

The health sector benefits from the partnerships with the private sector (PNFPs, Private Health Providers and CSOs). To strengthen the partnership and operationalize the national policy on PPPH, MoH has established a PPP Unit. The Unit will facilitate collaboration among partners under the stewardship of the MoH.

The contribution from the private sector to the achievement of the national health objectives is included in this report, which gives a good overview of PNFP performance, mainly from UCMB and UPMB. Contribution from some of the PHP and CSOs has also been documented. The inability to generate comprehensive reports from the private sector is still a major challenge, though some significant contribution is from PHPs and CSOs. This is largely due to lack of HMIS tools, capacity gaps in utilization of HMIS tools, and lack of feedback on reported data. However, the introduction of DHIS-2 has considerably improved the reporting rate for PNFP facilities. At the same time, most PHP facilities are

still lacking the required human resources, equipment and infrastructure to effectively report.

The PNFPs continue to provide significant inputs (financing, infrastructure, skilled human resources, training, etc) into the health system, despite growing evidence of declining financing. 65% of training capacity especially for nurses and midwives is by the PNFP training schools. Data from DHIS2 indicates that over 40% of outputs are from PNFPs.

The sub-sector is critical to the health system as it has a more diversified geographical distribution that enables deeper service reach, and has been critical in sustaining service provision during times of conflict and epidemic outbreaks.

### **Civil Society Response**

Non-facility based NGOs play a major role in delivering public health services (preventive, promotive and rehabilitative services) to communities. Quantification of the financial input and outputs from these NGOs is still a challenge as they are not well coordinated and are not yet linked to the sector HMIS.

### **Local Government Performance**

The objective of the District League Table (DLT) is to compare performance between the Local Governments. It highlights performance at district level and areas of improvements. The districts are ranked based on the league table performance by sector indicator categories. The composite index employed is computed by weighting the agreed upon indicators.

With the institution of regional performance monitoring teams (RPMTs) by the sector, regional clusters of LGs are also analysed to produce regional performance league tables. The 112 districts are used as the units of analysis with key objectives of comparing performance between districts; provide information to facilitate the analysis for good and poor performance at districts and thus enable corrective measures which may range from increasing the amount of resources (financial resources, human resources, infrastructure) to the LG or more frequent and regular support supervision; and increase LG ownership of achievements/ performance.

Ten indicators were used to evaluate and rank district performance: 8 coverage and quality of care indicators, given a collective weight of 80%; and 2 management indicators, accounting for the remaining 20%. The indicators were selected for consistency with the 26 core HSSIP 2010/11 – 2014/15 indicators.

## **CHAPTER ONE: Introduction**

### **1.1 Background**

The Annual Health Sector Performance Report (AHSPR) highlights progress, challenges; lessons learnt and proposes ways of enhancing sector performance. This thirteenth AHSPR marks the 4th year for the current Health Sector Strategic and Investment Plan (HSSIP) 2010/11 –2014/15. With one year remaining, the report is pivotal as it highlights opportunities that need greater focus to ensure the targets for the HSSIP are met.

Progress over 2013/14 is reviewed for: i) Effectiveness, responsiveness and equity in the health care delivery system, ii) Comparison with performance trends for selected indicators since 2010/11, iii) How well the integrated support systems have been strengthened, iv) Status of programme implementation.

The report takes into account the undertakings and commitments of the following documents: i) National Development Plan (NDP, ii) second National Health Policy (NHP II), iii) Joint Assessment Framework (JAF) under the Joint Budget Support Framework (JBSF) iv) HSSIP 2010/11 – 2014/15 core indicators, v) Budget Framework Papers (BFPs), vi) The Ministerial Policy Statement 2012/13, vii) The 2012/13 Joint Review Mission Aide memoire, viii) HSSIP Mid-Term Review Report ix) Medium Term Expenditure Framework (MTEF) x) Quarterly Reports.

### **1.2 Vision, Mission, Goal and Strategic Objectives during the HSSIP 2010/11 – 2014/15**

#### **1.2.1 Vision**

A healthy and productive population that contributes to socio-economic growth and national development

#### **1.2.2 Mission**

To provide the highest possible level of health services to all people in Uganda through delivery of promotive, preventive, curative, palliative and rehabilitative health services at all levels.

#### **1.2.3 Goal**

The overall goal for the Health Sector during HSSIP 2010/11 – 2014/15 is “**To attain a good standard of health for all people in Uganda in order to promote a healthy and productive life**”

#### **1.2.4 Strategic Objectives**

To achieve this goal, the health sector shall focus on achieving universal coverage with quality health, and health related services through addressing the following strategic objectives.

1. Scale up **critical interventions** for health, and health related services, with emphasis on vulnerable populations.

2. Improve the levels, and equity in **access and demand** to defined services needed for health.
3. Accelerate **quality and safety** improvements for health and health services through implementation of identified interventions.
4. Improve on the **efficiency**, and **effectiveness** of resource management for service delivery in the sector.
5. Deepen sector **stewardship** by the Ministry of Health.

### **1.3 The process of compiling the report**

The development process of the AHSPR 2013/14 was widely consultative with stakeholders from all departments of the MoH, Health Development Partners (HDPs), Bilateral Agencies, Implementing Partners and Civil Society Organizations (CSOs). The Health Policy Advisory Committee (HPAC) and Senior Management Committee provided guidance and monitored progress in the entire process. The overall coordination and technical support to Technical Working Groups (TWGs), and Departments was provided by the MoH AHSPR Task Force. The composition of the Task Force was drawn from all departments of MoH, CSOs and HDPs.

The information used in compiling the AHSPR 2013/14 mainly uses the HMIS aggregated monthly reports from the District Health Information Software (DHIS)-2 for the entire Financial Year (FY) and selected surveys<sup>1</sup>. It also draws from qualitative information obtained during the pre-Joint Review Mission field visits. The pre-JRM visits were conducted in 16 districts and mainly focused on poor and best performing, new and old districts. Population figures used for the league table analysis were based on the UBOS 2013 mid-year population projections. (See District League Table in annex two).

### **1.4 Outline of the report**

The first chapter provides the background to the Annual Health Sector Performance Report. Chapter two reports on performance based on specific indicators in the M&E Framework, the chapter is organized by level of indicators i.e. impact, outcome, outputs, partnerships and investments and also includes an analysis of district local government performance as ranked by the League Table. The annexes provide detail on performance of different departments, divisions and programmes in delivery of the UNMHCP, and the health system support functions.

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<sup>1</sup> Uganda Demographic Health Survey

## CHAPTER TWO: Overall sector performance and progress

This chapter provides an overview of the sector performance for FY 2013/14 and includes the overall performance of the sector against the HSSIP 2010/11 – 2014/15 indicators which also include the JAF indicators and; an assessment of the level performance against planned key outputs from the Ministerial Policy Statement of 2013/14; comparison of district performance using the District League Table (DLT) and comparison of hospital performance using the Standard Unit Output (SUO).

### 2.1 Health Impact Indicators

This section provides an overview of five health impact indicators. Four of these are taken from the Uganda Demographic Household Survey of 2011 (UDHS 2011) and these include: 1) Maternal Mortality Ratio<sup>2</sup> (MMR), 2) Neonatal Mortality Rate<sup>3</sup> (NMR), 3) Infant Mortality Rate<sup>4</sup> (IMR), and 4) Under 5 Mortality Rate<sup>5</sup>. The fifth impact indicator is proportion of household experiencing catastrophic payments as a proxy measure for financial risk (protection).

#### 2.1.1 Maternal Mortality Ratio

The Maternal Mortality Ratio stands at 438 per 100,000 (UDHS, 2011) live births [Kenya is at 400 per 100,000 live births (WHO 2014) and Tanzania at 460 per 100,000 (World Bank 2012)]. This is below the HSSIP and MDG target of 131 per 100,000 live births (MDG Country Assessment Report, 2013).

Various strategies to reduce the MMR included implementation of EmOC interventions, advocacy and the institution of mandatory maternal death notification and reviews. According to facility based reports, the institutional maternal death rates have dropped from 168 per 100,000 in 2012/13 to 146 per 100,000 in 2013/14 Table 1. There is a general decline in average annual facility based maternal deaths from 194 per 100,000 lives (2010/11) live births to 146 per 100,000 live births in 2013/14 (table 1).

*Table 1: Facility Based Deaths by Region*

Region	FY2012/2013			FY2013/14		
	Live Births in unit	Maternal deaths	Maternal deaths Per 100,000 Live Births	Live Births in unit	Maternal deaths	Maternal deaths Per 100,000 Live Births
<b>Central Region</b>	206322	433	209.9	222199	366	164.7
<b>Eastern Region</b>	168221	190	112.9	189504	180	95.0
<b>Northern Region</b>	137385	233	169.6	172697	247	143.0
<b>Western Region</b>	185729	313	168.5	199274	354	177.6
<b>NATIONAL</b>	<b>697657</b>	<b>1169</b>	<b>167.6</b>	<b>783674</b>	<b>1147</b>	<b>146.4</b>

Source: MoH HMIS 2013/14

<sup>2</sup> Maternal Mortality Ratio: Number of mothers dying per 100, 000 live births

<sup>3</sup> Neonatal Mortality Rate: Number of deaths during the first completed 28 days of life per 1000 live births

<sup>4</sup> Infant Mortality Rate: Number of deaths of children aged less than 1 year dying per 1000 live births

<sup>5</sup> Child Mortality Rate: Number of deaths of children aged less than 5 years dying per 1000 live births

**Table 2: Comparison of Maternal deaths notified by facilities to those reported through HMIS**

<b>Item</b>	<b>2010/11</b>	<b>2011/12</b>	<b>2012/13</b>	<b>2013/14</b>
Total number of deaths notified from MPDR	13	45	129	371
Number of maternal deaths reported through HMIS	1005	1206	1169	1147
Expected Number of Maternal Deaths (0.00438*live births)	2330	2581	2009	1740
% of maternal deaths notified compared to total maternal deaths	0.6%	1.7%	6.4%	21.3%
% of maternal deaths notified compared to reported in HMIS	1.3%	3.7%	11.0%	32.3%

Source: MoH HMIS 2013/14

Compliance to mandatory maternal death notification has improved over time as all notifications are facility based (32.3%), the estimated population coverage (21.3%) is much lower in 2013/14 (Table 2)

### **Primary causes of maternal deaths**

Trends from the Maternal and Perinatal Death Review (2009-2013) show that the top causes of maternal deaths included 1) Haemorrhage (36%), 2) Abortion related deaths (10%), 3) Pregnancy related hypertension (15%) and 4) Uterine rapture (11%) (See Table 3). The underlying causes of maternal death were related to delays<sup>6</sup> in 1) Seeking health care by the woman 2) Reaching the health service point 3) Receiving adequate health care. Table 4 provides more details.

**Table 3: Causes of maternal deaths reviewed from FY2012/13 to FY2013/14**

<b>Cause of death</b>	<b>2012 -2013<sup>7</sup></b>		<b>2013/14</b>	
	<b>Frequency</b>	<b>%</b>	<b>Frequency</b>	<b>%</b>
Ante partum hemorrhage	62	20%	21	10
Post partum hemorrhage	61	19%	57	26
Abortion	40	13%	22	10
Hypertensive disorders of pregnancy	31	10%	32	15
Uterine Rupture	26	8%	23	11
Pregnancy related sepsis	26	8%	31	14
Acute collapse/ unknown cause	21	7%	2	1
HIV / AIDS related	14	4%	7	4
Malaria	14	4%	8	3
Pre-existing maternal condition	13	4%	3	1
Others (severe anemia, meningitis, embolism.	3	1%	4	2
Non obstetrical causes	2	1 %	2	1
Anesthetic complications	2	1%	4	2
<b>Total</b>	<b>315</b>	<b>100%</b>	<b>217</b>	<b>100%</b>

<sup>6</sup><http://www.maternityworldwide.org/what-we-do/three-delays-model/>

<sup>7</sup>MPDR reporting during 2009 – 2011 was incomplete and therefore figures given were not the actual but used as baseline from reports submitted.

Source: MPDR Report FY2013/14

In the table above, it is observed that there was a reduction in the maternal deaths due to ante partum haemorrhage, abortions and uterine rupture ie reduction by 41, 18 and 3 deaths respectively. This could be attributed to recent recruitments and deployment of midwives and other health workers, in addition to the EmONC medical equipment which was distributed to health facilities across the country.

However deaths attributed to hypertensive disorders of pregnancy and pregnancy related sepsis still remained high necessitating improvements in health workers' clinical skills for proper management of hypertension and infection control respectively.

**Table 4: Common factors underlying maternal deaths**

Delay Factors	Underlying factors	2009-2011		2012-2013		2013-2014	
		Frequency	Sub-Total	Frequency	Sub-Total	Frequency	Sub-Total
<b>Health Seeking Behaviour</b>	A. Personal/ Family/ Woman factors	1. Delay of the woman seeking help	112	101		110	
		2. Lack of partner support	19	= 164	26	= 35	
		3. Herbal medication	17		18		17
		4. Refusal of treatment or admission	8			8	= 176
		5. Refused transfer to higher facility	8		11		6
<b>Reaching the health service point</b>	B. Logistical systems	1. Lack of transport from home to health facilities	13	19		17	
		2. Lack of transport between health facilities	11	= 134	18	= 93	18
<b>Receiving adequate health care</b>	C. Health service	1. Health service communication breakdown	54			0	= 79
		2. Lack of blood products, supplies &consumables	69		56		44
	D. Health personnel problems	1. Staff non-action	62			-	
		2. Staff oversight	60	=		-	

Delay Factors	Underlying factors	2009-2011		2012-2013		2013-2014	
		Frequency	Sub-Total	Frequency	Sub-Total	Frequency	Sub-Total
	3. Staff misguided action	32	194			-	
	4. Staff lack of expertise	22		24		20	=81
	5. Absence of critical human resource	11		24		25	
	6. Inadequate numbers of staff	7		16		36	

*Source: MPDR Report 2009 - 2011, 2012-2013*

In addition to the maternal death reviews strategies, the following were the key interventions to address identified causes of maternal and new born deaths:

1. Capacity building in Emergency Obstetric and newborn Care to address the major direct causes of maternal and perinatal deaths.
2. Increasing access to skilled attendance at birth so that complications during pregnancy (killers) are detected and managed in a timely manner. Skilled attendance comprises of the appropriate skills, environment and equipment & supplies. However, efforts to stream line referral of women with complications of pregnancy have yet to match the improvements in infrastructure.
3. Family planning to prevent unintended pregnancies and enables women not to have pregnancies too early, too late or too frequently. Family planning also has the potential to enhance Uganda's economic growth through: reduction of the economic dependency ratio, and increase in private consumption value per capita.
4. Effective antenatal care has the potential to prevent, detect, and treat problems such as malaria, anaemia, HIV/AIDS and other infections, which are important indirect causes of maternal deaths
5. Information, Education and Communication materials disseminated

#### **During the FY 2013/14 the following major investments were made**

1. Procured and distributed Maternal and New born equipment worth USD 4 million under the Uganda Health System Strengthening Project (UHSSP) to 230 health facilities which include NRH, RRH, GH including PNFPs and HCIVs country wide.
2. Procured and distributed Reproductive Health commodities including contraceptives worth USD 3.3 million by Government of Uganda and USD 8.6 million through the UHSSP. Donors also procured contraceptives including condoms worth USD 23 million.
3. Modest improvement in supply of blood and blood products although there is need for further streamlining.

4. Mentored 700 health workers on provision of Emergency Obstetric and Newborn Care including Post Abortion care and Long term and permanent methods of Family Planning.
5. Formation and strengthening of Maternal and Perinatal Death Review committees in all regional referral Hospitals and 70% in General Hospitals. MPDR data has been used to sensitize stakeholders at district and regional level on their roles in promotion of maternal and newborn health and addressing maternal health issues.
6. Procured and distributed VHT registers for the VHTs to mobilize, register and refer women to where they could get reproductive health services.

All these investments have contributed to the improved reproductive health service delivery in terms of availability and quality.

## Challenges

1. Inadequate critical cadres to offer Maternal and Newborn care services especially in the hard to reach areas where eMNO teams are hardly complete. In spite of the countrywide effort to recruit doctors and midwives, many HC IVs, & some hospitals have one and none of the key staff (doctor, anaesthetist, and midwife) and therefore cannot handle complications of pregnancy which often end fatally.
2. Deficient referral systems and poor transport means for mothers with complications. Boda boda transport is common in rural areas.
3. Insufficient multi-sectoral approach and none reporting of the private sector of maternal deaths.

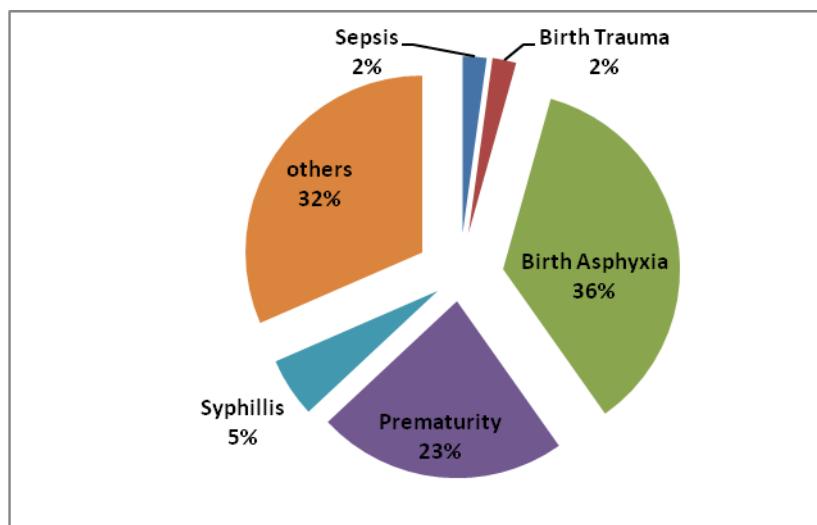
### 2.1.2 Neonatal Mortality Rate

The first 30 days after birth carry the highest risk of death for mother and newborns and risk for long term disability. Neonatal mortality rate is an important proxy measure of the quality of delivery (intrapartum) and immediate post delivery care. The UDHS (2011) estimates the neonatal mortality rate as 27 per 1000 live births as compared to HSSIP target of 23 per 1000 live birth by 2015 which suggests a slow progress. This implies that Uganda loses over 100 babies below one month every day. Never the less, Uganda's performance is comparable with other countries in the East African region Tanzania with 21 per 1000 live births Kenya 27 per 1000 live births (WHO, 2014). Prematurity (Born Too Soon) contributes to the highest mortality majorly because of hypothermia and respiratory Distress Syndrome. As per pie chart below, the top causes of neonatal mortality in 2013/14 were comparable to the previous year.

### Causes of perinatal deaths

Birth asphyxia and prematurity complications were among the commonest causes of the perinatal deaths. Other causes accounted for a large proportion as well, and these included: Jaundice, Respiratory distress syndrome, Intra-Uterine Growth Restriction (IUGR) and meningitis among others.

Figure 1: Causes of Perinatal Deaths FY 2012/2013



Source: MPDR REPORT 2012-2013

The high NMR is addressed at policy level by the sharpened plan (2013) to accelerate reduction of maternal, newborn and child mortality. The plan draws attention to the UN Commission on Life saving Commodities for women and children that emphasizes the need for increasing access to and use of critical medicines and health supplies by outlining 13 reproductive, maternal, newborn and child (RMNCH) commodities. For newborn mortality, the government of Uganda is committed to implement the RMNCH plan that includes; Antenatal corticosteroids, resuscitation equipment, injectable antibiotics and the newborn commodities. The plan reinforces the Continuum of Care Approach that recognizes adolescents, mothers, newborns, and children are inseparably linked in life and in health care needs.

The most prevalent underlying cause for perinatal death are related to inadequate human resource (HR) numbers and skills at the health facility level.

### **Key Interventions**

The high burden of maternal and perinatal deaths was addressed at policy level by launching and beginning Implementation of a Reproductive health maternal, newborn and child health (RHMNCH) sharpened plan 2013 to accelerate reduction of maternal, newborn and child mortality. This plan has five strategic shifts:

- Focus Geographically: Increase effort in geographical places, regions, districts and villages with the highest number of death.
- Increase access for high burden populations: Identify and increase effort among population groups with the highest disease burden and number of deaths prioritizing resources and refocusing health system to expand access to the under-served and hard-to-reach remote areas.
- Emphasize evidence based high impact interventions: Target and expand coverage of interventions of the biggest opportunity for impact of lives saved.

- Addressing the broader context – education, empowerment, economy and environment: Adopt a multi-sectoral approach to harness the structural and social determinants of health, including water, sanitation, and hygiene, income, gender considerations and education that enable survival of women and children.
- Strengthening mutual accountability for ending preventable deaths: Accountability will encompass political accountability to commitments, performance accountability to meet targets; economic accountability by linking results to resources and importantly, accountability to provide quality care to the population
- The HBB + model and current operational research to understand drivers and barriers to use of Antenatal corticosteroids. There are also plans to have centers of excellence/regional learning newborn labs for newborn care that will be used for learning and replication to other areas.

### **2.1.3 Infant and Under-Five Mortality Rates**

The UDHS (2011) estimates the infant mortality rate at 54 per 1000 live births and under five mortality rate 90 per 1000 live births. The HSSIP target for 2015 is 41 per 1000 live births while the under five mortality target is 56 per 1000 live births.

Similarly to maternal and neonatal mortality, the policy response to the high number of child deaths was a sharpened plan (2013) to acceleration plan to address the underlying factors for child mortality.

**Table 5: Top ten causes of InPatient Mortality (Under 5)**

Diagnosis (2012/13)	%	Diagnosis (2013/14)	%
Malaria	28.0	Malaria	28.8
Pneumonia	14.8	Pneumonia	13.0
Anaemia	9.7	Anaemia	11.6
Respiratory Infections (Other)	8.7	Perinatal Conditions (in new borns 0 -7 days)	7.9
Perinatal Conditions	3.9	Neonatal Septicaemia	4.4
Septicemia	2.6	Respiratory Infections (Other)	3.1
Diarrhoea – Acute	2.6	Septicemia	2.8
Severe Malnutrition (Kwashiorkor)	2.1	Perinatal Conditions (in new borns 8-28 days)	2.6
*Injuries - (Trauma Due To Other Causes)	1.4	Diarrhoea – Acute	2.4
Severe Malnutrition (Marasmus)	1.2	Severe Malnutrition (Kwashiorkor)	2.1

\*Injuries other than road traffic accidents

Source: MOH HMIS DATA

### **2.2 Health Outcome Indicators**

Five HSSIP outcome indicators are discussed in this section. Of these, only the “percentage of households with latrine” is assessed annually. The rest are measured periodically and the data are indicated in Table 6.

Most of the outcome indicators that have been measured are on track except for contraceptive prevalence rate and client satisfaction that are far below the HSSIP target. A client satisfaction survey is currently ongoing to gauge the proportionate change from the previous survey.

**Table 6: Performance of other health determinants and risk factor indicators**

<b>Indicator</b>	<b>Source</b>	<b>2010/11</b>	<b>2011/12</b>	<b>2012/13</b>	<b>2013/14</b>		<b>HSSIP Target</b>
		<b>Target</b>	<b>Performance</b>				
% of households with latrine	EHD Data tool	71%	71%	71.2%	71%	74.58%	72%
% U5 children with height for age below lower line -2 SD (stunting)	UDHS	38% (2006)	33% (2011)	33% (2011)	33% (2011)*	33% (2011)*	32%
% U5 children with weight for age below lower line -2 SD (wasting)	UDHS	16% (2006)	14% (2011)	14% (2011)	14% (2011)*	14% (2011)*	13%
Contraceptive Prevalence Rate	Uganda National Panel Survey / UDHS	33%*	30% (2011)	30% (2011)	30% (2011)*	30% (2011)*	41%
% clients expressing satisfaction with health services (waiting time)	Survey – waiting for the report	No data	46% (2008)	45.8%*		Study underway	60%

\*The survey variables are updated to the most recent 2011 UDHS.

### 2.3 Health Output Indicators

Eight output indicators have been selected for monitoring the sector performance at output level. Table 7 summarises the performance trends from 2010/11 to the financial year 2013/14. Overall, the performance fell short of the set HSSIP targets for the period. For example deliveries in health facilities achieved 44 % instead of 65%, pregnant women attending four ANC achieved 31% instead of 55%. Sector performance for these output indicators was constrained by sub-optimal staffing and essential resource scarcities, among other causes.

The proportion of pregnant women attending at-least four sessions of Antenatal care has remained stagnant at 32% over the HSSIP period. The sharpened plan on Reproductive Health needs to prioritise sustainable demand creation for Antenatal care. The proportion of institutional deliveries increased by 5% over the last 4 years. This remains a significant challenge to the sector and country's drive to reducing maternal morbidity and mortality. Information on the VHTs has consistently been unavailable however, the sector commissioned a process of updating the status of VHTs country wide.

The country has achieved tremendous progress in sustaining high levels of immunization coverage. Other sector programs could learn from what UNEPI has done right to achieve this sustained high level of performance. The PMTCT also registered significant positive progress.

**Table 7: Performance for health services core indicators**

Indicator <sup>s</sup>	Source	2010/11	2011/12	2012/13	Sex		2013/14	
					M	F	HSSIP Target	Achievement
% pregnant women attending 4 ANC sessions*	HMIS	32%	35%	31%	-	-	55%	32.4%
% deliveries in health facilities*	HMIS	39%	40%	41%	-	-	65%	44.4%
% children under one year immunized with 3 <sup>rd</sup> dose Pentavalent vaccine (m,f)*	HMIS	90%	85%	87%	83% (M)	85% (F)	83%	90.9% (M) 95.1% (F)
					87% (Total)		Total 93.0%	
% one year old children immunized against measles (m,f)	HMIS	85%	89%	85%	86% (M)	83% (F)	85%	84.7% (M) 88.3% (F)
					85% (Total)		Total 86.5%	
% pregnant women who have completed IPT <sub>2</sub>	HMIS	43%	44%	47%	-	-	60%	48.6%
% of children exposed to HIV from their mothers accessing HIV testing within 12 months	EID database	30%	32.3%	46%	-	-	55%	53.8%
% U5s with fever receiving malaria treatment within 24 hours from VHT	HMIS	No data	No data		-	-	60%	No data
% ART coverage among those in need	ACP	53%	59.3%	83 % based on 2010 WHO Guidelines(46% based on 2013 WHO Guidelines)	-	-	75%	Total 48% (Based on 2013 WHO Guidelines)

<sup>s</sup>\*Joint Action Framework Indicators

## **Conclusions**

The ministry should sustain the immunization performance while putting more investments in maternal health interventions to meet the HSSIP targets.

The indicator on the percentage of U5s with fever receiving malaria treatment within 24 hours from VHT has consistently lacked data. The ministry changed the strategy from Home Based Management of Fever (HBMF) to integrated Community Case Management (iCCM). The iCCM strategy is being rolled out and the system for data collection is being streamlined.

## **2.4 Health Partnerships**

Health Partnerships Performance assesses progress in implementation of the Compact for implementation of the HSSIP as well as the overall technical and financial support for health of Partners.

### **2.4.1 The Compact for Implementation of the HSSIP 2010/11 – 2014/15**

The Compact for implementation of the HSSIP is an instrument aimed at maintaining policy dialogue, promoting joint planning and ensuring implementation and monitoring of the HSSIP 2010/11 – 2014/15. The partnership in this compact is between the Government of Uganda (MoH) and all other stakeholders (HDPs, PNFP, PHP and CSOs), which are collectively referred to as health sector partners.

The HPAC serves as the overall oversight and steering body for monitoring the implementation of the Compact. Functionality of the HPAC is very crucial in monitoring implementation of the Compact and provision of advice on the implementation of the HSSIP and policies.

Three areas of focus extracted from the list of indicators for monitoring implementation of the Compact 2010/11 – 2014/15 were used for the assessment. These are 1) planning and budgeting, 2) monitoring programme implementation and performance, and 3) policy guidance and monitoring.

**Planning and Budgeting:** Only two out of the five indicators measuring performance of the planning and budgeting processes were partially achieved. There was slow progress in achieving the remaining 3 outputs. The Departments of Planning should address these three indicators to ensure compliance during the current FY

**Monitoring program implementation and performance:** The sector performed well in monitoring programme implementation and performance especially through quarterly performance reviews, annual sector performance review and production of Reports. However, failure by the MoH to conduct regular supervision and monitoring of programme implementation in the districts was a big set back in realization of the mandate of the centre. In addition the TWGs continued to meet irregularly, including the SBWG, thus affecting coordination and provision of technical guidance.

**Policy Guidance and monitoring:** The sector performed well in policy guidance and monitoring through attendance of most of the planned meetings for the governance structures. There is however need to re-emphasize participation of HPAC members representing MoH, autonomous institutions and related ministries. There is need to review membership to HPAC in line with the MoH Guidelines for the Governance Structures.

HPAC meets monthly to receive, discuss and make recommendations on policy issues and progress reports submitted through the Senior Management Committee.

Attendance of HPAC meetings by the various stakeholders is varied, with the HDP representatives attending more consistently than other members. There is satisfactory presence of Private Sector Representatives and CSOs, while most concerning is the very low participation of other Line Ministries, whose activities have a significant influence on the determinants of health, and thus on overall population health..

**Table 8: HPAC Institutional representatives' attendance**

Representatives	Average Annual Attendance Rate			
	2010/11	2011/12	2012/13	2013/14
MoH (11)	45%	45%	41%	37%
HDP (4)	88%	109%	138%	161%
CSO (3)	48%	67%	44%	67%
Private (1)	NA	66%	58%	72%
NMS (1)	58%	42%	92%	72%
Medical Bureaus(2)	N/A	N/A	N/A	73%
District (1)	17%	8%	58%	18%
NRH (2)	0%	4%	4%	0%
RRH (1)	0%	0%	0%	0%
Line Ministries (5)	0%	2%	8%	11%

*Source: HPAC Minutes*

**Table 9: Progress in implementation of the Country Compact during FY 2013/14**

No	Indicator	Measurement	Achievement	Compliance
<b>Planning and Budgeting</b>				
i.	MoH Annual Workplan reflecting stakeholder contribution (all resources on plan)	Annual Work plan analyzed and report submitted to 1 <sup>st</sup> HPAC of FY	Annual workplan analysed but not presented to HPAC	Partially compliant
ii.	All new sector investments are appraised by SBWG	Reports from SBWG on appraised Projects submitted to HPAC	Not done	Not Compliant
iii.	All planned procurements reflected in the Comprehensive Procurement Plan	Quarterly assessment of implementation of procurement plan to HPAC	Not done	Not Compliant

No	Indicator	Measurement	Achievement	Compliance
iv.	Response to the Auditor General's Report	Response to AG's report presented to HPAC		Not Compliant
v.	Implementation of Harmonized Technical Assistance (TA) Plan	Progress towards implementation of agreed TA Plan	No implementation	Not Compliant
<b>Monitoring Programme Implementation and Performance</b>				
i.	Area Team Visits Quarterly Reports	Presentation of reports to HPAC within 30 days after completion of Area Team visits		Compliant
ii.	MoH Quarterly Performance Assessment	3 quarterly performance reviews took place	All four quarters reviewed in two biannual meetings	Compliant
iii.	Technical Review Meeting	Present Report from TRM to HPAC by 30 April	Not done	Not Compliant
iv.	Technical Working Group meetings	Target 80% of TWG meetings held	TWG meetings held irregularly	Not Compliant
v.	Annual Health Sector Performance Report	Submission of Final Report by 30 <sup>th</sup> September	Done	Compliant
vi.	Joint Review Mission – performance review	Aide Memoire presented to HPAC by November 30 <sup>th</sup>	Done	Compliant
vii.	Submission of Annual Report to OPM	Submission to OPM by 30 <sup>th</sup> September	Done	Compliant
<b>Policy Guidance and Monitoring</b>				
i.	Senior Management Committee	Proportion of planned meetings held		Compliant
ii.	Health Policy Advisory Committee meetings	Proportion of the scheduled meetings took place	11 out of 12	Compliant
iii.	Country Coordinating Mechanism (CCM)	Proportion of the meetings occurred on the scheduled dates.	6 out of 12	Partially compliant
		Performance for CCM meetings	Target 6, output 8 meetings	Compliant
		Attendance of at least % of meetings by all members		

## 2.5 International Health Partnerships+

Uganda is a signatory to the IHP+ Global Compact which committed members to be held to account in implementing this compact. The Global compact is regularly monitored with the aim of strengthening mutual accountability for results and is based on the eight principles for greater aid effectiveness in health. IHP+ signatories agreed on a set of six key issues to monitor at the fourth IHP+ Country Health Teams Meeting in Nairobi, in 2012. The IHP+ 2014 monitoring framework has a strong emphasis on using findings to support accountability for results.

During the first months of 2014 the fourth IHP+ Monitoring Round on development effectiveness in 2012/13 FY took place. The following aspects of development cooperation were monitored against both Government and HDPs.

**Table 10: Progress in implementation of the IHP+ commitments**

<b>Issue monitored</b>	<b>Government Indicator</b>	<b>Achievement</b>	<b>Associated DP indicator</b>	<b>Achievement</b>
1. Health development co-operation is focused on results that meet developing countries' priorities	An agreed transparent and monitorable country results framework* to assess health sector progress exists.	Y	The country health sector results framework is used.	Y
2. Civil Society operated in an environment which maximized its engagement in and contribution to development	Evidence that Civil Society is meaningfully represented in health sector policy processes – including planning, coordination & review mechanisms.			
	Annual reviews			
	Monthly / quarterly sector coordination meetings	Y		
	TWGs	Y		
	Budget development / resource allocation	N		
3. Health development cooperation is more predictable	Development of medium term health sector plan	Y		
	Proportion of health sector funding disbursed against the approved annual budget.	Not available	Percentage of health sector aid for the government sector disbursed in the year for which it was scheduled.	100%
	Projected government expenditure on health provided for 3 years.	Y (MTEF)	Estimated proportion of health sector aid covered by indicative forward expenditure and / or implementation plans covering at least three years ahead.	Most HDP indicative expenditure is for a one year period not 3 years
4. Health aid is on budget	National Health Sector Plans / Strategy in place with current targets & budgets that have been jointly assessed.	Y	% of health sector aid scheduled for disbursement that is recorded in the annual budgets approved by the legislatures of developing countries.	100%
			AfDB	8.35 Million
			Belgium	2.12 Million
			GAVI	22.85 Million
			GFTAM	8.35 Million
			Italy	1.4 Million
			Japan	1.58 Million
			Spain	1.96 Million
			World Bank	37.75 Million
			WHO	1.57 Million
5. Mutual accountability among health development cooperation actors is strengthened through inclusive reviews	An inclusive mutual assessment of progress in implementing agreed health sector commitments exists and meets at least 4 of the 5 proposed criteria.	Y	Mutual assessments have been made of progress implementing commitments in the health sector, including on aid effectiveness.	Y
6. Effective institutions: developing countries' systems are strengthened and used;	Country public financial management systems either (a) adhere to broadly accepted good practices or	Rated at 3 out of 4	Amount of health sector aid disbursed for the government sector that uses national public financial management systems in countries where systems are generally considered to adhere to broadly accepted good practices, or to have a reform system in place	Still have off budget funding not utilizing the PFM system
	• Financial Management System • Procurement Systems		Have a reform programme in place to achieve these.	Y

## 2.6 Health Investments

This section provides an overview of the sector investments categorized as i) Human Resources; ii) Financing; iii) Infrastructure & Equipment; iv) Essential Medicines and Health Supplies. Overall, the level of investment for health from GOU has been steadily rising, though it is still below the HSSIP and Abuja targets.

### 2.6.1 Human Resources

The health sector is committed to attainment and maintenance of an adequately sized, equitably distributed, appropriately skilled, motivated and productive workforce. This has been done in collaboration with the development partners.

The percentage of approved posts filled by health workers (public facilities) improved from 56% in 2011/12 to 63% in 2012/13, to 69% in 2013/14. This included both the trained health workers, administrative and support staff in public health facilities. The improved staffing level was attributed to the recruitment drive that was supported by government and development partners. Remote districts however, have not fully benefitted from the recruitment drive owing to personnel tendency to avoid areas with poor social infrastructure.

*Table 11: Performance coverage for health investments and governance indicators*

Indicator	Source	2010/11	2011/12	2012/13	2013/14	
					HSSIP Target	Achievement
% of approved posts filled by health workers (public health facilities)	HRIS	56%	58%	63%	70%	69%
% annual reduction in absenteeism rate	Survey	No data	No data		20% reduction from previous year	No data
% of villages / wards with trained VHTs	HMIS	72%	78%		75%	Update underway

The table 12 shows the human resources for health staffing position for public health facilities in 2 national hospitals, 3 central specialized institutions, 14 Regional Referral Hospitals (RRH) as well as 105 districts, 21 municipal councils comprising of 42 General Hospitals (GH), 179 HC IVs, 936 HC IIIIs and 1,619 HC IIs and 69 big town councils.

**Table 12: Human resources for health, staffing by unit**

Name	No. of Units	Norm	Filled	Filled %	Vacant %
Butabika National Referral Hospital	1	422	359	85%	15%
Mulago National Referral Hospital	1	2,461	1,880	76%	24%
Uganga Blood Transfussion Services	1	242	215	89%	11%
Uganda Cancer Institute	1	213	122	57%	43%
Uganda Heart Institute	1	190	134	71%	29%
Regional Referral Hospital	14	4,744	3,820	81%	19%
<b>Sub-Total Central Level</b>	<b>19</b>	<b>8,272</b>	<b>6,530</b>	<b>79%</b>	<b>21%</b>
District Health Officer's Office	105	1,155	938	81%	19%
MHO's Office	21	189	184	97%	3%
Town Council	69	345	111	32%	68%
General Hospital	42	7,980	5,383	67%	33%
Health Centre IV	179	8,640	6,734	78%	22%
Health Centre III	936	17,746	13,399	76%	24%
Health Centre II	1,618	14,364	7,096	49%	51%
<b>Sub-Total Local Government</b>	<b>2,979</b>	<b>50,419</b>	<b>33,845</b>	<b>67%</b>	<b>33%</b>
<b>Total National Level</b>	<b>2,998</b>	<b>58,691</b>	<b>40,375</b>	<b>69%</b>	<b>31%</b>

*Source: MOH-HRH BI Annual Report July, 2014*

As seen from the table above, the overall staffing level is at 69% of the established norms, with staffing of central institutions at 79% of the total established norms and 67% for the Local Governments (LGs).

### **Regional Referral Hospitals**

The table below presents the HRH staffing position for the 14 Regional Referral Hospitals (RRH) including the China-Uganda Friendship Hospital (CUFH)-Naguru.

**Table 13: Staff per Regional Regional Hospital**

SN	Name	Norm	Filled	Filled %	Vacant %
1	Arua	293	316	108%	-7.8%
2	Mbale	372	386	104%	-3.8%
3	FortPortal	326	313	96%	4.0%
4	Gulu	321	304	95%	5.3%
5	Mbarara	329	304	92%	7.6%
6	Jinja	421	375	89%	10.9%
7	Masaka	312	261	84%	16.3%
8	Lira	340	271	80%	20.3%
9	Hoima	308	234	76%	24.0%
10	Soroti	340	253	74%	25.6%
11	Kabale	340	237	70%	30.3%
12	Naguru	344	232	67%	32.6%
13	Mubende	349	191	55%	45.3%
14	Moroto	349	143	41%	59.0%
<b>Total</b>		<b>4,744</b>	<b>3,820</b>	<b>81%</b>	<b>19%</b>

*Source: MOH-HRH BI Annual Report JULY, 2014*

As evident from the table above, Arua RRH has the highest staffing level at 108% of the staffing establishment followed by Mbale at 104% with both hospitals having filled positions greater than the established norms. At the bottom of the RRH staffing continuum is Moroto RRH at 41% staffing level, Mubende at 55%, Naguru at 67% and Kabale at 70%. The average staffing level for RRH is 81%.

It can be seen that 11 RRHs have established staffing positions filled by at least 70% and one RRH with established positions filled below 50%. In addition a total of seven RRH have a staffing level below the RRH average. These include Moroto (41%), Mubende (55%), Naguru (67%), Kabale (70%), Soroti (74%), Hoima (76%) and Lira (80%).

### Specialized Central Institutions

*Table 14: showing the staffing level of specialized central institutions*

Name	Norm	Filled	Filled %	Vacant %
Uganda Blood Transfussion Services	242	215	89%	11.2%
Uganda Cancer Institute	213	122	57%	42.7%
Uganda Heart Institute	190	134	71%	29.5%

*Source: MOH-HRH BI Annual Report July, 2014*

### Staffing level bands (range) in LGs by level of care

*Table 15: Analysis of staffing level bands according to levels of care in districts*

District	0%-40%	41%-50%	51%-69%	70%-100%	50%-100%
General Hospital	10%	10%	29%	52%	81%
Health Centre II	42%	17%	29%	12%	41%
Health Centre III	9%	8%	35%	48%	84%
Health Centre IV	7%	3%	37%	53%	91%
<b>ALL</b>	<b>30%</b>	<b>13%</b>	<b>31%</b>	<b>26%</b>	<b>58%</b>

*Source: MOH-HRH BI Annual Report July, 2014*

42% of all HC IIs have a staffing below 40% compared to 9% of all HC IIIs, 9% of all HC IVs and 10% of all GHs. On the other hand, 91% of all HC IVs have at least 50% of established positions filled by health workers compared to 81% of all HC GHs, 84% of all HC IIIs and 41% of all HC IIs.

The table 16 shows the overall staffing status for the different categories of staff.

**Table 16: Overall staffing status for the different categories of staff**

Cadre Category	Staffing Norm	Filled	Staffing Level
Administrative	1,354	1,370	101%
Anaesthetic cadre	725	215	30%
Support Staff	8,939	4,607	52%
Other health	6,127	3,352	55%
Health Administration	441	126	29%
Nursing cadre	19,539	16,681	85%
Midwifery	6,188	4,639	75%
Other Allied Health Staff	1,197	821	69%
Doctor	1,218	941	77%
Clinical Officer	2,766	2,800	101%
Cold Chain cadre	284	117	41%
Consultant	327	107	33%
Dispensing cadres	380	233	61%
Laboratory cadres	2,678	2,396	89%
Pharmacist	376	31	8%

Source: MOH-HRH BI Annual Report July, 2014

### **2.6.2 Health Financing**

The health system, including service delivery were financed by a multiplicity of stakeholders namely; Government, private firms, households and development partners. Service delivery and developments in public facilities were mainly financed through Government grants, concessional loans and grants from development Partners. Government continued to support service delivery in the Private-Not-for-Profit facilities by way of grants and seconded personnel.

Health service delivery was financed by the government, private sources and development assistance under the sector wide arrangement (SWaps). Government of Uganda capital budget for health (excluding donor) for the FY 2013/14, accounted for 15% of health sector public expenditure while recurrent expenditure such as wages, utilities and other operational costs accounted for 85%. The recurrent budget outturn was 93% (U Shs 592.4bn) while that of the development budget outturn was 92% (U Shs 451bn).

General Government allocation for health as percentage of the total Government budget has averaged about 8% from 2010/11 to 2013/14, which is 1.8% short of the HSSIP target of 9.8% (table 9). This translates into a government contribution of US \$ 12 per capita expenditure on health.

The new Health Financing Strategy is expected to streamline the way the sector raises funds for health care, purchases and monitors progress of outputs in pursuit of value for money.

*Table 17: Budget sources for the sector*

Budget Sources	FY 2013/14 (UShs Bn)	Percentage of the total budget
Recurrent- wage	305.67	27%
Recurrent-Non wage	331.5	30%
Sub total Recurrent	<b>637.17</b>	<b>57%</b>
Domestic dev't Grant-GOU	73.65	6%
Donor	416.67	37%
Sub total Development	<b>490.32</b>	<b>43%</b>
Total Budget performance	<b>1,127.49</b>	<b>100%</b>

*Source: Ministerial Policy Statement 2014/15*

### **Progress on Budget Performance**

There was 93% release of funds and the budget expenditure performance was 99%.

### **Trends of Health financing 2010/11-2013/14**

The trend in allocation of funds to the health sector shows that there has been an average increase in budget allocation of 20% per annum over the past 4 years of the implementation of the HSSIP as illustrated in the Table 10 below. The increment is largely attributed to wage bill and external financing towards health.

*Table 18: Government allocation to the Health Sector 2010/11 to 2013/14*

Year	GoU Funding (Ushsbns)	Donor Projects and GHIs (Ushsbns)	Total (Ushsbns)	Per capita public health exp (UGX)	Per capita public health exp (US \$)	GoU health expenditure as % of total government expenditure
<b>2010/11</b>	569.56	90.44	660	20,765	9.4	8.9
<b>2011/12</b>	593.02	206.10	799.11	25,142	10.29	8.3
<b>2012/13</b>	630.77	221.43	852.2	23,756	9	7.8
<b>2013/14</b>	710.82	416.67	1127.48	32,214	12	8.7

The per capita public expenditure increased from \$9 to \$12 due to additional government, GAVI and Global Fund financing.

## Primary Health Care Allocations (PHC NWR FY 2013/14)

*Table 19: PHC Non-wage allocation to public health facilities and DHOs offices*

Level of health service delivery	Number	Ratios	Number (Adjusted for ratios)	Total annual NWR allocation per level	Annual average per individual facility/ office	Monthly average per facility/ office
DHOs (LG health offices)	137	2	137	3,168,000,000	23,124,088	1,927,007
HC IV	166	4	664	2,071,444,609	12,478,582	1,039,882
HC III	868	2	1736	5,415,704,579	6,239,291	519,941
HC II	1662	1	1662	5,184,850,812	3,119,645	259,970

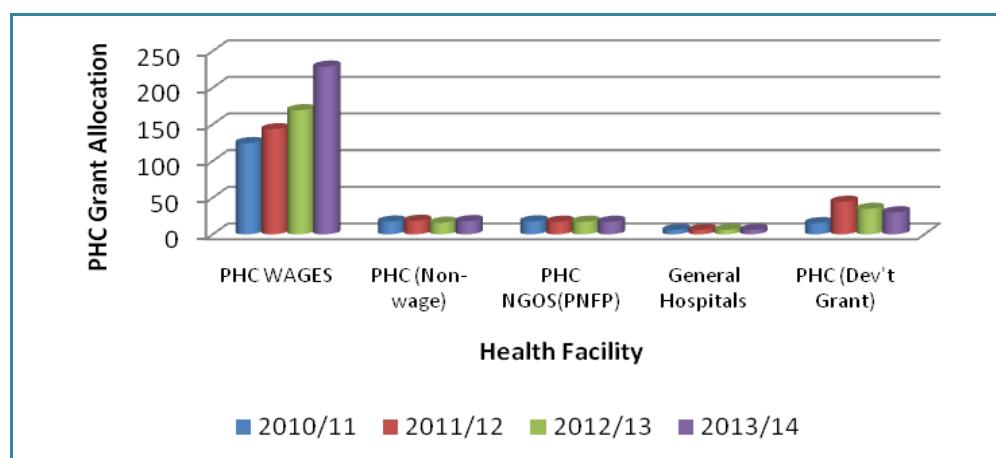
*Table 20: Primary Health Care Grants FY 2010/11-2013/14 in Ushs billions*

FY	PHC Wages	PHC (Non- wage)	PHC NGOS (PNFP)	General Hospitals	PHC (Dev't Grant)	Total
2010/11	124.5	17.4	17.7	5.9	15.3	180.8
2011/12	143.43	18.5	17.19	5.94	44.43	229.49
2012/13	169.38	15.84	17.19	5.94	34.81	243.16
2013/14	228.69	18.05	17.19	5.94	30.08	299.95

*Source: Approved Budget of revenue and expenditure-MoFPED*

Figure 2 below shows that there has been steady increase in PHC wages over decade with no significant increase in the remaining components of the non wage PHC grant. The result shows overall increment in PHC allocation. Non wage allocation has remained the same over the years. The mismatch between non wage and development means that the recurrent costs cannot be met for the maintainance of the infrastructure.

*Figure 2: Trends in PHC Grant Allocations FY 2010/11-2013/14 in Ushs billions*



## **Challenges**

1. There is inadequate funding for sector activities especially Primary Health Care Services. Only Ushs 41.185bn was allocated as recurrent budget to run health service delivery in 137 LGs with 56 General Hospitals, 61 PNFP Hospitals and 4,205 Lower Level Health Units.
2. There is a challenge of the alignment of off-budget funding to sector priorities.
3. There is skewed input mix in financing health facilities, for instance there have not been comensurate funding for recurrent costs for utilities and/or maintenance arising from the construction of new buildings and equipment especially for hospitals at all levels.
4. There are also institutional weaknesses in capacity of LGs in areas of financial reporting, leadership and financial management.

## **Conclusion:**

Whereas government financing in the sector has been increasing steadily, it is still below the recommended per capita government expenditure on health of US \$ 34 per capita as per the WHO Commission of Macro Economics on Health (CMH). It is also below the HSSIP target of per capita government expenditure on health of US \$ 17. The comprehensive health financing strategy under development should be expeditiously finalized and adopted to guide sector resource mobilization, allocation, tracking and monitoring. In addition, there is need to ensure transparency and accountability in resource allocation and use plus improvements in management of development assistance for health.

### **2.6.3 Health Infrastructure and Equipment**

The mandate of the Health Infrastructure Division (HID) is to oversee development and implementation of standards and guidelines on Health infrastructure, and to ensure availability of a network of functional, efficient and sustainable health infrastructure for effective health services delivery closer to the population in need.

Performance of the health infrastructure is assessed by;

- The proportion of the population living within 5 km of a health facility,
- Proportion of HC iis and HC ivs with complete basic equipment and supplies for addressing emonec,
- Number of new health facilities,
- Proportion of HC IVs and hospitals with functional ambulances.

### **Core HSSIP Indicator**

- The proportion of the population of Uganda living within 5 km of a health facility increased from 72% to 90% by 2015

- Proportion of HC III's and HC IV's with complete basic equipment and supplies for addressing EmONC increased to 100% by 2015
- Number of health facilities increased by 30% by 2015
- Proportion of HC IV's and hospitals with functional ambulances for referral increased to 100%

Significant progress has been made in the rehabilitation of infrastructure and supply of new equipment in the sector at various levels. For instance work was done at National, Regional Referral including KCCA, and selected General hospitals. In addition, work was done at Health centres, DHOs' office in the areas of staff houses, maternity wards, OPD and Transport among others under NUSAf II and PRDP. This was achieved with funding from GOU and partners.

Mapping of Health facilities in the 112 districts was also done and geo-referenced maps produced with support from UBOS, OPM, WHO and CDC. The exact location of health facilities was captured using Global Positioning System devices, commonly referred to as GPS's to enable analysis of physical accessibility.

The main challenge is inadequate funding for medical equipment and rehabilitation and maintenance of health facilities especially general hospitals.

**Table 21: Health infrastructure achievements**

Item	Number	Comments
Hospitals: Regional Referrals	14	Undergoing construction and renovation of regional and 2 National referral hospitals
General Hospitals	11	2 General hospitals under construction in Kampala and 9 being rehabilitated under the Uganda Health System Strengthening Project
Health Centre IVs	No data	Data not available
Transport	19	Ambulances have been supplied to hospitals and health centres under NUSAf
	8	mobile workshop vehicles were procured to support maintenance of medical equipment by regional workshops under SUSTAIN and IDI
Equipment		Different medical equipment were supplied under NUSAf project,
Staff Houses	95	3 roomed Staff houses constructed under NUSAf
Others	35	medical waste incinerators in Hospitals across the country have been installed

*Figure 3: Selected Pictures on Progress of Civil Works within the hospitals***Moroto Hospital staff quarters****Side elevation of the T-block and its extension  
2014, Kiryandongo General Hospital**

#### **2.6.4 Management of Essential Medicines and Supplies**

The Pharmacy division is responsible forensuring adequate supply of medicine and health supplies in the health sector. This is done by periodically conducting a national forecast and quantification plan for essential medicines and health supplies, building capacities of health workers, at district and health facility level, in medicine logistic management and other medicine management related activities and developing operational guidelines on management of health supplies. Most of these activities are implemented with the support of implementing partners. It utilizes the six HSSIP indicator items to assess medicines and supplies adequacy.

**Table 22: Indicators for medicine and other health supplies**

<b>Indicator</b>		<b>Baseline</b>	<b>Achievements</b>				<b>Target 2014/ 15</b>
		<b>2009/ 10</b>	<b>2010/ 11</b>	<b>2011/ 12</b>	<b>2012/ 13</b>	<b>2013/ 14</b>	
The % of Health facilities with no stock out of the six tracer medicines in the last six months	Artmenther /lumenfantrine Cotrimoxazole tab 480mg Depo-provera Oral Rehydration Salt Sulphadoxine/Pyremetamine Measle Vaccine	- - - - - -	83 61 92 89 96 81	83 82 91 90 89 91	78 94 88 81 88 87	87 87 96 71 88 94	- - - - - -
The percentage of health units with no stock outs of any indicator medicines in the previous six months	21% 2	43% 2	49%	53% 1	57%	60%	
Government of Uganda budget for procurement of EMHS increased from meeting 38% to 66% of MoH estimated need <sup>9</sup>	-	38%	72%	66%	63%	80%	
Utilization of government funds spent by NMS increased from 59% to 95%.	59%	75%	95%	103%	101%	80%	
The % of NDA budget directly financed by GoU (consolidated funds at 0 %).	0%	0%	0%	0%	0%	25%	

Over the years government has increased funding for medicines and health supplies from 201.7 billion 2010/2011 to 219.4 billion 2013/2014 (including ARV's, ACT's, Lab Commodities, TB and Vaccines). However, this is still inadequate. Per capita government expenditure on EMHS in the FY 2013/14 was about US\$ 2.4 which is below the estimated requirement in the HSSIP of US\$ 12. This leaves a funding gap which is financed by development partners and the private sector mainly through out of pocket expenditure.

**Table 23: Planned activities for management of essential medicines**

Planned activities	Targets	Achievements (Outputs)	Comments
Monitoring of Stock status Report	Produce six bi monthly reports	Six reports were produced	Data quality and timelines of the report still a challenge
Support supervision and monitoring of medicines logistics management	Supervise and monitor 15 general hospitals and 200 lower level units	Supervised and monitored 10 Hospitals and 120 lower level health facilities	Supported by IPs. Targets were not achieved due to Inadequate funding
Promote rational use of medicines	Dissemination of the UCG and EMHSL in six regions	UCG and EMHSL were disseminated in two regions	Low coverage due to low funding
Coordination meetings with IPs	Hold two meetings with IPs and MMS involved in logistics management	One meeting was held	
Conduct TWGs and Commodity security group meetings	12 TWGs and 12 Commodity security group meetings	7 TWGs and 12 CGS were held	
Support in prioritizing their requirements	40 hospitals to be supported	None	Some support was provided through IPs

### Main achievements

- Published quantification reports for ARVs, TB, Malaria, condoms, cotrimoxazole, Laboratory and, Reproductive Health commodities.
- Completed two grant applications for the Global Fund; Interim application and the costed extension
- Developed dispensing guidelines for lowe level Health Facilities
- Planned and monitored procurement of ARVs, TB, malaria, Lab, cotrimoxazole , condoms and Reproductive Health commodities
- Finalised and published the annual Pharmaceutical Sector performance report
- Developed the M/E plan and conducted Mid term review of the pharmaceutical Strategic plan
- Rolled out SPARS to cover 97 districts in Uganda

## **Challenges**

- Lack of funding despite allocations
- Low IP support compared to initial anticipation
- Low staffing level with most of them seconded by implementing partners whose support are winding up. A case in point is the SURE program
- Lack of office space

## **Recommendations**

- Conduct an assessment on equity in budget allocation for EMHS and revisit resources allocation criteria to achieve equity in financing and management of EMHS.
- Government to increase financing in the pharmaceutical sector for sustainability of SPAS with the pending exit of the IP's.
- All IP's supporting districts in medicines management should embrace SPAS.

Human resources inadequacies, capital investment and logistical management issues (orders versus actual supplies) are hindering the public sector mandate of providing medicines to meet the requirements for universal access.

## **2.7 Performance at different levels of the health system**

### **2.7.1 MoH Headquarters Performance**

At headquarters performance assessment was based on vote execution both at the centre and the districts.

### **Sector monitoring and quality assurance**

The sector monitors quality and performance under the leadership of the quality assurance department. The aim of the planned outputs highlighted in Table 14 is to ensure compliance to the set standards by the various entities and programs. The following were achieved during the period under review.

In order to ensure continuous performance improvement the department organized quarterly sector performance review meetings, quarterly area team monitoring, updating of sector operational standards and assessment of sector implementation of the Compact.

### **Policy, Planning and Support Services**

Policy, Planning and Support Services aims to ensure relevant policies are in place through formulating new policies and appraising old ones. Subsequently strategic plans and annualised plans for all stakeholders are drafted in a harmonized manner and monitoring and evaluation of planned activities is coordinated across the sector to ensure overall achievement of sector objectives.

The performance for the FY 2013/14 included; production of quarterly financial reports, drafting of the AHSPR FY 2013/14, production a draft Health Financing strategy, undertook six regional planning meetings covering 76 Local Governments. Periodic technical supervision and inspection of sector activities for consistency with Government Policies was also undertaken. The BFP and MPS for FY 2014/15 were produced. In addition a Health sector issues paper FY 2015/16- FY2019/20 for the NDP II was prepared and also produced PHC grant guidelines for FY 2013/14.

Under policy, the sector drafted and submitted to cabinet the following bills, protocol and policies;

- principles of National Food and Medicines Authority Bill, 2014,
- Uganda Hearts Institute Bill, 2014,
- National Health Laboratory Bill, 2013,
- Uganda Immunization Bill, 2014 and submitted a Uganda Immunization Bill to Parliament.

In addition, a regulatory impact assessment for the National Food and Medicines Authority Bill, 2014 was conducted.

### **Human Resource Management and Development**

Under human resources management the following planned activities were implemented; Decentralisation of payroll implemented and salaries paid, seven staff members were seconded to Ministry of Public Service (MoPS), to help in data capture to clear backlog of un paid salaries for health workers country wide. 191 critical positions submitted to MoPS and cleared for filling at MoH HQtrs & RRHs, 218 cases of Retired Officers' cases submitted to Ministry of Public Service for pension payment. Press release for submission of health workers with payroll issues to MoPS run on Television and Print media. Implemented 978 Service Commission decisions on time, 455 submissions to health service commissions timely made. 1,300 Health Workers were recruited under PEPFAR for districts and Regional Referral Hospitals (RRH). 300 bonded health workers were deployed and assumption of duties monitored. Field visits were conducted across the country and induction of 1,434 health workers who were recruited under TASO, PEPFAR and Global Fund was coordinated.

In an effort to enhance motivation and retention of Health Workers, Medical Officers at HCIVs were paid retention allowances and 393 Health Workers offered scholarships under UHSSP in Hard-To-Reach areas. The Ministry also coordinated, central level institutions (NRHs, RRHs, UHI, UCI, UBTS, UVRI) and guided them to develop their recruitment plans. Performance agreements for 14 Hospital Directors (RRHs) and 7 Heads of department at MOH headquarters were signed, implemented and assessed.

The contribution of HSC to HRM and development are summarize in the tables 17, 18 and 19 below.

**Table 24: Health Workers recruited**

Institution	Senior Consultants	Consultants	Health Managers	Total
Ministry of Health	-	-	02	02
Mulago National Referral Hospital	-	05	-	05
<b>Butabika National Referral Hospital</b>	<b>02</b>	-	01	
CUFH-N	02	03	01	
Uganda Heart Institute	02	01	01	04
Regional Referral Hospitals	07	08	01	16
<b>Total</b>	<b>13</b>	<b>17</b>	<b>06</b>	<b>36</b>

**Table 25: Summary of vacancies cleared, filled and created in selected institutions**

Institution	Cleared	Filled	Not Filled	Created	% filled
Ministry of Health - Hqtrs	20	11	8	6	55.0
Mulago National Referral Hospital	97	78	15	31	80.4
Butabika National Referral Hospital	33	31	3	3	93.9
Ministry of Internal Affairs	1	1	0	0	100.0
Health Service Commission	2	2	0	0	100.0
Uganda Blood Transfusion Services	37	24	11	4	64.9
Uganda Heart Institute	10	9	1	5	90.0
Uganda Cancer Institute	1	1	0	0	100.0
UPHS	6	6	0	0	100.0

**Table 26: Summary of vacancies cleared, filled and created in Regional Referral Hospitals**

Institution	Cleared	Filled	Not Filled	Created	% filled
Mubende	24	19	2	5	79.2
Kabale	44	27	8	7	61.4
Moroto	11	10	1	0	90.9
Mbarara	26	12	13	3	46.2
Gulu	30	22	8	7	73.3
Lira	26	19	4	12	73.1
MOH-RRH (EM, Anaesthetics & Dispensers )	0	19	0	0	
<b>Sub total</b>	<b>367</b>	<b>288</b>	<b>83</b>	<b>109</b>	<b>78.5</b>
<b>Grand Total</b>	<b>907</b>	<b>715</b>	<b>170</b>	<b>187</b>	<b>78.8</b>

Arising from the 911 vacant posts cleared for recruitment by Ministry of Public Service, 78.5% (715) Health Workers were appointed into health service hence a shortfall of 21.5%. This in turn hinders service delivery.

### **Finance and Administration**

Mandate is to provide political direction and render administrative and support services to ensure efficiency in resource management in the sector.

**Table 27: F & A outputs achieved against plans for all recurrent programmes FY 2013/14**

<b>Annual planned output target</b>	<b>Actual output achieved (Qty and location)</b>
<b>Ministerial &amp; Top Management Services: 20</b> Political Supervision of sector activities to ensure for consistence with Government policies done	<ul style="list-style-type: none"> <li>▪ 20 political supervision of sector activities in the Districts &amp; Referral Hospitals done (Moroto, Napak, Sheema, Hoima, Kabale, Kibale)</li> <li>▪ Seven Health sector events presided over (International Nurses day, Safe motherhood day, World No Tobacco day, Mental Health Day)</li> <li>▪ Six National ward rounds carried out (Jinja, Mubende, Lira, Gulu, Masaka, Mbale, Mulago, Mbarara)</li> <li>▪ Entitled officers emoluments paid</li> </ul>
20 Administrative Monitoring & Supervision of sector activities done	<ul style="list-style-type: none"> <li>▪ Twenty Administrative Monitoring of sector activities carried out. (mbale, Arua, Moroto, Kumi, Lira, UCI, Kasese, Sheema, Kabale, Ntungamo, Isingiro...)</li> <li>▪ Fourty eight Senior Top management meetings held &amp; facilitated.</li> <li>▪ Three Senior Special top management meetings held &amp; facilitated.</li> <li>▪ Twelve HPAC meetings held &amp; facilitated</li> </ul>
7 Cabinet Memoranda & 9 briefs to Parliament submitted.	<ul style="list-style-type: none"> <li>▪ Six Consultative meetings in the District LGs and communities on key policy proposals on health matters carried out. (Tororo, Mbale, Hoima, Gulu ...)</li> <li>▪ Nine Briefings to Parliament done</li> <li>▪ Eighteen Technocrats facilitated to make a presentation on homosexuality at the Cabinet retreat in Kyankwanzi</li> </ul>
Press statements on sector matters issued	<ul style="list-style-type: none"> <li>▪ Press statements &amp; media briefs on sector matters given</li> <li>▪ 12 supplements and advertorials were published</li> <li>▪ 27 press conferences to update the public on the different sector issues held</li> <li>▪ 26 press releases were disseminated</li> <li>▪ Eight Ministerial Press Statements released.</li> <li>▪ Six media tours were conducted. The journalists were taken around the country to see different programs being undertaken by the sector.</li> <li>▪ 43 radio talk shows and 27 television talk shows were held</li> </ul>
Information sharing & advocacy meetings held.	<p>Nine Key International fora on health matters attended (Washington, Harvad, Switzerland, Tanzania, Angola, Malaysia ...)</p> <p>Advocacy meetings with key stakeholders / Development partners within the country (4) &amp; abroad (3) held (China, Japan, UK)</p>

<b>Annual planned output target</b>	<b>Actual output achieved (Qty and location)</b>
<b>Ministry support services:</b> Staff facilitated & monitored to deliver sector services against plans	<ul style="list-style-type: none"> <li>▪ 25 non routine activities facilitated.</li> <li>▪ Gazetted Ministry events held</li> <li>▪ Ministry Premises kept clean.</li> <li>▪ Office equipments /supplies provided &amp; maintained</li> <li>▪ Departmental vehicles maintained</li> <li>▪ Staff training facilitated</li> <li>▪ Basic utility supplies maintained</li> <li>▪ ICT infrastructure maintained</li> <li>▪ Assets register maintained</li> <li>▪ Established committees facilitated to function</li> <li>▪ Departmental meetings held</li> <li>▪ F&amp;A Annual work plan &amp; budget submitted.</li> <li>▪ Supervision &amp; monitoring of other stores carried out.</li> </ul>
Staff welfare provided	<ul style="list-style-type: none"> <li>▪ Response to audit queries by audit institutions submitted</li> <li>▪ Financial statements &amp; reports submitted.</li> <li>▪ IFMS maintained</li> <li>▪ Accountabilities for advances to individuals &amp; institutions obtained</li> </ul>
Gazetted Ministry events held	40 contracts committee meetings held and facilitated, 319 evaluation committee meetings held and facilitated, 18 procurement adverts run, 601 procurement contracts signed & completed. 292 micro procurements handled
Ministry Premises kept clean.	<ul style="list-style-type: none"> <li>▪ Review of PHC releases to 40 Districts carried out</li> <li>▪ Review of the operations of CDC for 2012-2014 carried out</li> <li>▪ Review the operations of Uganda Sanitation Fund carried out</li> <li>▪ Follow up of delivery of equipments under EAPHLNP in 5 Districts carried out</li> <li>▪ Follow up the delivery of medical equipments supplied to Hospitals &amp; Health Centers under UHSSP in 31 Districts carried out</li> <li>▪ Review of GAVI operations conducted</li> <li>▪ Review of activities under Global Fund carried out</li> <li>▪ Audit of Integrated Financial Management Systems conducted</li> </ul>

### **Challenges**

- An aging fleet of 260 motor vehicles that has resulted into high motor vehicle operations maintenance costs.
- Inadequate office space. Despite the opening of the new office extension, this has remained a challenge as a number of staff are still not accommodated.
- Recruitment plans made over years without provision in the budget to fund them

- Low remuneration of staff leading to failure to attract critical health cadres to rural areas
- Delayed release and budget cuts affecting timely implementation of activities as planned
- Inadequate resources for facilitating senior Top Management
- Accountability has remained a big challenge because of failure by the technical officers to respond in time
- Reluctance of DLGs to absorbing contracted and bonded health workers where there are vacancies and wage provisions, creating a backlog of unpaid salary arrears for the subject health workers for.

## **Clinical and Public Health**

### **Community oral health**

Dental problems are important public health problems because of their high prevalence. According to the information from a rapid assessment done in 2004/2005, the estimated oral conditions found in the community were dental caries affects (93.1%) pain (82.1%), tooth loss (48.3%), bad breath (43%), oral HIV lesions (29%), tooth bud extractions (17%), jaw fractures (14%) tumors (3.4%) and Noma (2.8%)

In Uganda dental caries and gum diseases are the most prevalent of all diseases among children. Dental caries is the major cause of early loss of primary teeth. The number of dental health care workers in the districts is limited and sometimes absent hence the need to incorporate other health care workers in offering oral health care advice to mothers and the children.

### **Highlights of planned activities during the FY 2013/14**

- Re-orientation of oral health workers towards community oral health care instead of concentrating only on their usual clinical practice.
- Sensitizing some non-dental health workers in the Health Sub districts on public oral health and hygiene.
- Printing of guidelines for teachers in nursery and primary schools on oral health care.
- Monitoring and support supervision of districts on community oral health care.

### **Main achievements**

- Sensitization of district health teams on oral health care in the community has been done.
- The guide for teachers in nursery and primary school teachers on oral health care was produced and disseminated.
- Monitoring and support supervision of districts has been done.

## **Challenges**

- The number school are too many in the country compared to the guides we are able to print and disseminate.
- Limited transport and facilitation in the districts to carry out community oral health care.

## **Key recommendations**

- There is a need to foster collaboration with the Ministry of education and sports on oral health care in schools.
- All health care workers involved in PHC activities should be sensitized on oral health care in the community.
- There is need to recruit oral health workers in the new districts to handle oral health care activities.

## **Palliative Care**

Palliative Care is an approach that improves the quality of life of patients and their families facing the problems associated with threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual problems.

## **Lead Program indicators FY 2013/14**

- Palliative Care policy developed
- Number of districts offering palliative Care services
- Number of districts supervised on palliative care
- Number of Personnel trained on palliative care
- Number of community members sensitized on palliative care
- Per capita morphine consumption.
- Number of health facilities accredited to offer palliative care services

## **Achievements**

- Palliative Care policy was developed and is ready for presentation to Senior Management Committee.
- Process of development of palliative care guidelines and communication starategy initiated.
- Carried out 6 Stakeholders consultative workshops to develop Palliative Care Policy
- A total of 90 districts out of 112 now offer palliative care services
- Support supervision conducted in 40 districts.

- A total of 96 qualified in Bachelor of Science in Palliative care
- A total of 29 Qualified with a Diploma Clinical Palliative Care
- A total of 230 Health care workers were trained on palliative care (Five days in service training)
- Trained 187 Medical students on palliative care
- Trained 140 VHTs on Palliative care, of which 49 were empowered with basic legal knowledge to help patients with their legal needs
- A total of 40 Spiritual leaders trained on palliative care
- Sensitized 240 People on palliative care including members of parliament, district leaders and Journalists/editors (20 Parliamentarians , 60 District leaders, 120 Hospital Managers , 40 Journalists/editors)
- A 23,341 Morphine powder utilized in FY 2013/2014

### **Challenges**

- Inadequate funding
- Human resource constraints
- Competing priorities
- Guidelines and communication strategy not yet available
- Lack of logistics (lack of field vehicle for support supervision and accreditation activities)
- Inadequate baseline data for evidence based planning

### **Recommendations**

- Prioritize Palliative Care integration into the health care system
- Lobby for palliative care specialists to be incorporated in public service structure
- Scale training and sensitization of health workers
- Scale up sensitization of policy makers, parliamentarians, religious leaders
- Scale up sensitization/training of VHTs
- Conduct operational research on palliative care

### **Planned activities for 2015/16**

- Disseminate Palliative Care Policy
- Disseminate Palliative Care guidelines
- Procure Vehicle for palliative care field activities
- Continue palliative care training and sensitization
- Scale up accreditation of health facilities to provide palliative care

- Lobby for palliative care specialists to be streamlined into public service
- Ensure availability of adequate palliative care medicines and supplies

### National Drug Authority

The National Drug Authority (NDA) was established in 1993 by the National Drug Policy and Authority (NDP/A) Act, Cap. 206, Laws of Uganda. The mandate of NDA is to ensure availability, at all times drugs which are of good quality, safe, efficacious and cost-effective to the entire population of Uganda, as a means of providing satisfactory healthcare and safeguarding the appropriate use of drugs.

### Achievements

Internal Quality audits and nine Statutory Instruments approved by Hon MoH 24th into regulations in March, 2014.

*Table 28: National Drug Authority - Evening operations*

Region	Outlets visited	Closed	Court cases	Arrests
Central region	1021	652	3	0
South / Western	287	208	0	1
West Nile	200	60	5	03 convicted
Northern (routine)	1153	142	41	24 convicted
Eastern (routine)	185 pharmacies 791 drug shops	-	-	
Western (routine)	418	178	5	2 won by NDA 2 Pending 1 dropped
S/Eastern	90	44	12	10 convicted

**Reasons for closure were** unlicensed premises, Unsuitable premises, Possession of counterfeits, expired drugs government drugs, and manned by unqualified personnel

*Table 29: National Drug Authority - Number of units reached against closures*

Period	Drug shops		Clinics		Pharmacies		Totals	
	Visited	Closed	Visited	Closed	Visited	Closed	Visited	Closed
June/July	81	49	280	174	65	34	426	257
Aug/Sept	92	40	137	84	13	2	242	126
October	162	124	72	52	0	0	234	176
November	82	64	34	27	3	2	119	93
<b>Totals</b>	<b>417</b>	<b>277</b>	<b>523</b>	<b>337</b>	<b>81</b>	<b>38</b>	<b>1021</b>	<b>652</b>

### **2.7.1.8 Kampala District: Kawempe, Nakawa, Makindye and Rubaga divisions: Central Division – Pharmacy village (Luwum/William Street) Wakiso District: Gayaza, Namasuba, Kireka**

The department was able to test the following samples as shown in the table below in the FY 2013/14

*Table 30: National Drug Authority - Achievements July 2011 to March 2014*

Item	Tested	% failed
Medicine	2372	23.1
Male latex condoms	1166	5.0
Medical gloves	595	26.2
LLINs	235	0.0

- There is a marked improvement in terms of quality for the medicines, male latex condoms and medical gloves on the Uganda market.
- Established the Quality Management Systems, three internal quality audits done in collaboration of key stakeholders such as URA, Police, Interpol etc.
- Maintained an online drug register on <http://server/drugregister>
- The Draft NFMA Bill was finalised and discussed by NDA Senior Management in February, April and May 2013. Further consultations with the Ministry of Health, MAAIF and stakeholders are ongoing.
- July 2014 cabinet approved additional principles
- July 2014 minister of health forwarded the approved principles to solicitor general for finalizing the draft bill, Impact of NDA activities
- Reduced the level of counterfeits on the market
- Improved access to good quality medicines / users confidence in products
- Improved GMP compliance by manufacturers
- Reliable Pool of drug regulatory experts
- Proposal from government to take on regulation of food safety, cosmetics a sign of confidence.

### **2.7.1.9 National Medical Stores**

NMS is set up by an Act of Parliament NMS Act (Cap 207 of 1993), as a statutory autonomous body responsible for procurement, storage and distribution of essential medicines and medical supplies, primarily to Government health facilities.

The NMS receives funds are for all levels of healthcare namely, National Referral hospitals/Institutes (including Uganda Heart Institute, Uganda Cancer Institute ,Uganda Blood Transfusion Services and UNEPI (for vaccines), Regional Referral Hospitals, General Hospitals, Health Centres IV, III and II.

Upon receiving funds NMS procures and distributes a whole range of essential and specialized medicines, sundries and lab supplies to all government health facilities and Medicines and health supplies delivered at NMS are appropriately embossed.

Door to door deliveries are done at least once every two months to all government and other accredited facilities (over 2800) countrywide following the predetermined delivery schedule. The routine delivery of medicines is once every 2 months for GH and lower health facilities and once every month for RH. There is a system that enables processing of emergency orders within hours and deliveries are made from 8am-5pm from Monday to Friday, including weekends and public holidays if necessary.

**Table 31: NMS-Routine delivery of medicines to all government and accredited facilities**

Item supplied	Costing (UGx)
EMHS to HC2	11,163,237,000
EMHS to HC3	18,360,000,000
EMHS to HC4	7,992,000,000
EMHS to General Hospitals	18,106,000,000
EMHS to Regional Referral Hospitals	13,024,000,000
EMHS to National Referral Hospitals	12,365,600,000
ACTs, ARVs & TB Therapies to Accredited Facilities	100,000,000,000
EMHS to specialised units (UCI, UHI, UBTS, UNEPI)	27,863,750,000
Emergency and donated medicines	2,500,000,000
Reproductive Health Items	8,000,000,000
<b>Total</b>	<b>219,374,587,000</b>

### Achievements for the FY 2013/2014

- 100% of the budgeted for funds were released and all was spent.
- Concluded the procurement of mattresses for GH and delivery is expected to be in October, 2014.
- We were able to better harmonize the cycle orders of most of the Regional Referral Hospitals to their procurement plans.
- We opened a new Regional customer care office in Arua and we have concluded with identifying the offices for one in Moroto, to be opened in September, 2014.

### Challenges

For higher level health facility, the biggest challenge is inadequate quantification of their needs and non-adherence to procurement plans during ordering.

For lower health facilities the biggest challenge is the elastic nature of new /upgrading of facilities

- Need to align cycles order to procurement plans
- MOH has advised Districts not to construct new or upgrade facilities without coordinating their actions with MoH, for better service delivery.
- There is need for more funds especially Mbale, Jinja, Soroti,F/Portal, Mbarara RH for the specializations that they have developed.
- NMS also needs 50bn(20bn for a start) for lab supplies

## **Health Research**

In order for the sector to ensure effective and efficient service delivery, evidence based interventions are guided by health research. This is coordinated by Uganda National Health Research Organisation (UNHRO). During the year under review UNHRO organized series of dissemination workshops.

### **Uganda Virus Research Institute (UVRI)**

Baseline studies were carried out to determine epidemiological patterns for malaria transmission on Lake Victoria in Kiimi and Nsadzi Islands.

In addition UVRI carried out confirmatory tests for 1,319 sera samples from suspected measles cases country wide, conducted an AFP (Acute Flaccid Paralysis) surveillance of 4,191 stool samples and the UVRI Polio laboratory was fully accredited in January 2014.

Aborvirus Routine surveillance was carried out in Kisubi (Zika Forest), Nkokonjeru (both in the community and in Nkokonjeru St. Francis Hospital), Sseganga in North Eastern Wakiso District.

A collection of mosquitos and ticks was done in Kitgum to determine insecticide resistance in the main malaria vector population and to monitor immune responses for plague, yellow fever and other out-breaks due to viral haemorrhagic fevers.

Improved diagnostic capacity, distributed DTS (Dried tubes specimens) panels to known 4,000 HIV testing sites in the country and 12,800 samples from the 33 sentinel sites were tested for both HIV and syphilis. Trained 50 staff in Bio- safety and Bio- Security

### **Challenges:**

- Inadequate transport,
- Inadequate funds to carry out field activities and
- Delayed procurements affects activities.

### **Key recommendations:**

- UVRI be given a delegated Contracts Committee and a Vote function given its location in Entebbe which is far away from Ministry of Health Headquarters.

### **Uganda Cancer Institute**

The Uganda Cancer Institute (UCI) is a semi-autonomous institution with key functions of Cancer Prevention/Screening, Effective Treatment, Rehabilitation and Palliative Care, Research and Training

*Table 32: Uganda Cancer Institute performance - FY 2013/14*

<b>Planned Outputs</b>	<b>Performance FY2013/14</b>	<b>Comments on Performance</b>
i. Develop a 5 year strategic plan.	The development of the 5-year strategic plan was completed.	Target achieved
ii. Remodeling existing facilities and completion of the construction and operationalisation of the new Cancer ward.	With support from the Government of Uganda the Institute was able to complete construction of a six cancer ward with the aim of reducing the current congestion levels at the Institute and improves service delivery. Care and social psychosocial support was given to 41,595 inpatients-days.	Inability to fully functionalize the completed Cancer wards building. There is still overcrowding which negatively impacts on service delivery.
iii. Construct the Mayuge satellite center.	The construction of the Mayuge community cancer surveillance clinic Institute successfully completed.	Target achieved
iv. Clinical outreach services to be piloted in Mbarara and Arua RRHs.	In a bid to increase Cancer awareness the Institute conducted 34 community outreach screening campaigns countrywide and 5,147 were screened for breast cancer; 1,678 screened for cervical cancer and 359 for prostate cancer.	Target achieved
v. Construction of the 3 Level USAID – funded Fred Hutchinson building	Construction works still ongoing.	

### **Uganda Heart Institute**

The mandate of the Uganda heart institute is to provide heart care services with vision of becoming a centre of excellence in provision of comprehensive cardiovascular care in the Great Lakes region of Africa.

## Performance against the planned services

**Table 33: Uganda Heart Institute - Clinical services**

Planned Output	Performance FY2013/14	Comments on performance
10,000 Outpatient attendances	13,561	Increased number of patients
1,000 General Admissions	1,372	Increased number of patients
180 Intensive Care Unit Admissions	107	Minimal bed capacity
500 Coronary Care Unit Admissions	495	Increased number of patients
80 Endoscopy	0	Machine break down
260 Stress Test	0	

**Table 34: Uganda Heart Institute - Diagnostic services**

Planned Output	Performance FY2013/14	Comments on performance
12,000 Echocardiography (ECHO)	8,028	Machine failure, (A new machine bought in the mid year) Increased activities
11,000 Electrocardiography (ECG)	6,599	Inadequate number of machines and increased activities
180 Holter Monitoring		Increased number of patients

**Table 35: Uganda Heart Institute - Surgical services**

Planned Output	Performance FY2013/14	Comments on performance
240 Closed Heart and Thoracic Surgeries	174	Less costly & most children required these operations.
100 Open Heart Surgeries	37	Very costly to be done and requires highly skilled personnel
14 Cath-Lab Procedures	172	Though the target was supposed there were challenges of limited sundries
Outreaches to RRH	13	Need for clinics in RRH
10 Outreaches to facilities	9	More public awareness needed
4 Research publications	5	Including PhD Thesis

## Challenges:

UHI has challenges with Human Resource issues like skills gap, poor staff retention, limited training and staff development. There are also constraints in procurement of specialized sundries, reagents, medicines and implants for heart operations and cath lab procedures. There is inadequate budget for operationalisation of the newly installed Cath. Laboratory and the dedicated Cardiac theatre aid.

With this performance, this contributed to increased access to heart related services and consequently a reduction in high OOPs related to seeking services outside the country.

In abid to address the space challenge due to the increasing number of patients, UHI needs a new Home at a cost of US \$ 64.7 Million.

### **Uganda Blood Transfusion Services (UBTS)**

UBTS is mandated to make available safe and adequate quantitites of blood and products to all hospitals in the country. UBTS works closely with Uganda Red Cross Society (URCS) in the area of voluntary blood donor recruitment through a formalized MoU.

*Table 36: UBTS - Achievements against the planned performance:*

<b>Planned Outputs</b>	<b>Performance FY 2013/2014</b>
Increase blood collection by 10% from 220,000 units to 242,000 units	<p>UBTS has become more visible in blood donor mobilization, collection almost doubled from 2003 to 2013 (210,505 units of blood collected this year from 170,000 blood donors) and voluntary blood donation still stands at 100%.</p> <p>1.5 million people were sensitised through blood donor mobilization</p> <p>Population up from 27 million in 2003 to 34 million in 2013.</p> <p>Arua and Masaka received machines for testing blood.</p> <p>No stock out of NMS supplies</p> <p>A number of contract staff have been recruited into Civil service</p> <p>Established seven Regional Blood Banks in Arua, Fort Portal, Gulu, Kitovu, Mbale, Mbarara and Nakasero &amp; this contributed to the increase in blood collection</p> <p>Improved supply of quality blood products through testing all blood for TTIs and operate an effective nationwide Quality Assurance program that ensures safety of the entire Blood transfusion process – from vein to vein</p>
Complete construction of Gulu and Fort Portal Regional blood banks; Furnish and equip them	<p>Gulu RBB was commissioned by the Minister of Health and US Ambassador.</p> <p>Six collection centers in Hoima, Masaka, Kabale, Rukungiri, Jinja and Soroti were established.</p> <p>Expanded blood collection capacity to operate adequately within a decentralized health care delivery system.</p> <p>Gulu RBB was commissioned by the Minister of Health and US Ambassador</p> <p>Designs to construct a centralized store were completed</p> <p>22 mobile blood collection teams – with two new teams started in Lira and Arua</p>

### **2.7.2 Public-Private Partnership for Health**

The MoH has institutionalized the public-private partnership in health in the provision of preventive, promotive and curative health care to all Ugandans.

#### **Planned activities**

- Disseminate the National Policy on PPPH to 76 Districts
- Establish a PPP Coordination Unit at the Central MOH
- Extend PHC financialsupport to PNFPs and PHPs
- Finalize the PPPH implementation guidelines for PNFPs and PHPs
- Conduct a PPPH district coordination status survey
- Support participatory inclusive planning by the public and private sectors in LGs

#### **Main achievements**

1. The PPPH Policy was disseminated to 76 LG DHMTs
2. Have commenced on building institutional arrangements for operationalizing the pph policy by securing financial and technical support to form coordination structures at the central (PPP Coordination Unit) and Local Government levels- BTC, USAID and IFC support
3. PHC funds (U Shs. 17.7 billion) was extended to the private sector (PNFPs and PHPs) for PHC activity implementation
4. The Implementation guidelines for the PPPH Policy (PNFP and PHP guidelines) have been completed and await review by SMC and TMC
5. The PPPH District Coordination status survey was conducted and report produced under USAID support (PHS Project)

*Table 37: PPPH - Summary of Key output Indicators for*

<b>Indicator</b>	<b>Target 2013-14</b>	<b>Actual Performance</b>
PPPH Coordination Unit established at MOH	Establish PPPH Unit at MOH	PPPH Coordination Unit set up
Number of LGs with private sector coordination committees	112 LGs	No data
Number of districts which have developed a joint public-private District Health Plan	112 LGs	No data
Number of districts in which PHP sub-sector contributes to the HMIS	112 LGs	No data
Number of LGs with active DHMTs with private sector representation as per DHMT guidelines	112 LGs	No data

### **2.7.3 Local Government / District Health Performance**

The District League Table (DLT) was launched in 2003 with a primary objective of comparing performance, determining degree of performance, understand reasons behind observed performance, learn from best practices and improve local government ownership of results among others. It highlights the sector performance at district level and areas of improvements. The districts are ranked based on the league table performance by sector indicator categories and giving reasons for the current status.

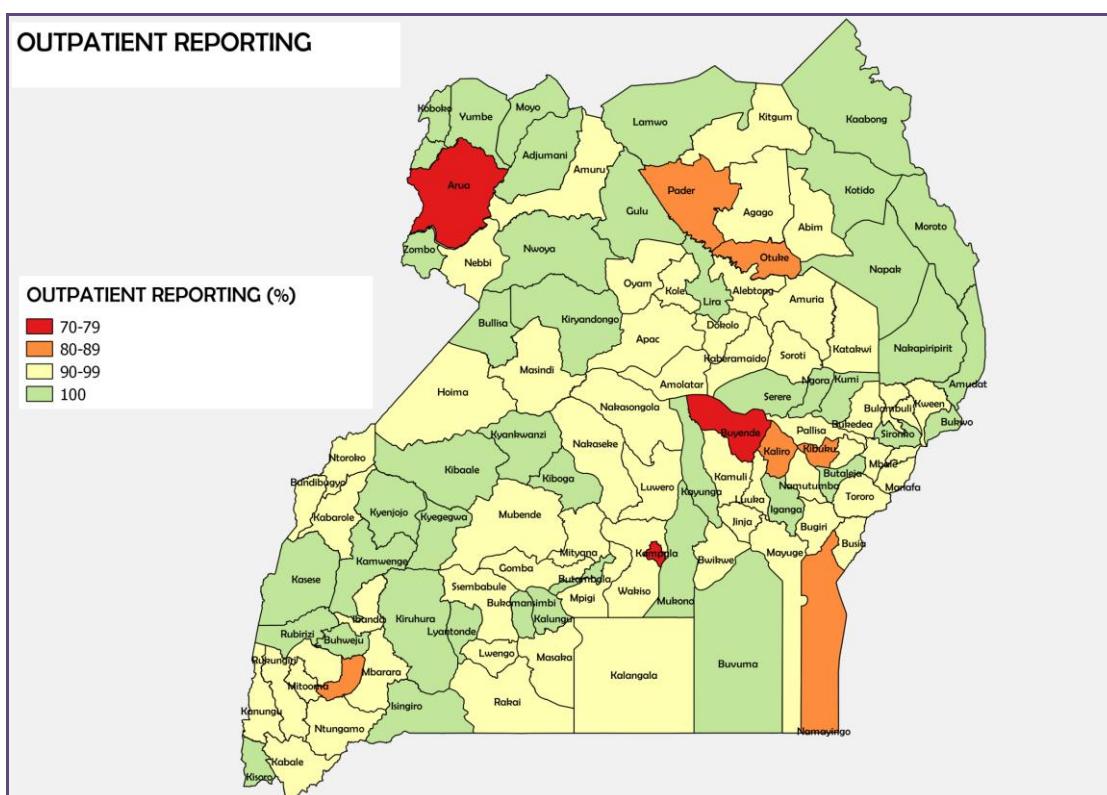
It is composed of input, process and output indicators – e.g. deliveries in health facilities, Out Patient Department attendance, latrine coverage, among others; in line with the Health Sector Strategic Plan and MDGs.

The composite index employed is computed by weighting the agreed upon indicators, ranking districts from best to worst performer.

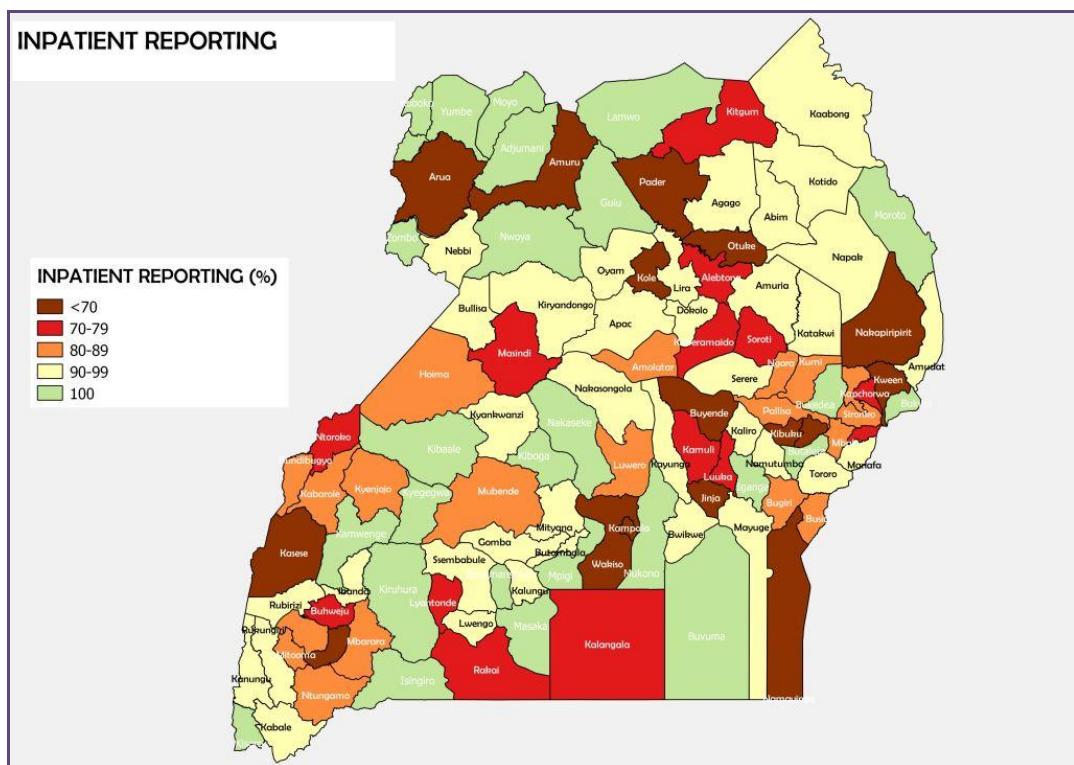
*Table 38: Trends in monthly HMIS reporting completeness and timeliness*

<b>Financial Year</b>	<b>% Monthly reports sent on time</b>	<b>% Completeness monthly reports</b>	<b>% Completeness facility reporting</b>
2010/11	77	94	85
2011/12	78	89	87
2012/13	80	79	94
2013/14	80.9	85.9	95.6

*Figure 4: In-patient Reporting for FY2013-14*



*Figure 5: In-patient Reporting for FY2013-14*

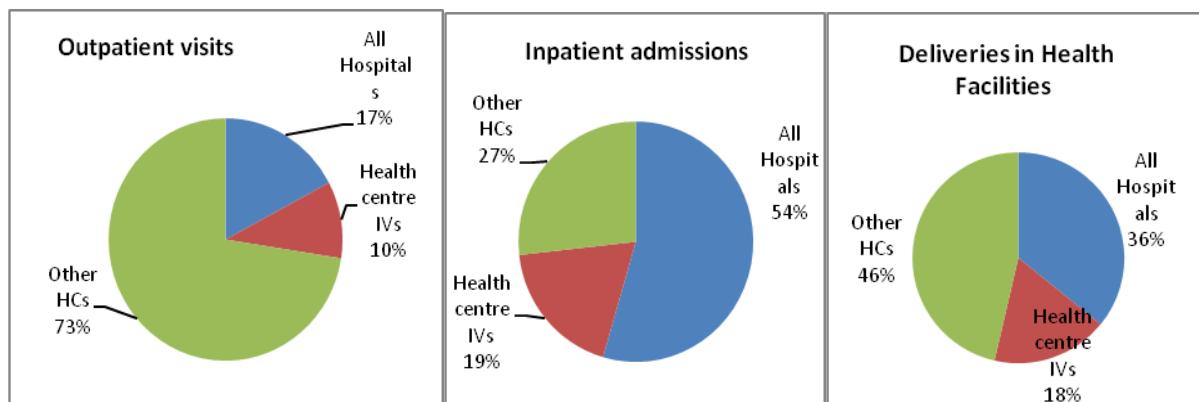


#### 2.7.4 Hospital Performance

According to the MoH Health Facility Inventory July, 2013 the total number of hospitals (public and private) is 155. Of these 2 are National Referral Hospitals (Mulago and Butabika), 14 are RRHs and 139 are GHs. In terms of ownership, 65 are government owned, 63 private not for profit (PNFP) and 27 are Private.

Hospitals remain major contributors to outputs of essential clinical care and take up a large volume of human and financial resources. As it can be seen below for the financial year 2013/14, hospitals produced 54% of all inpatient admissions, 17% of total outpatients, and 36% of all deliveries. At the same time we recognize the high contribution of health centers that are indeed closer to the people. Table 4 Annex Two, shows the comparative contribution of the different levels of health care to national service outputs.

*Figure 6: Comparison of Hospitals and HC Outputs*



Owing to the new DHIS2 reporting from hospitals has improved compared to the previous years' although completeness remains a challenge. Information analyzed is from 90% of general hospitals, 100% of Regional hospitals and 100% of National Hospitals. Private hospitals have the highest failure in reporting and completeness rate among hospitals.

Analysis of hospital information largely looks at outputs of hospitals and relates inputs to outputs and outcomes. In order to have uniform comparison of outputs of hospitals we will continue to use the Standard Unit of Output (SUO).<sup>10</sup> The SUO is a composite measure of outputs that allows for a fair comparison of volumes of output of hospitals that have varying capacities in providing the different types of patient care services. The standard unit of output attempts to attribute the final outputs of a hospital a relative weight based on previous cost analyses taking the outpatient contact as the standard of reference. The SUO converts all outputs to outpatient equivalents. The basis of this parameter rests on the evidence that the cost of managing one inpatient is 15 times the cost managing one outpatient, one immunization 0.2 times more, one delivery 5 times more and one (ANC+MCH+FP) client 0.5 times the cost of managing one outpatient.

Basic efficiency indicators for resource use are generated and tables comparing hospitals generated.

### **Main causes of mortality and morbidity in hospitals**

Malaria remains the leading cause of mortality in hospitals (12.8%) followed by new smear positive Tuberculosis (8.6%), Pneumonia (7.5%), Anaemia (7.4%) and Perinatal Conditions in newborns (3.1%). Over the years, there has been a rise in non-infectious disease conditions as a result injuries road traffic accidents (2.3%) and cardiovascular disease (2.2%) have made it to the top ten causes of mortality in hospitals. The other conditions among the top ten include non-smear positive tuberculosis (2.5%), HIV related deaths (2%) and abortions (2%).

Stratifying the age groups, for the under-5 year olds, Malaria becomes an even greater cause of death (19.9%) followed by Pneumonia (12.4%), Anaemia (12.2%) and Perinatal Conditions (9.7%). For the age group above 5 years, smear positive TB (12.3%) overtakes Malaria (9.4%) as the leading cause of death. Table 24 in the annex shows the details of the top ten causes of mortality in hospitals.

Malaria (30.4%), Pneumonia (5.4%), Respiratory infections (4.7%) and Anaemia (4.6%) lead the top ten causes of morbidity in hospitals. Again non-infectious diseases are increasingly prominent as causes of morbidity notably hypertension (3.7%) and injuries other than road traffic accidents (2.9%) and injuries due to road traffic accidents (1.9%). Acute diarrhea, abortions and GIT disorders make up the remaining conditions for the top ten causes of morbidity in hospitals. Stratifying by age groups, Malaria is responsible for nearly half

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<sup>10</sup> SUO stands for standard unit of output an output measure converting all outputs in to outpatient equivalents. SUO total =  $\Sigma(IP*15 + OP*1 + Del.*5 + Imm.*0.2 + ANC/MCH/FP*0.5)$  based on earlier work of cost comparisons.

(49%) of morbidity under 5 years of age followed by Pneumonia (9.2%). While Malaria retains the top slot (16.1%) in the 5 and above year age group, hypertension and injuries show an increasing prominence at 6.4% and 4.5% respectively. Table 25 in the annex shows the details of the top 10 causes of morbidity in hospitals.

### Hospital Based Mortality for all Ages

A total of 10,210 among under fives and 21,658 among adults hospital deaths were reported during 2013/14 FY. Hospital based mortality data indicates that malaria remains the top most 12.8% cause of all deaths followed by Tuberculosis (new smear positive cases) 8.6%. Among under fives malaria, pneumonia and anaemia are the top three causes of mortality whereas among adults TB and anaemia are among the top four causes. See Table 24

### Mortality: Level and Trends

*Table 39: Top ten causes of hospital based mortality for all ages 2013/2014*

Data	Under 5 Mortality	Under 5 Mortality %	5 and over mortality	5 and over %	Total deaths	Total %
Malaria	2,036	19.9%	2,028	9.4%	4,064	12.8%
TB (new smear positive cases)	97	1.0%	2,659	12.3%	2,756	8.6%
Pneumonia	1,263	12.4%	1,112	5.1%	2,375	7.5%
Anaemia	1,241	12.2%	1,105	5.1%	2,346	7.4%
Perinatal Conditions (in new borns 0 -7 days)	991	9.7%	0	0.0%	991	3.1%
Other Tuberculosis	44	0.4%	766	3.5%	810	2.5%
Injuries - Road Accidents	122	1.2%	623	2.9%	745	2.3%
Cardiovascular Diseases (Other)	72	0.7%	621	2.9%	693	2.2%
HIV Related Psychosis	22	0.2%	611	2.8%	633	2.0%
Abortions	0	0.0%	630	2.9%	630	2.0%
All Others	4,322	42.3%	11,503	53.1%	15,825	49.7%
<b>Total</b>	<b>10,210</b>	<b>100.0%</b>	<b>21,658</b>	<b>100.0%</b>	<b>31,868</b>	<b>100.0%</b>

### Morbidity: Level and Trends

*Table 40: Top ten causes of hospital based morbidity for all ages 2013/2014*

Data	Under 5 cases	Under 5 cases %	5 and over cases	5 and over cases %	Total cases	Total cases %
Malaria	236,026	49.3%	101,729	16.1%	337,755	30.4%
Pneumonia	44,244	9.2%	15,476	2.4%	59,720	5.4%
Respiratory Infections (Other)	35,115	7.3%	17,341	2.7%	52,456	4.7%
Anaemia	33,834	7.1%	17,017	2.7%	50,851	4.6%
Hypertension (Old cases)	12	0.0%	40,584	6.4%	40,596	3.7%
Injuries - (Trauma - Other Causes)	3,932	0.8%	28,403	4.5%	32,335	2.9%
Diarrhoea – Acute	21,465	4.5%	7,412	1.2%	28,877	2.6%
Abortions	0	0.0%	28,233	4.5%	28,233	2.5%
Gastro-Intestinal Disorders (Non Infective)	7,300	1.5%	15,949	2.5%	23,249	2.1%
Injuries - Road Accidents	1,644	0.3%	19,560	3.1%	21,204	1.9%
<b>All Others</b>	<b>95,470</b>	<b>19.9%</b>	<b>340,035</b>	<b>53.8%</b>	<b>435,505</b>	<b>39.2%</b>
<b>Total IPD</b>	<b>479,042</b>	<b>100.0%</b>	<b>631,739</b>	<b>100.0%</b>	<b>1,110,781</b>	<b>100.0%</b>

Source: MoH HMIS data

## National referral hospitals

### Mulago

Mulago Hospital is the main national referral hospital and a teaching hospital for the Makerere College of Health Sciences it also serves as a general hospital for Kampala city; currently it has a bed capacity of 1,790.

#### Inputs:

In 2013/14 Mulago had 1,999 staff of these 8 were expatriates and 159 are locally hired private patients services staff. The approved establishment for Mulago is 2,166 but only 84.6% of these positions are filled leaving a gap of 334 staff. For effective service delivery, an establishment of 2,426 staff is required at Mulago. The largest staff vacancies are for allied health staff, nursing staff (56) and medical officers special grade (31).

Mulago hospital had an annual budget of 37.985 billion in 2013/14, except for wage all the other budget lines (non-wage and development) were released and spent fully. The total release was 37.10 billion, 97.6% of the budget and the total expenditure was 35.4 billion 97% of the release. The table 28 below shows the financial report of Mulago hospital.

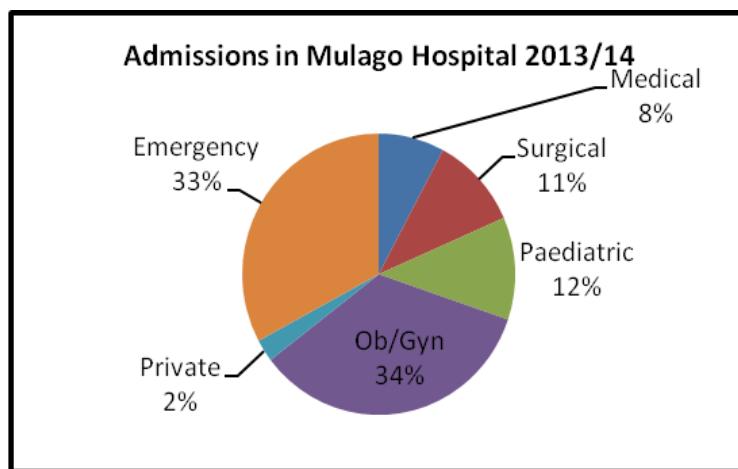
*Table 41: Financial report of Mulago hospital*

Item	Approved budget in billions	Release	Amount spent	% Releases spent
Wage	19.744	18.860	17.162	91%
Non wage	13.221	13.221	13.221	100%
Capital development	5.020	5.020	5.020	100%
<b>Total</b>	<b>37.985</b>	<b>37.10</b>	<b>35.40</b>	<b>95%</b>

#### Outputs

The patient load in Mulago hospital continues to be too heavy and affecting quality of services. During the year, there were 603,876 outpatient visits, 105,593 inpatient visits. These outputs were less than for the year before representing 95% and 82% respectively of the outputs for 2012/2013. Most of the admissions in Mulago are obstetric/Gynecological and Emergency admission as shown in the pie chart below. It is likely that the newly created hospitals are beginning to take up some of the patient load. The hospital also made 34,411 total deliveries (22% cesarean section), 32,493 antenatal visits and 199,102 immunizations.

Figure 7: Mulago Admission FY 2013/14



The bed occupancy rate in Mulago ranges from 103% to 135% for all the major wards (medical, surgical, paediatric, obstetrics/gynecology and emergency) except the private wards where it is only 39%. Probably private outpatient services are not yet appealing enough to the service users.

### Plans for improvement

Mulago plans to improve its services befitting of a national regional referral. Plans and actions are under way within the 2014/15 financial year to start kidney transplant and further on start also liver and bone marrow transplants. In an effort to kick start this; a team of delegates led by the Executive Director visited Yashoda Hospital in April 2014 to have a one stop centre in India where referrals, consultation and trainings could be done. Delegation of consultants from Yashoda hospital visited Mulago in early June to make an assessment of Mulago's readiness to conduct a kidney transplant and a memorandum of understanding has been signed. 10 Arteriovenous shunts for dialysis patients have so far been done by the visiting Yashoda consultants together with Mulago team (urologist consultants). A team of health workers will be trained by Yashoda Hyderabad Hospital in India.

### Challenges

Mulago continues to face the following challenges to service delivery;

- Overwhelming number of patients & their attendants
- Old & out dated infrastructure
- Under staffing due constricted structure.
- Low pay for staff
- Poor motivation of staffs including lack of vehicles for senior consultants
- Very low capital development funds.

## Butabika Hospital

Butabika hospital is meant to offer super specialized and general mental health services, conduct mental health training, carry out mental health related research and provide support to mental health care services in the country for economic development.

### Inputs

During the financial year, the hospital had 350 staff representing 83.7% of approved positions. Most (27), of the vacancies not filled are for nursing officers however only 5 of the approved psychiatrists are in post and 3 of the approved 9 medical officers are in post. The current approved structure is inadequate given the huge patient load and training responsibility.

The hospital used the following financial resources to deliver the services in 2013/14 year. Overall the hospital received 95% of the approved budget and spent 96% of what was released. Under performance was in the wage budget.

*Table 42: Budget performance for Butabika Hospital 2013/14*

Item	Approved Budget	Releases	Expenditure	Variance	% Release Spent
Wage	3,699,000,000	3,186,323,944	2,798,196,810	388,127,134	88%
Non Wage	3,601,000,000	3,701,031,800	3,700,855,693	176,107	100%
Development	1,808,000,000	1,808,140,246	1,805,681,102	2,459,144	100%
<b>Total</b>	<b>9,108,000,000</b>	<b>8,695,495,990</b>	<b>8,304,733,605</b>	<b>390,762,385</b>	<b>96%</b>

### Outputs

In 2013/14 financial year the hospital treated 6,712 inpatients, in addition 55,754 patients were treated in the specialized mental and medical clinics in line with Primary Health Care (PHC) requirements; including HIV, TB, Dental, Eye, Orthopedic, Family planning and General Outpatient.

Butabika also carried out mental health outreach clinics in the six (6) outreach clinics of Nansana, Kitetika, Katalemwa, Nkokonjeru, Kawempe-Maganjo, and Kitebi, treating a total of 3,267 patients. In Luzira prison 43 Forensic clinics were conducted; 948 patients were resettled around Kampala and other districts. Rehabilitation and re-integration of 4,149 patients was done getting them to attain normal function and get reintegrated into the community, these patients are now engaged in gainful employment.

**Mental health training was done, benefiting 1,612** students received from various institutions of higher learning for mental health placement including, undergraduates, postgraduates of different specialties, student nurses as well as Clinical Officers.

**Mental Health Advocacy** activities were done in a number of districts and centrally through the mass media both print and electronic, Mental Health Film shows took place at the National Theatre and a Carers' Forum and Peer Support workers is place. The hospital also conducted research on adverse effects of alcohol interpersonal trauma and post traumatic stress disorder. Technical Support Supervision to Regional Referral Mental health units was carried out to regional referral mental units of Arua, Fortportal, Gulu, Jinja, Hoima, Kabale, Lira, Masaka, Mbale, Mubende, Moroto and Soroti. In total, 20 visits were carried out.

### **Plans for improvement**

The hospital intends to improve on infrastructure and its maintenance, with completion of 12 staff units and expansion of Outpatient department. It also intends to expand the private wing and rehabilitation unit and rehabilitate junior staff quarters. To improve staff welfare there is a plan to procure a staff bus. In addition there is intention to set up a records centre and acquire a CT scan, assorted furniture and other equipment and machinery.

### **Challenges**

The Hospital has inadequate numbers of mental health specialist staff such as Psychiatrist, psychiatric nurses, psychiatric clinical officers, psychiatric social workers and clinical psychologists. There is limited community and social support for the discharged patients. This has continued to result into frequent relapses and re-admissions. The weak referral system has made Butabika a walk in hospital rather than a National referral. Bed occupancy has remained at over 130% for the last several years. Patient attendance has also remained high in spite of opening up new Mental Health Units in all the Regional Referral Hospitals. Owing to the nature of illness of patients there is a high rate of destruction of infrastructure and consumables leading to high maintenance costs. There is an inadequate budget to support all the mandated activities of the hospital. At times Patients leave the hospital unauthorized because the fencing around the hospital is porous and needs reinforcement yet the budget is inadequate.

### **Regional Referral Hospitals**

The mandate of regional referral hospitals is: To provide specialized and general health care, train workers and conduct research in line with the requirements of the Ministry of Health. For the year 2013/14, reports have been received from all the 14 RRHs (public) and the 4 large PNFP hospitals (Nsambya, Rubaga, Mengo and Lacor) through the DHIS-2 and other hospital reports. The 4 PNFP hospitals have been included because their volume of activity, service type and skill mix of staff is similar to that of regional referral hospitals. It therefore makes sense to analyze them in the regional referral hospitals group and they would be outliers under general hospitals. The performance of the 18 hospitals has been analyzed in this section.

The assessment for the RRHs will focus on the inputs (finances and human resource) and the key outputs.

## Inputs

### Finance

The total approved budget for RRHs was U Shs. 70.385 billion Shs. and actual release was U Shs. 67.665 billion Shs. Overall, the percentage of the funds released against the approved budget was 100% in non-wage and development budgets but only 93% for the wage budget. The total budget performance was 96%. Financial performance for the 4 large PNFP hospitals has not been included in the analysis due to lack of the comprehensive financial reports from these hospitals.

*Table 43: Financial Performance for 14 RRHs for FY 2013/14 (UGX Billions)*

Institution	Wage (000,000s)		Non Wage (000,000s)		Development (000,000s)		Total (000,000s)		Performance	
	Approved Budget	Releases	Approved Budget	Releases	Approved Budget	Releases	Approved Budget	Releases	2013/14	2012/13
Arua	2,910	2,655	1,206	1,219	796	796	4,912	4,670	95%	91%
Fortportal	3,432	3,432	1,066	1,066	736	736	5,234	5,234	100%	90%
Gulu	2,837	2,621	930	930	1,151	1,151	4,918	4,703	96%	93%
Hoima	2,458	2,258	807	807	1,400	1,400	4,665	4,465	96%	81%
Jinja	3,570	3,433	906	906	1,200	1,251	5,676	5,590	98%	94%
Kabale	2,385	2,279	862	862	1,050	1,050	4,297	4,190	98%	84%
Lira	2,569	2,287	901	974	500	500	3,970	3,761	95%	106%
Masaka	2,574	2,574	898	898	706	706	4,178	4,178	100%	91%
Mbale	3,826	3,822	1,498	1,489	538	538	5,862	5,849	100%	160%
Mbarara	3,279	2,582	1,078	1,070	750	750	5,107	4,401	86%	89%
Moroto	1,403	1,386	638	638	1,388	1,388	3,429	3,412	100%	85%
Mubende	1,807	1,807	718	718	1,192	1,152	3,717	3,677	99%	97%
Soroti	2,671	2,671	899	899	1,600	1,600	5,170	5,170	100%	86%
Naguru	3,420	2,538	2,278	2,276	3,551	3,551	9,249	8,365	90%	102%
<b>Total</b>	<b>39,141</b>	<b>36,346</b>	<b>14,685</b>	<b>14,750</b>	<b>16,558</b>	<b>16,569</b>	<b>70,385</b>	<b>67,665</b>	<b>96%</b>	<b>96%</b>

Source: MOH Financial Report, FY 2013/14

### Human Resources

Staffing information was got from 10 regional referral hospitals; the overall fraction of filled positions is 76% all cadres combined. There is a wide range however from 59% in Kabale to 86% in Arua. Analyzing respective groups of staff, doctors positions are only 40% filled leaving a gap of 236 vacancies. Nurses and Midwives have 87% of their positions filled leaving a gap of 182 to be filled. Allied health professionals have 77% of their positions filled, 193 vacancies have to be filled to close the gap. There is a gap of 157 finance and administration staff given the 53% of the positions currently filled. Support staff have 83% of their positions filled leaving a gap of 127 to be filled. With the very high bed occupancy rates shown below, the quality of care is likely to be compromised especially by lack of enough doctors to manage patients in these hospitals.

**Table 44: Staffing at the 10 RRHs**

Hospitals	Establishment	In post	Vacant	% Filled
Arua	352	301	51	86%
Fortportal	426	315	111	74%
Jinja	418	357	50	85%
Kabale	385	227	158	59%
Lira	348	262	92	75%
Masaka	325	252	73	78%
Mbale	438	361	77	82%
Mbarara	326	229	99	70%
Mubende	347	224	123	65%
Soroti	328	267	61	81%
<b>Total</b>	<b>3693</b>	<b>2795</b>	<b>895</b>	<b>76%</b>

Source: MOH Regional Referral Hospitals Reports 2014

## Outputs

In the year 2013/14., the 14 RRHs and 4 large PNFPs hospitals attended to a total of; 2,856,343 outpatients (2012/13 = 2,537,666); 99,648 deliveries (2012/13 = 89,626) and 346,704 admissions (2012/13 = 339,670) among other outputs. On average each hospital attended to; 158,686 outpatients (2012/13 = 140,981), conducted 5,536 deliveries (2012/13 = 4,979) and 19,261 admissions (2012/13 = 19,981).

The hospitals have registered an increase in SUO in 2013/14 compared to 2012/13 from 8,189,908 to 8,727,279. Mbale hospital continues to lead in volume of outputs pushed by the very high number of admissions 48,754. Masaka retains the second slot despite a 19% reduction in SUO. Naguru Hospital (China-Uganda Friendship Hospital), Gulu and Lira Hospital registered the highest increases compared to the previous year 179%, 48.4% and 29.3% respectively.

**Table 45: Key Hospital Outputs and Ranking of RRHs and Large PNFP Hospitals**

RRH	IPD Admissions	Total OPD	Deliveries in unit	ANC	Postnatal attendance	Family Planning	Immunization	SUO 2013/14	SUO 2012/2013
Mbale	48,754	95,103	9,864	6,973	7,721	1,582	9,844	885,840	858,116
Masaka	26,108	195,273	8,961	13,087	2,367	1,183	8,533	641,723	792,551
Lira	19,020	301,855	5,715	15,836	449	1,883	12,170	627,248	485,103
Fort Portal	24,786	218,909	5,732	10,077	362	1,056	7,390	626,585	543,577
Mbarara	25,277	160,421	10,019	11,304	2,701	911	9,698	599,069	648,460
Jinja	23,466	157,610	6,497	13,340	226	1,889	9,112	551,635	575,066
Gulu	18,698	184,147	4,631	11,821	575	972	8,225	496,101	334,344
Soroti	22,055	132,854	4,466	7,667	971	1,498	6,955	492,468	468,051
Hoima	18,622	172,388	5,606	11,865	287	1,029	8,619	488,062	431,842
Arua	16,459	173,467	2,747	15,357	946	625	14,555	445,462	514,926
Rubaga	15,102	167,042	5,866	23,932	2,109	0	17,991	439,521	413,959
St. Mary's Hospital Lacor	18,816	113,290	3,904	9,310	1,346	0	8,649	422,108	533,562
Kabale	12,704	203,597	4,128	7,831	293	1,131	5,344	420,493	336,466

RRH	IPD Admissions	Total OPD	Deliveries in unit	ANC	Postnatal attendance	Family Planning	Immunization	SUO 2013/14	SUO 2012/2013
Naguru Hospital	12,849	126,951	6,175	26,796	142	1,589	8,672	366,559	131,297
St. Francis Nsamba	8,986	175,467	6,323	14,087	2,156	0	22,655	354,525	432,167
Mubende	14,884	90,155	3,944	10,353	1,146	1,159	7,563	340,977	332,338
Mengo	9,709	144,491	4,362	12,571	2,116	315	16,888	322,815	132,132
Moroto	10,409	43,323	708	2,869	2,037	328	2,377	206,090	225,951
<b>Total</b>	<b>346,704</b>	<b>2,856,343</b>	<b>99,648</b>	<b>225,076</b>	<b>27,950</b>	<b>17,150</b>	<b>185,240</b>	<b>8,727,279</b>	<b>8,189,908</b>

Source: MOH HMIS

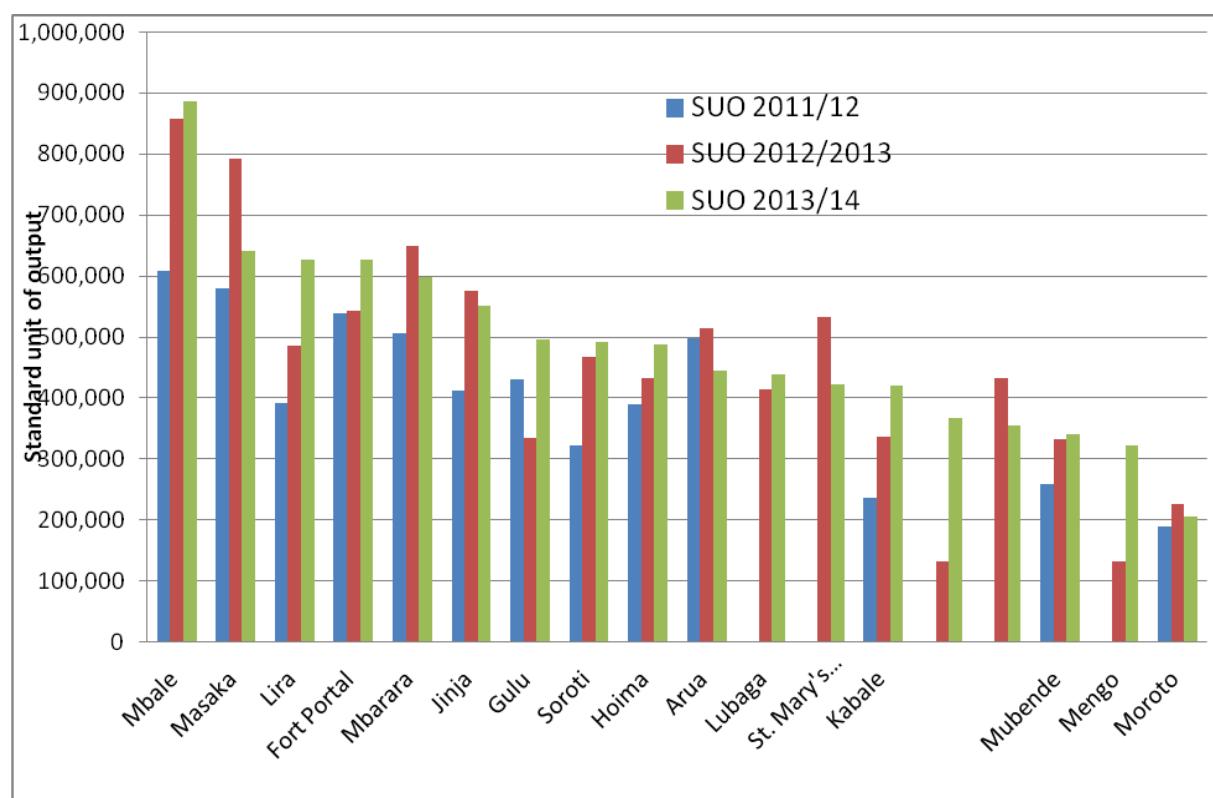
**Table 46: Summary of Key Outputs for RRHs and Large PNFPs**

	Admissions	Total OPD	Deliveries in unit	ANC Total	Postnatal attendance	Family Planning	Immunization	SUO 2013/14	SUO 2012/13
Total	346,704	2,856,343	99,648	225,076	27,950	17,150	185,240	8,727,279	8,189,908
Average	19,261	158,686	5,536	12,504	1,553	953	10,291	484,849	454,995
Minimum	8,986	43,323	708	2,869	142	0	2,377	206,090	131,297
Maximum	48,754	301,855	10,019	26,796	7,721	1,889	22,655	885,840	858,116

Source: MOH HMIS

The figure 5 below shows the variation of SUO in the last three years. Compared to 2012/13 increases were noted in 11 hospitals and decreases in 7. For the majority of hospitals, the three year trend is going up.

**Figure 8: Volume of Outputs for RRHs and Large PNFPs 2011/12 – 2012/13 – 2013/14 FYs**



Source: MoH HMIS

## Efficiency

The outputs described above do reflect only the volume of activity and does not relate this volume to resource inputs used in production of those outputs. The key resource inputs are staff, beds, and funds. Efficiency has been analyzed by comparing output to these inputs. Owing to incompleteness of staff information we have excluded outputs to staff ratio from the analysis of efficiency. The ratios calculated here are not adjusted for quality differences and should be interpreted with caution.

The first efficiency indicator is utilization of beds, a more efficient hospital should have a high Bed Occupancy Rate (BoR) and vice versa, similarly the average length of stay should be shorter for better efficiency. However WHO defines optimum bed efficiency as 85% BoR. Table 47 below shows variation across hospitals. The average BoR is 77% minimum 37% and maximum 137%. Hospitals with BoR between 80 and 90% are considered optimally operating while those below that or above that need to make corrective actions to attain optimum state. One action is to address the average length of stay – for example in Moroto.

The second efficiency indicator analyzed is utilization of recurrent funds (wage and non-wage, excluding development). The recurrent cost per Standard Unit of Output and the recurrent cost per bed are shown in the table 44 below and figure 6 below. The average recurrent cost per SUO is UGX 5,855 otherwise explained as – 1 outpatient equivalent takes UGX 5,855 to produce. The minimum recurrent cost per SUO was shown by Lira hospital (UGX 5,199) and the maximum UGX 13,133 shown by Naguru hospital. Recurrent cost per bed follows a similar pattern to that of recurrent cost/SUO; the average cost per bed is UGX 9,515,270, the minimum UGX 8,255,696 (Lira hospital) and the maximum is UGX 48,140,000 (Naguru hospital).

Ultimately, efficiency has to be measured in financial terms; as such the recurrent cost per SUO can be considered the reference efficiency. Hospitals that have demonstrated high efficiencies are those that have managed to increase the utilization of their services.

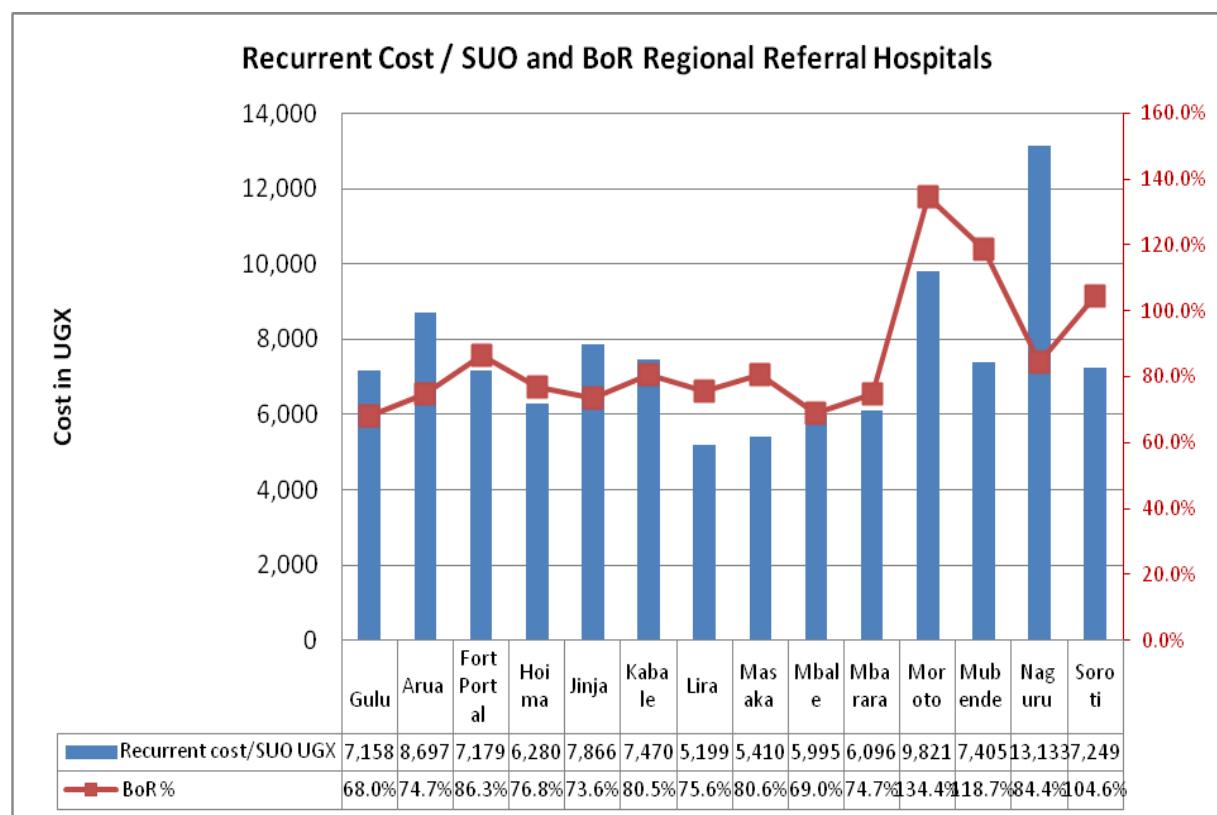
**Table 47: Selected Efficiency Parameters for RRHs and Large PNFP Hospitals FY 2013/14**

Hospitals	Beds Available	IPD Patient Days	SUO	BoR	ALOS	Recurrent cost	Recurrent cost/SUO	Recurrent cost per bed
Mbale	447	112,640	885,840	69%	2.3	5,311,000,000	5,995	11,881,432
Masaka	330	97,133	641,723	81%	3.7	3,472,000,000	5,410	10,521,212
Lira	395	109,048	627,248	76%	5.7	3,261,000,000	5,199	8,255,696
Fort Portal	368	115,968	626,585	86%	4.7	4,498,000,000	7,179	12,222,826
Mbarara	411	112,129	599,069	75%	4.4	3,652,000,000	6,096	8,885,645
Jinja	412	110,658	551,635	74%	4.7	4,339,000,000	7,866	10,531,553
Gulu	374	92,862	496,101	68%	5.0	3,551,000,000	7,158	9,494,652
Soroti	254	96,972	492,468	105%	4.4	3,570,000,000	7,249	14,055,118
Hoima	274	76,781	488,062	77%	4.1	3,065,000,000	6,280	11,186,131
Arua	316	86,138	445,462	75%	5.2	3,874,000,000	8,697	12,259,494

Hospitals	Beds Available	IPD Patient Days	SUO	BoR	ALOS	Recurrent cost	Recurrent cost/SUO	Recurrent cost per bed
Lubaga	275	66,804	439,521	67%	4.4	0	0	0
St. Mary's Hospital Lacor	482	124,035	422,108	71%	6.6	0	0	0
Kabale	240	70,507	420,493	80%	5.5	3,141,000,000	7,470	13,087,500
Naguru	100	30,810	366,559	84%	2.4	4,814,000,000	13,133	48,140,000
St. Francis Nsambya	188	29,816	354,525	43%	3.3	0	0	0
Mubende	175	75,849	340,977	119%	5.1	2,525,000,000	7,405	14,428,571
Mengo	169	24,015	322,815	39%	2.5	0	0	0
Moroto	160	78,509	206,090	134%	7.5	2,024,000,000	9,821	12,650,000
All hosp	<b>5,370</b>	<b>1,510,674</b>	<b>8,727,279</b>	<b>77%</b>	<b>4.4</b>	<b>51,097,000,000</b>	<b>5,855</b>	<b>9,515,270</b>
Average	<b>298</b>	<b>83,926</b>	<b>484,849</b>			<b>2,838,722,222</b>		
Min	<b>100</b>	<b>24,015</b>	<b>206,090</b>	<b>39%</b>	<b>2.3</b>	<b>0</b>	<b>0</b>	<b>0</b>
max	<b>482</b>	<b>124,035</b>	<b>885,840</b>	<b>134%</b>	<b>7.5</b>	<b>5,311,000,000</b>	<b>13,133</b>	<b>48,140,000</b>

Source: MoH HMIS

Figure 9: Recurrent / SUO and Bed Occupancy Rate (BoR) in Regional Referral Hospitals



## Outcomes

Hospital based deaths especially maternal deaths and fresh still births are indicators of quality of care. The total maternal deaths reported in 14 RRHs and 4 PNFP hospitals were 337 giving a mean death of 8.7 mothers per hospital per year with a minimum of 4 in Naguru RRH and maximum of 36 in Mbarara RRH. The risk of dying during delivery was highest in Mubende RRH, followed by Arua and Hoima hospitals (a mother died for every 116, 162 and 165 deliveries respectively). The risk was lowest in Naguru, Mengo and Kabale hospitals (a mother died for every 1,544, 727 and 688 deliveries respectively). A follow up of these deaths to establish causes and related factors is necessary.

The risk of a fresh still birth was highest in Arua, followed by Mubende and Hoima Hospitals (a fresh still birth was delivered for every 19, 24 and 26 deliveries) respectively. The risk of a fresh still birth was lowest in Rubaga, followed by Naguru and Mengo (one fresh still birth was delivered for every 168, 151 and 106 deliveries) in the above mentioned hospitals respectively.

**Table 48: Selected Quality of Care Parameters for RRHs and Large PNFP Hospitals 2013/14**

Hospitals	IPD Admissions	Deliveries in unit	IPD Deaths	Maternal Deaths	Fresh Still births	A Maternal death compared to number of deliveries	Risk of fresh stillbirth compared to number of deliveries
Mbale	48754	9864	1061	21	318	1:470	1:31
Masaka	26108	8961	1061	33	127	1:272	1:71
Lira	19020	5715	797	17	119	1:336	1:48
Fort Portal	24786	5732	934	30	140	1:191	1:41
Mbarara	25277	10019	1245	36	182	1:278	1:55
Jinja	23466	6497	1604	32	169	1:203	1:38
Gulu	18698	4631	371	17	56	1:272	1:83
Soroti	22055	4466	563	18	92	1:248	1:49
Hoima	18622	5606	788	34	214	1:165	1:26
Arua	16459	2747	902	17	143	1:162	1:19
Lubaga	15102	5866	391	9	35	1:652	1:168
St. Mary's Hospital Lacor	18816	3904	849	9	62	1:434	1:63
Kabale	12704	4128	340	6	100	1:688	1:41
Naguru	12849	6175	71	4	41	1:1,544	1:151
St. Francis Nsambya	8986	6323	1266	10	82	1:632	1:77
Mubende	14884	3944	356	34	165	1:116	1:24
Mengo	9709	4362	149	6	41	1:727	1:106
Moroto	10409	708	112	4	11	1:177	1:64
<b>All hosp</b>	<b>346704</b>	<b>99648</b>	<b>12860</b>	<b>337</b>	<b>2097</b>	<b>1:296</b>	<b>1:48</b>
<b>Average</b>	<b>19261.33</b>	<b>5536</b>	<b>714.4444</b>	<b>18.7222</b>	<b>116.5</b>	<b>-</b>	<b>-</b>
<b>Min</b>	<b>8986</b>	<b>708</b>	<b>71</b>	<b>4</b>	<b>11</b>	<b>1:116</b>	<b>1:19</b>
<b>max</b>	<b>48754</b>	<b>10019</b>	<b>1604</b>	<b>36</b>	<b>318</b>	<b>1:1,544</b>	<b>1:168</b>

Source: MoH HMIS

## General Hospital Performance

This section presents findings for the assessment of general hospital performance. There are 139 GHs in the country providing; preventive, promotive outpatient curative, maternity, inpatient, emergency surgery and blood transfusion and laboratory services.

The assessment is largely based on the data aggregated through the DHIS-2. Of the 139 General hospitals, 127 had information in system, 4 PNFP large volume hospitals have been excluded as they have been analyzed with regional referral hospitals. Thus we have 123 hospitals in this analysis. (See Annex Two. Table 6)

### Inputs

#### Human Resource

Staffing information in GHs was not analyzed due scarcity of information in the DHIS2.

#### Finance

Staffing information in GHs was not analyzed dues to scarcity of information on DHIS2

#### Outputs

Hospital performance is assessed using 5 main outputs which include; admissions, outpatient visits, deliveries, ANC/FP/PNC (Antenatal care, Family planning, Postnatal care) and immunization. The hospital indicators have been summed up in composite units – the SUO.

A total of 3,849,271 outpatient visits were made; the hospitals also conducted 159,460 deliveries and 688,024 admissions among other outputs. On average each hospital attended to; 32,077 outpatients, conducted 1,387 deliveries and 6,035 admissions. See Table 49.

The total SUO for GHs has increased from 15,129,354 in 2012/13 to 15,514,147 this is generally attributed to increased number of hospitals reporting in the DHIS2 from 110 to 123. The average outputs were lower compared to the 2012/2013 for admissions, outpatients, family planning, and deliveries this is attributed to a higher number of smaller hospitals in the set. The averages were higher for antenatal, postnatal and immunization.

The minimum SUO for GHs was 151 and maximum 530,729. The SUO / Staff was not analyzed due to lack of staffing levels per hospital. The range is so big and calls in to question the classification of some health units as hospitals.

**Table 49: Summary of Outputs from the General Hospitals FY 2013/14 (N=123)**

Output	Total 2013/14	Number reporting	% Reportin g	Minimum	Maximu m	Average 2013/14	Total 2012/13	Number reporting 2012/13	Average 2012/13	Average 2011/12
Admissions	688,024	114	93%	102	20,860	6,035	690,621	109	6,412	8,644
Total Outpatients	3,849,271	120	98%	43	171,001	32,077	3,754,144	110	35,080	51,646

<b>Output</b>	<b>Total 2013/14</b>	<b>Number reporting</b>	<b>% Reportin g ratio</b>	<b>Minimum</b>	<b>Maximu m</b>	<b>Average 2013/14</b>	<b>Total 2012/13</b>	<b>Number reporting</b>	<b>Average 2012/13</b>	<b>Average 2011/12</b>
Deliveries	159,460	115	93%	1	6,171	1,387	150,276	110	1,392	2,040
Total ANC Visits	432,427	118	96%	4	16,247	3,665	234,625	110	2,169	5,409
Postnatal Visits	55,124	113	92%	4	4,662	488	41,418	105	410	NA
FP Visits	41,804	93	76%	1	2,716	450	47,771	82	689	NA
Immunization	1,286,885	123	96%	0	44,171	10,462	513,042	109	4,893	14,380
SUO	15,514,147	123	100%	151	530,729	126,131	15,129,354		139,781	206,012

*Source: MOH HMIS*

The 5 top performing (high volume) hospitals were Iganga, Bwera, Tororo, Mityana and Kawolo. Compared to the year 2012/13, Tororo and Kawolo are new entrants to the list while Busolwe and Pallisa dropped off the list. Among the PNFP the highest volume hospital is Angal St. Luke.

The 5 lowest performing (low volume) hospitals were Hunter, Kitintale, Ntinda, Middle East Bugolobi and Bethany Women and Family. There is need to re-visit the level classification of some of the very low volume hospitals. These hospitals tend to have very low bed capacities well below the minimum number (60) defined in the definition of hospitals by the hospital policy. Annex Two. Table 7 shows the full list and outputs of General Hospitals.

**Table 50: The Top 15 high volume Hospitals**

<b>Hospital</b>	<b>IPD Admissions</b>	<b>Attendan ce OPD total</b>	<b>Deliveri es in unit</b>	<b>ANC Total</b>	<b>Postnatal attendanc e</b>	<b>Family Planning</b>	<b>Immuniz ations</b>	<b>SUO</b>	<b>Rank</b>
Iganga	20,860	171,001	6,171	13,396	1,213	1,106	40,577	530,729	1
Bwera	13,783	72,110	4,361	11,085	286	2,340	28,297	313,175	2
Tororo General	14,810	59,527	4,114	9,102	2,073	584	15,946	311,316	3
Mityana	13,759	57,201	5,497	11,824	1,494	1,117	20,747	302,438	4
Kawolo	11,829	88,042	3,728	10,284	555	1,757	21,197	294,654	5
Angal St. Luke	15,943	33,653	2,244	5,165	306	3	17,111	290,177	6
Busolwe	12,209	79,973	1,598	4,184	867	165	9,528	275,612	7
Adjumani	11,731	83,953	1,695	4,099	836	302	9,656	272,943	8
Kamuli	11,490	75,836	2,063	5,521	1,937	1,276	16,477	266,163	9
Nebbi	12,824	51,965	2,105	7,249	571	323	20,263	262,974	10
Pallisa	12,355	48,918	3,465	7,796	1,414	728	20,873	260,712	11
Kalongo Ambrosoli Memorial	13,805	28,772	3,003	6,722	2,672	0	12,627	258,084	12
Kagadi	13,544	21,966	3,304	8,608	146	108	13,270	248,731	13
Yumbe	11,361	56,328	2,242	4,301	846	1,214	20,658	245,265	14
Kayunga	10,317	69,956	2,565	5,057	335	1,006	19,626	244,660	15

*Source: MOH HMIS*

### Efficiency of use of services

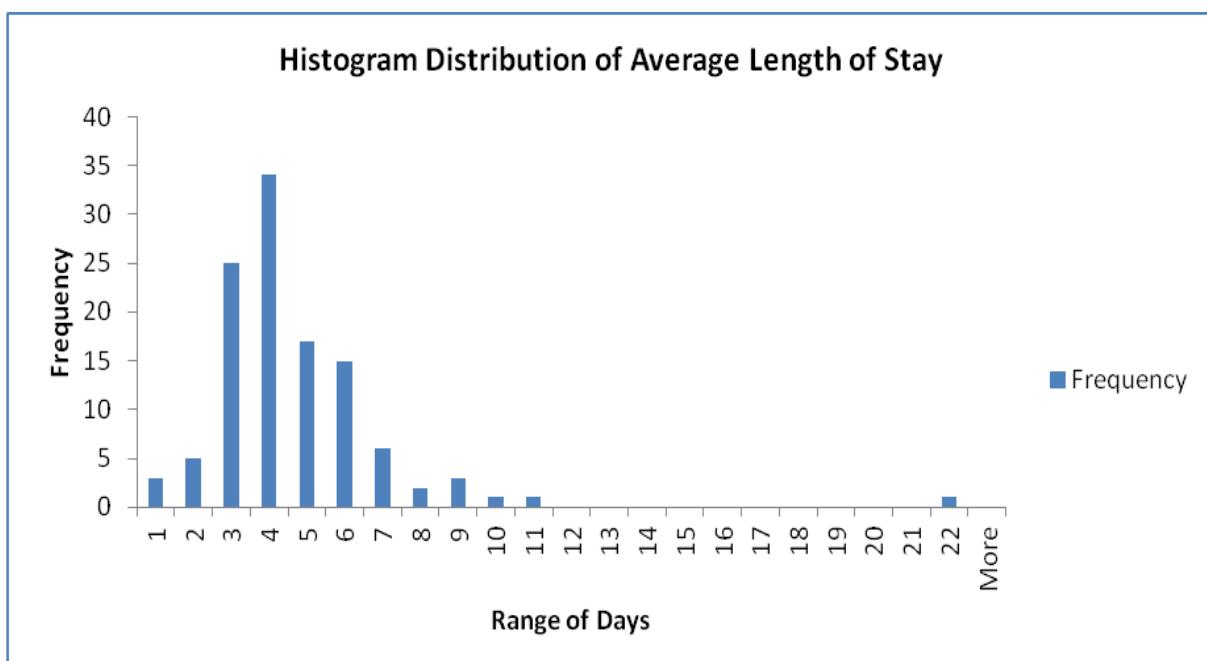
With the information available, we can only assess efficiency in utilization of beds. That is Bed occupancy rate and average length of stay. There was no financial or staff information available to do other efficiency analysis.

The range of bed capacity was 15 beds (Divine Mercy, and Senta Medicare) to 302 beds for Kalongo Ambrosoli hospital. There has been inconsistency in bed size declared at different times of the year and a number of hospitals reported no bed capacity.

The average bed occupancy rate was 54.1%. A majority (90) of hospitals were operating below the efficient range of 80-90% bed occupancy; these hospitals can produce more without a large input of additional resources. They are not maximizing their fixed factors of production. Only 7 (Kayunga , Kiboga , Nakaseke , Bududa , Kamuli , Katakwi General, Tororo General )hospitals are operating within the efficiency range, however 17 (Mityana, Saidina Abubakar Islamic, Bugiri, Bukwo General, Iganga, Kanginima, Pallisa, Adjumani, Apac, Nebbi, Angal St. Luke, Yumbe, Bundibugyo, Bwera, Kiryandongo, Kisoro)hospitals are operating beyond the efficiency range – BoR greater than 90%. The BoR is 1.3% found in Divine Mercy hospital and the maximum is 163.9% found in Mityana hospital.

Average length of stay (ALOS) similarly has a very wide variance, the average is 4.1 days, in three hospitals (Divine Mercy, Ngora and Galilee Community) the ALOS is less than 1 day this may indeed be an error. The maximum ALOS is 21.5 days is indeed an outlier as shown in the histogram below. Gulu Military hospital and Mildmay also have very long ALOS indicating a presence of conditions that require long treatment – e.g. fractures and Chronic HIV complications.

*Figure 10: Histogram for distribution of Average Legnth og Stay*



Compared to the previous year 2012/2013, there was no change significant change in the average BoR 54% versus 54.1% in 2013/14. Similarly the ALOS stayed virtually the same as well 4% versus 4.1% in 2013/14.

For the current resources used in general hospitals, we are not getting the best return in terms of productivity. May be we even have more hospitals than we need.

## **Outcomes**

Maternal deaths were reported in 78 hospitals, a total of 449 deaths were recorded giving an average of 5.8 deaths per hospital. However taking the denominator as hospitals conducting deliveries -115 the average death per hospital is 3.9. The minimum is 0 and the maximum is 23 observed in Iganga – a high volume hospital and Matany hospital in Napak district as a result of Hepatitis E outbreak that has a high case fatality rate in pregnant women.

Overall there was a maternal death for every 241 deliveries, 5 hospitals with the highest risk of a maternal death were: Matany 1 death in 46 deliveries, Kuluva 1 in 91, Nkokonjeru 1 in 108, Buluba 1 in 114 and Kaabong 1 in 123. While Matany has a clear explanation, the other hospitals have to be investigated to establish the reason for the high maternal death to deliveries ratio. 5 hospitals with the lowest risk of a maternal death were: Kitgum 1 death in 2,298 deliveries, Kawolo 1 death in 1,1864, Atutur 1 death in 1,772, Entebbe 1 death in 1,682 and Bwindi community hospital 1 death in 1,294 deliveries.

Fresh stillbirths were reported in 106 hospitals, a total of 3,493 fresh still births were recorded, minimum 1 (Ntinda, Nakasongola Military, Uganda Martyrs, Kanginima, Rubongi Military, Gulu Military, Gulu Independent) and maximum 192 (Iganga hospital). Overall the risk of having a fresh still birth taking total deliveries as the denominator is 1 in 42 deliveries. The minimum risk is 1 in 378 deliveries in Nakasero hospital and maximum is 1 in 6 deliveries in Dabani.

## **Functionality of HC IVs**

According to the Health Sub-District (HSD) concept, a HC IV is the first referral facility where there is no hospital. The total number of HC IVs is 206; of these 182 are government, 17 NGO and 7 privately owned. The key feature of the HSD strategy was that each HSD, which has an approximately 100,000 people, would have a Hospital or a HC IV. The facility should have the capacity to provide basic preventive, promotive, outpatient curative, maternity, inpatient health services, emergency surgery and blood transfusion and laboratory services. In addition, it should supervise and support planning and implementation of services by the lower health units in its area of jurisdiction. Being a key strategy of the sector, the functionality of HC IVs has been reviewed every year in the last 7 health sector reports

The DHIS2 has enabled 196 HC IV to provide information for assessment of inputs, management and outputs better than 2012/2013 (193 HC IVs) and 2011/2012 (88).

## Inputs

### Human Resource

Staffing information in GHs was not analyzed due scarcity of information in the DHIS2.

### Finance

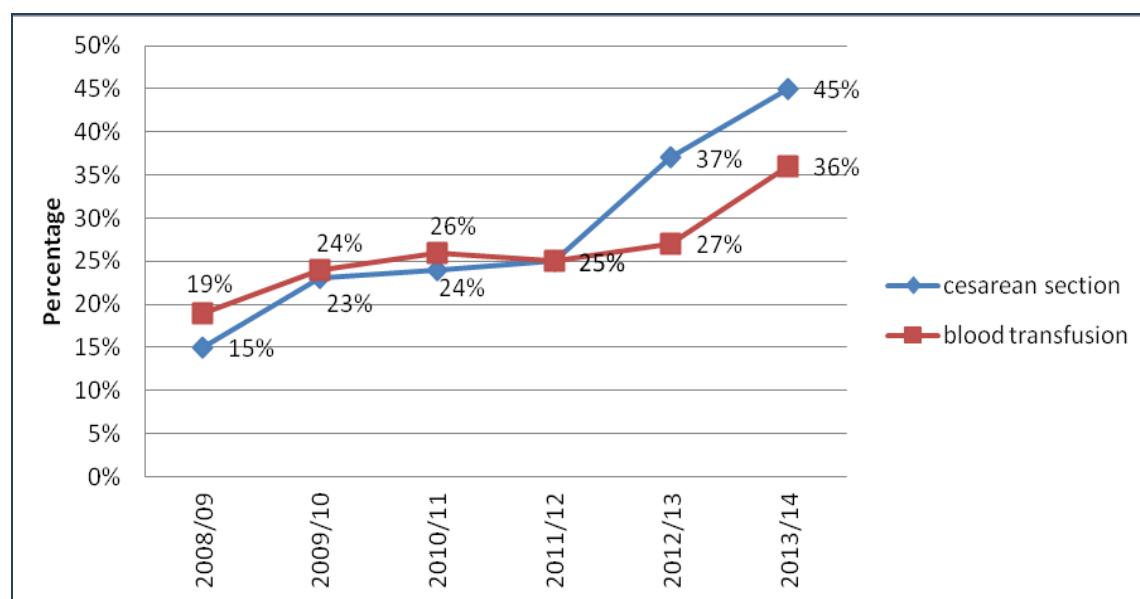
Staffing information in GHs was not analyzed dues to scarcity of information on DHIS2

## Outputs

Functionality of HC IV is determined by outputs from selected components of the minimum service standards i.e. maternity (deliveries), inpatient, blood transfusion, theatre (caesarean section, major and minor surgery), HCT, PMTCT, ART, long term contraception and outpatient services.

Since the main objective of setting up HC IVs was to provide Comprehensive Emergency Obstetric Care (CEmOC) – that is being able to provide intervention in case of complications during delivery, which includes the ability to provide a caesarean section and blood transfusion, for this assessment HC IVs have been judged “functional” if they have been able to carry out at least one caesarean section. Using these criteria, 45% (88/196) of the HC IVs were “functional” meaning able to do cesarean section. For blood transfusion 36% (70/196) were able to provide this service. Those able to provide both cesarean section and blood transfusion were 29% (57/196). There is an improvement compared to the functionality of 2012/2013 when 37% (72 out of 193) of the HC IVs were able to do cesarean section and 27% able to do blood transfusion. Figure 9 below shows the trend of these functionality indicators over the years. Government efforts and a number of partner efforts to make HC IVs functional are beginning to pay off. The recruitment of health workers for HC IVs and IIIIs contributed to observed improvements.

*Figure 11: Trends in Caesarean Section and Blood transfusion*



Source: MoH HMIS

There are 12 high performing HC IVs (Mukono T.C. HC IV, St. Ambrose Charity HC IV, Bishop Asili Ceaser HC IV, St. Paul HC IV, Kabuyanda HC IV, Mukono CoU HC IV, Rukunyu HC IV, Nyahuka HC IV, Rubaare HC IV, Mpigi HC IV, Serere HC IV and Rwekubo HC IV) whose cesarean section numbers fall within the range of hospitals. These HC IVs need to be recognized and funded differently from other HC IVs. Mukono Town council HC IV maintains the top position (594) for cesareans sections followed by St. Ambrose Charity HC IV in Kibaale (545).

Annex Two. Table 8 shows the outputs and functionality of HC IVs.

HC IV performance has been assessed using the SUO as well. A total of 196 HC IVs reporting through the DHIS-2 were assessed. In total HC IVs attended to 4,309,611 outpatients; conducted 145,124 deliveries; and admitted 424,828 patients. The mean outpatient attended to was 21,988, mean deliveries 748 and mean admission 2,347. See Table 51 below.

The total SUO for HC IVs was 11,812,901 with a minimum of 1,826 and maximum of 180,815.

**Table 51: Summary of Outputs from the HC IVs FY 2013/14 (N=196)**

	IPD Admissions	Total OPD	Deliveries in unit - OPD	Total ANC	Postnatal Attendances	Family Planning contacts	Immunization	SUO
sum	424,828	4,309,611	145,124	354,793	75,489	77,242	757,440	11,812,901
minimum	1	1,335	2	-	5	1	-	1,826
maximum	8,192	48,970	5,225	10,150	5,057	8,611	25,683	180,815
Average	2,347	21,988	748	1,810	391	409	3,864	60,270
count	181	196	194	196	193	189	196	196

The 5 top performing HC IVs in 2013/14 were Mukono T.C. HC IV, River Oli HC IV, Kabuyanda HC IV, Serere HC IV, PAG Mission HC IV. See Annex Two. Table 8 for ranking all HC IVs.

In 2013/14 the number of beds increased, from 6,065 to 6,324 admissions then followed suit and increased to 424,828 from 395,898 the year before, as expected with more admissions death also increased. While the average length of stay stayed the same, the bed occupancy rate increased to 49% from 46.6%. The table 53 below shows the comparisons.

**Table 52: Summary of Efficiency & Usage Measurements of HC IVs**

Output	2013/2014	2012/2013	2011-2012
Number of Beds	6,324	6,065	3,466
Admissions	424,828	395,898	551,695
Deaths	4,621	4,276	1,276
Case Fatality Rate	1.1%	1.08%	0.23
Patient Days	1,125,651	1,031,096	535,866
Bed Occupancy	49%	46.6%	32.4%
Average Length of Stay	2.6	2.6	3

Source: MoH HMIS

### **2.7.5 District League Table (DLT)**

The DLT is a tool used to assess district performance and identify areas of strengths and weakness and use it to identify ways in which that performance can improve. In this report, the 112 districts are used as the units of analysis with key objectives of comparing performance between districts; provide information to facilitate the analysis for good and poor performance at districts and thus enable corrective measures which may range from increasing the amount of resources (financial resources, human resources, infrastructure) to the LG or more frequent and regular support supervision; and increase LG ownership of achievements/ performance.

**The specific objectives of the DLT are:**

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

For the year 2013/14, ten indicators were used to evaluate and rank district performance: 8 coverage and quality of care indicators, given a collective weight of 80%; and 2 management indicators, accounting for the remaining 20%. The indicators were selected for consistency with the 26 core HSSIP 2010/11 – 2014/15 indicators.

The primary data source for majority of the indicators were derived from the routine HMIS (Pentavalent Vaccine 3<sup>rd</sup> Dose coverage, institutional deliveries, outpatient visits, Sulfadoxine / Pyrimethamine (SP) 2<sup>nd</sup> dose for IPT, 4<sup>th</sup>ANC visits, HMIS timeliness and completeness of reporting, and submission of inventory data; some of the indicator data was provided by the respective MoH programmes such as HIV/AIDS, TB and environmental health division.

Table 53 shows the top and bottom 15 performing districts with their ranks and total scores. The full district league tables can be seen in the Annex. Get the quartile of all the districts and identify policy recommendations in line with HSSIP period.

The top five LGs in performance are Nwoya, Gulu, Masaka, Lyantonde and Rukungiri. The bottom five LGs in performance are Amudat, Kaabong, Ntoroko, Moyo, and Kween. It is notable that Nwoya is classified as a hard-to-reach district and is among the new districts, yet it is the best performing LG, and a lot can be learned on what makes them better performers.

**Table 53: Fifteen (15) Top and Bottom performing districts FY 2013/14**

Top 15 Districts			Bottom 15 Districts		
District	Score	Rank	District	Score	Rank
Nwoya	88.1	1	Amudat	35.8	112
Gulu	86.3	2	Kaabong	50.8	111
Masaka	85.8	3	Ntoroko	56.1	110
Lyantonde	85.7	4	Moyo	57.6	109
Rukungiri	84.0	5	Kween	58.4	108
Kamwenge	83.8	6	Sembabule	58.4	107
Kyegegwawa	83.3	7	Moroto	58.4	106
Soroti	82.5	8	Amuria	62.4	105
Mityana	81.6	9	Luuka	62.5	104
Abim	81.3	10	Kotido	62.9	103
Mbale	79.7	11	Pader	63.2	102
Lira	79.6	12	Yumbe	63.8	101
Luwero	79.5	13	Kiryandongo	63.8	100
Mbarara	79.3	14	Kalangala	63.9	99
Jinja	79.1	15	Adjumani	65.0	98

**Table 54: District ranking for new districts**

District	Total Score	Rank	National Rank
Nwoya	88.1	1	1
Kyegegwawa	83.3	2	7
Serere	78.6	3	18
Zombo	77.5	4	26
Butambala	77.2	5	30
Kalungu	75.3	6	43
<b>National</b>	<b>74.9</b>		
Mitooma	74.8	7	47
Ngora	73.9	8	53
Agago	73.9	9	54
Buikwe	72.4	10	58
Lamwo	72.4	11	59
Lwengo	71.5	12	67
Bukomansimbi	71.4	13	68
Kibuku	70.4	14	75
Rubirizi	70.2	15	77
Otuke	69.2	16	79
Bulambuli	69.0	17	81
Buyende	68.9	18	82
Kyankwanzi	68.8	19	83
Gomba	68.7	20	84
Napak	68.2	21	88
Kole	67.8	22	89
Buhweju	67.5	23	91
Sheema	66.9	24	92
Buvuma	66.3	25	95
Namayingo	65.6	26	96
Kiryandongo	63.8	27	100
Luuka	62.5	28	104
Kween	58.4	29	108
Ntoroko	56.1	30	110
Amudat	35.8	31	112

*Table 55: District ranking for hard-to-reach districts as per the DLT*

Top 5 Hard-To-Reach			Bottom 5 Hard-To-Reach		
District	Score	Rank	District	Score	Rank
Nwoya	88.1	1	Kotido	62.9	22
Gulu	86.3	2	Moroto	58.4	23
Abim	81.3	3	Ntoroko	56.1	24
Kisoro	78.8	4	Kaabong	50.8	25
Bukwo	76.2	5	Amudat	35.8	26

The hard to reach districts have mixed performance with some of them in the top 15 and others in the bottom 15.

#### **2.7.6 The 12 Regional Performance Monitoring Teams**

These teams were introduced and inducted in November 2013, with the main objective of strengthening decentralized capacity for active performance monitoring and surveillance of program outputs and support the performance management of implementing agencies at all levels.

Specific Objectives are;

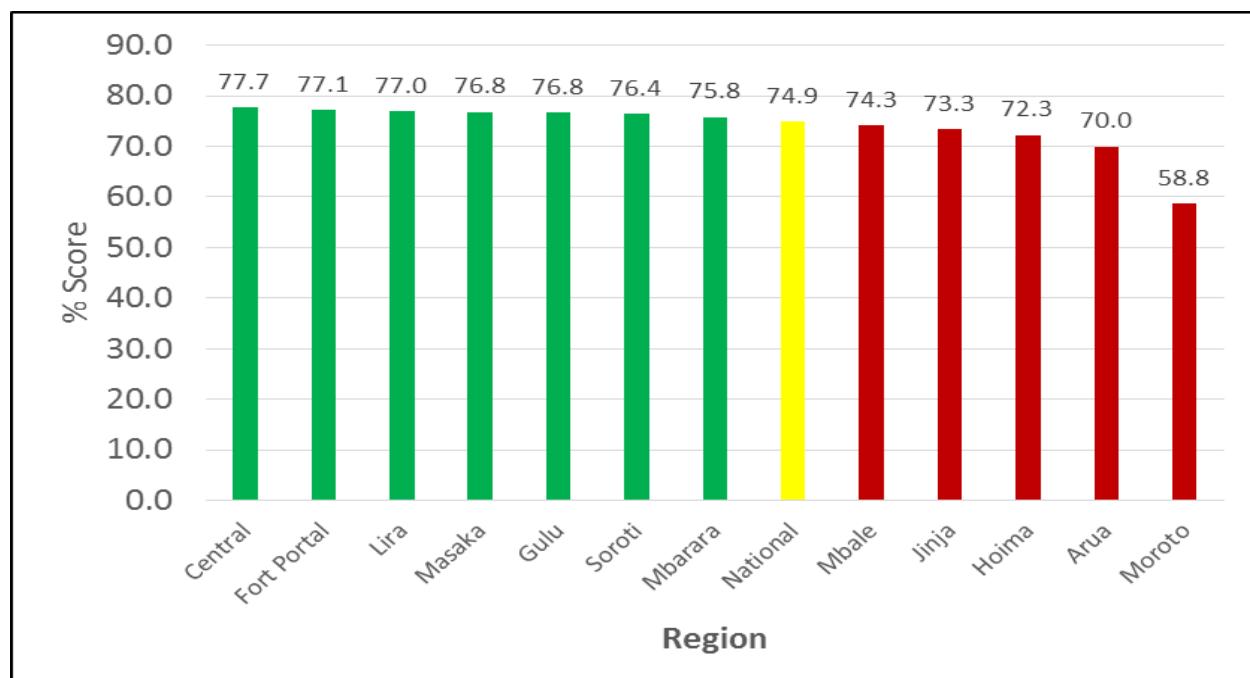
1. To provide a regional framework for tracking progress and demonstrating results of partner performance.
2. To build capacity of semi-autonomous institutions (RRHs), LGs, PNFP/Private facilities and CSOs in the regions, to regularly and systematically track progress of HSSIP implementation.
3. To facilitate stakeholders, including the Global Fund, to assess their performance in accordance with the agreed objectives and performance indicators to support management for results (evidence based decision making).
4. To provide a framework for dissemination of results, feedback to stakeholders in the health investment and promote the use of locally generated health information.
5. To facilitate continuous learning (document and share the challenges and lessons learnt) by Local Governments and other stakeholders during implementation.

The regional zonal league table shows the ranking of regions and further broken down by districts. See table 56 and Table 3 in annex two.

**Table 56: Regional Zone League Table**

<b>Region/Zone</b>	<b>Total Score</b>	<b>Rank</b>
Central-Region	77.7	1
Fort Portal-Region	77.1	2
Lira-Region	77.0	3
Masaka-Region	76.8	4
Gulu-Region	76.8	5
Soroti-Region	76.4	6
Mbarara-Region	75.8	7
Mbale-Region	74.3	8
Jinja-Region	73.3	9
Hoima-Region	72.3	10
Arua-Region	70.0	11
Moroto-Region	58.8	12

Central, Fortal Portal and Lira regions had the highest scores for the Regional League Table at 77.7%, 77.1%, and 77.0%, respectively. Out of the 12 regions, 5 were below the national League Table average of 74.9%. These are; Mbale (74.3%), Jinja (73.3%), Hoima (72.3%), Arua (70.0%) and Moroto (58.8%).

*Table 10: Total Scores for each against the Regional League Table*

In respect to the objectives of the RPMTs the health sector expects improvement in the decentralized capacity for active performance monitoring and surveillance. Timely submission and completeness of the monthly HMIS reports is one of the key outputs of the monitoring and evaluation platform in the health sector.

Analysis of the trends in monthly HMIS reporting, completeness and timeliness shows an increase in performance from 80% to 80.9% in timeliness, 79% to 85.9% in completeness and from 94% to 95.6% in completeness of facility reporting.

Regional performance against HMIS monthly reporting, timeliness and completeness varies between the different regions. Overall there is good performance in terms of completeness of facility reporting in terms of numbers of health facilities reporting per district at 95.6% with Soroti region having the highest (98.2%) facility completeness rate and Fortportal region with the lowest (90.5%).

Completeness of monthly reports was highest (97.6%) in Hoima region and lowest in Fort Portal region; whereas timeliness of monthly reports was highest (92.9.7%) in Arua region and lowest (59.5%) in Fortportal region.

Table 57 shows the regional Performance against selected league table indicators.

- All regions with the exception of Moroto had 100% medicines orders submitted timely.
- HIV testing in children born to HIV positive women was above 90% in all regions. This is above the HSSIP target for the year.
- The highest DPT3 coverage was realized in Fort Portal, Gulu and Jinja regions at 100% in the 3 regions and lowest in Arua (76%) and Moroto (72%) regions.
- Average national TB treatment success rate was 80.4% with the highest in Masaka (89.9%) followed by Lira (88.7%) and lowest in Moroto (65%) and Arua (64.3%) respectively.
- The national average for approved posts filled is 70.1% and this varies across regions with the highest in Lira (88.1%) followed by Central region at 85.7%. Lowest staffing levels are in Hoima (60.7%) and Mbarara region (57.8%).
- Latrine coverage is highest (86.7%) in Mbarara region and lowest (20.6%) in Moroto region with a national average of 71.8%.
- Among all the indicators maternal health indicators remain low with;
  - IPT2 coverage ranging from 59% in Gulu region to 32.2% in Moroto region. National average was 48.6%.
  - Deliveries in government and PNFP facilities ranging from 54.3% in Central region, followed by Soroti at 53.4% to 24.6% in Mororo region. National average 44.4%.
  - Overall performance was lowest in ANC 4<sup>th</sup> having the highest in Fort Portal region at 41.1% followed by Mbarara at 39.6% and lowest (25%) in Mbale and Moroto (21.7%) regions. National average was only 32.4%.

The MoH expects the RPMTs to utilize Regional League Table for benchmarking and setting performance targets for the next implementation period. Districts with remarkable contribution to the regional league table should be recognized for the good performance and those with weak performance should be supported to improve performance.

### 2.7.7 Core HSSIP indicators

Table 57: HSSIP 2010/11 – 2014/15 indicators summary

Indicator	Baseline 2009/10	Achievement 2013-14	Target 2014-15
<b>Health Status</b>			
Maternal Mortality Ratio	435/100,000	438/100,000	131
Under-5 Mortality Rate	137/1,000	90	56
Infant Mortality Rate	76/1,000	54	41
Neonatal Mortality Rate	29/1,000	26	23
Child Stunting Rate	38%	33%	28%
Child Wasting Rate	16%	14%	10%
<b>Coverage of Interventions</b>			
ANC at least 4 visits	47%	48%   32.4%(HMIS)	60%
IPT2 coverage	47%	25%   48.6%(HMIS)	80%
Deliveries in health facilities	33%	57%   44.4%(HMIS)	90%
Contraceptive Prevalence Rate	24%	30%	40%
Penta 3 immunization coverage	76%	93.0% (HMIS)	85%
Measles immunization coverage	72%	82%	95%
Malaria treatment <24h for U5s with fever (VHT)	70%	61%	85%
TB case detection rate	56%		70%
HIV testing of HIV-exposed infants	29%	53.8%	75%
ART coverage among those in need	53%	48% (2013 WHO Guidelines)	75%
Households with pit latrine	70%	74.58%	72%
<b>Health Systems</b>			
Government allocation for health (%)	8.3%	8.7%	15%
Catastrophic payments (% households)	43%	No data	13%
Annual reduction in absenteeism	Absenteeism 46%	Panel survey	20%
Villages/wards with VHTs	75%	HMIS	100%
Approved posts filled (%)	56%	HRIS   67.8%	75%
No stock-outs of tracer medicines	21%	57.0% (HMIS)	80%
Outpatient visits per capita	0.9	HMIS   1.0	1.0
HC IVs providing EmONC	23%		50%
Client satisfaction	46%	Panel survey	70%

## 2.7.8 Progress in Implementation of the 19th JRM

*Table 58: Progress in the implementation of the 19th JRM*

Milestone	Action by	Time frame	Expected output / outcome	Progress
<b>Leadership / Governance</b>				
Harmonize the regional structures to support planning monitoring and supervision	Director Health Services, Planning & Development  Health Development Partners	By June 2014	Baseline assessment of existing regional structure completed  Feasibility study for the operationalization of regional structures  Geographic areas defined  Roles and functions of the Regional Structures defined	Report done complete  A waiting implementation
Implement the PPPH	Director Health Services, Planning & Development  MoH PPPH Desk Officer  Health Development Partners  All DHOs	By June 2014  By June 2014	PPPH coordination unit established in the Planning Department (Jan 2014)   PPPH Implementation Guidelines developed and approved (Dec 2013)   Private sector involved in planning and supervision	PPPH Coordination Unit established (Two TAs recruited by IFC and BTC to support unit)  Draft PPPH implementation guidelines still under consultation among stakeholders  Private sector participates in all sector TWGs and other governance structures in MOH  Private sector involved in regional planning meetings for 2014-15
Revamp and functionalize all the leadership / governance structures at Central level	Permanent Secretary	By June 2014	Requirements of annex 8 of the Compact met (HSSIP Monitoring Indicators)	HSSIP indicator tracking matrix in AHSPR 2013-14
Revamp and functionalize all the leadership / governance structures at Referral hospitals	Hospital Directors	By June 2014	Board and technical committees meetings held as planned	Hospital Board and technical committee meetings regularly held
Revamp and functionalize all the leadership / governance structures at District Levels	District Health Officers	By June 2014	DHC and DHMT meetings held as planned  Health Unit management committee meetings held as planned	
Reactivate the inter-sectoral/Inter-	Permanent Secretary	March 2014	Structure and composition of the Inter-ministerial standing	Work in progress

ministerial committees at central level Reactive the inter-sectoral committees at district levels	DHO	June 2014	committees (ISC) defined ISC committees meeting held as planned Structure and composition of the Inter-ministerial committees (IC) defined Inter-sectoral committees meeting held as planned	Work in progress
The MoH facilitate and coordinate a structured district planning process involving all stakeholders, able to capture financial contributions from all sources	Director Health Services, Planning & Development  Health Development Partners  Civil Society Organizations	By March 2014	12 Regional Planning meetings conducted.  District Health Plans available from all districts.  Joint planning at district level and service delivery focuses on identified priorities.	6 Regional Planning Meetings held (Central-Seeta, Southern-Masaka, West Nile-Arua, Rwenzori-Fort Portal, Acholi Region-Lira, and Eastern-Soroti)
Further strengthen systems for accountability and efficient use of resources.	Permanent Secretary  Hospital Directors	By June 2014	Response to the AG report presented to HPAC every November  Actions taken on the recommendation of the AG report	
Follow up and provide update on the restructuring process initiated by Ministry of Public Service.	Under Secretary Administration and Finance	By December 2013	MoH has an approved restructuring plan to guide planning	Draft Restructuring report produced
Assign an officer to track off budget funding	Director Health Services, Planning & Development  Health Development Partners	By December 2013	<b>Health Care Financing</b>  Tracking mechanism established Biannual update on off budget contribution Biannual analytical reports on alignment of off budget support to sector priorities Off budget funding tracked and included in the sector budget and financial reports	Being tracked under the NHA report.
Costing of delivering the Uganda National Minimum Health Care Package at each Primary Health Care level (General Hospitals to HC II) for both public and PNFP	Commissioner Planning	By December 2014	Consultant recruited Costing for service delivery for PHC level facilities	Planned under the Health Sector Development Plan.

health facilities in order to inform and guide the sector budget requirements.				
Resource allocation formula (funds, medicines and logistics) revised and applied taking into consideration actual service delivery outputs	Director Health Services, Planning & Development	By June 2015	New formula applied for resource allocation	
Finalize the Health Financing Strategy	Director Health Services, Planning & Development	By December 2013	HFS approved by HPAC and Top Management Committee Implementation modalities including alternative health financing mechanisms defined	Draft Health Financing Strategy produced
Estimate, budget and allocate funds for post shipment, customs clearance and other handling charges for donated items.	Sector Budget Working Group Program Managers	By January 2014	Budget available for clearance and handling charges	Clearing and handling charges budgeted for in the 2014-15 work plan
Enforce the MoH guidelines for designating or upgrading health facilities	Permanent Secretary Assistant Commissioner, Health Infrastructure	By November 2013	Dissemination of the guidelines for designation, establishment and upgrading of health units Circular issued on compliance to the guidelines Coordinated establishment and upgrading of health facilities in the sector	Guidelines developed
Monitor financial inflows and performance of NGOs/CSOs/IPs operating in the districts.	Chief Administrative Officers / DHOs	By March 2014	Financial contributions of CSOs/IPs/NGO are tracked and performance assessed	
Establish a national ambulance service to improve referral.	Director General Health Services	By June 2014	Finalize guidelines for managing ambulance services	Guidelines and Strategic plan in place
		By June 2015	Operational modalities for the national ambulance services defined Functional ambulance system	
Draw a plan and direct resources for new district vehicles based on need	Assistant Commissioner, Health Infrastructure	By June 2014	Updated vehicle inventory Vehicle needs assessment done and vehicle allocated based on need Consolidated status for procurement of vehicles from DPs	an inventory updated and

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<b>Human Resources for Health</b>				
Establish a Coordination Committee Framework (CCF) for Health Workers to address some of the HR issues.	Director General of Health Services	By March 2014	Composition and Terms of reference for the CCF drawn Revise modalities for bonding, appointing, promoting and training health workers. Framework to assess conditions under which health workers provide care in private, public, PNFP, Institutions such as army, police, schools etc, including traditional healers / herbalists / TBAs developed	Documentation
Develop an efficient system to enforce the annual registration of health professional with respective councils.	Registrars of Professional Councils	Annually	Health Professionals registered annually Registration status verified and published annually	Registers
Establish an effective mechanism for monitoring attendance with the involvement of the served community.	Chief Administrative Officers / DHO	By December 2013	Utilize mTRAC system to monitor and take action to reduce absenteeism Absenteeism rate monitored regularly Reduced absenteeism rate	Reports
Develop and operationalize guidelines for the reward and sanctions committees at all levels	Chairpersons of the Rewards and Sanctions Committees	By March 2014	Implementation guidelines developed and approved Reward and sanctions committees meeting at least quarterly	Guidelines Minutes
Organize a stakeholders' meeting involving MoPS, MoFPED, Health Service Commission and MoLG to discuss absorption of project recruited health workers into the Public Service	Permanent Secretary	By April 2014	Absorption modality for project staff agreed	Minutes
Advocate for training an adequate number of midwives for the next 2 years	Director General Health Services	By June 2014	Need for midwives assessed Negotiations with MoES / Training schools conducted	Report Minutes
Regularize the appointment of health unit managers into the management positions with	Director General Health Services	By December 2014	Evidence based concept formulated and presented to MoPS Well motivated and accountable health managers	Concept Note

accompanying  
remuneration based  
on responsibilities

<b>Medical Products and Technology</b>				
Mechanism to continue funding the Credit Line at JMS for PNFP facilities re-established.	Director General Health Services	By January 2014	Continued funding for EMHS in PNFP facilities	
Ensure timely response to issues arising for medicines and health supplies delivered to health facilities e.g. erroneous packing, non-supply of essential supplies, etc.	General Manager National Medical Stores	By December 2013	Timely response and action taken to rectify anomalies	Reports
<b>Information and Research</b>				
Revise the quality assessment tools and indicators for all levels	Commissioner Quality Assurance	By June 2014	Quality Assessment tools and indicators revised and disseminated	Tools and indicators documented
Conduct regular data validation exercises which are coordinated by the MoH Resource Centre.	Assistant Commissioner Health Services, Resource Center	By June 2014	Data validation exercises coordinated	Reports
Hold Regional Pre-JRM meetings to support the compilation of the Annual Report this should involve the Primary Health Care Workers	Director Health Services, Planning and Development	By August 2014	Regular data validation conducted and disseminated	
Solicit support from all MCH partners in Uganda to mobilise the needed resources for the urgent printing of the MCH passport	Director General of Health services	January 2014	Districts and PHC staff engaged more in the review process	
<b>Service Delivery</b>				
Organize a meeting of stakeholders on the status of the implementation of the VHT operational guidelines and guidance on corrective	ACHS Health Promotion and Education	By March 2014	Status of the implementation the VHT operational guidelines is assessed Information on corrective measure provided to stakeholders for adherence to the said guidelines	

<u>measures</u>				
Regularly monitor and report resistance of medicines and other substances applied for medical interventions e.g. ARVs, anti-TB, IRS.	Commissioner Health Services, National Disease Control	By June 2014	Mechanism reviewed and implemented Monitoring and reporting of resistance to medicines and other substances applied for medical interventions conducted at least once a year	Reports
HIV/AIDS control program to put more focus on the prevention aspects of HIV/AIDS.	Program Manager ACP  Health Development Partners	By January 2014	Increased resource allocation for the HIV/AIDS prevention strategy Communication strategy disseminated and implemented	Workplan / budget  Reports
Scale up the Maternal Perinatal Death Notification and Review as a Quality Improvement Tool and ensure integration in the existing health facility Quality Improvement initiatives	Civil Society Organizations  Assistant Commissioner Health Services, Reproductive Health  Assistant Commissioner Health Services, Child Health	By June 2014	Number of facilities conducting death notification and review increased	MPDR reports
Implement targeted Reproductive Health interventions in districts / localities that are performing poorly.	Commissioner Health Services, Community Health	By January 2014	Intra-district performance mapped Workplan based on specific needs developed and implemented Anthropologists/social scientists involved.	
Implement the Sharpened Plan for MNCH	Commissioner Health Services, Community Health	By December 2013	Plan finalized and disseminated the plan Plan integrated in the HSSIP Improved RMNCH indicators	The sharpened Plan for MNCH finalised
Functionalize more HC IVs in the next 2 years	Commissioner Health Services, Clinical Services	By June 2015	At least 45% HC IVs functional Blood transfusion services available in at least 45% of HC IVs Maternal and newborn health improved	Work in progress
Disseminate and implement Male involvement Strategy in RMNCH services.	Commissioner Health Services, Community Health	By January 2014	Male involvement strategy disseminated and families utilizing the available services	Strategy being implemented
Conduct regular maintenance of medical equipment	Commissioner Health Services, Clinical Services	By June 2015	Regular maintenance of medical equipment conducted	Work in progress

<p>Revise, consolidate and disseminate all service delivery standards i.e. health care services, equipment, infrastructure and staffing.</p> <p>Harmonize the complaint redress management and feedback system for the health sector</p>	<p>Commissioner Health Services, Quality Assurance</p> <p>Assistant Commissioner Human Resource Management</p>	<p>By June 2014</p>	<p>User training scaled up Medical inventory conducted annually Revised and consolidated service delivery standards developed and disseminated</p> <p>Patients' Charter appropriately disseminated to target population Documentation of the existing complaint management and feedback systems A harmonized complaint management and feedback system developed</p>	<p>Service standards being developed</p> <p>Reports Done</p>
<p>Implement the revised comprehensive support supervision strategy that promotes integration and coordination of the visits (Public, Private, HDP).</p>	<p>Commissioner Health Services, Quality Assurance</p> <p>Health Development Partners</p>	<p>By June 2014</p>	<p>Comprehensive supervision strategy revised and disseminated Centre and DHTs oriented on the use of the strategy Sub-national and district supervision plans developed Comprehensive supervision strategy implemented in a coordinated manner</p>	<p>Revised supervision strategy</p> <p>Supervision plans</p> <p>Reports</p>

## **ANNEXES**

### **ANNEX ONE: Delivery of the Uganda National Minimum Health Care Package**

This section gives details of progress in implementation of priority activities under the; Uganda National Minimum Health Care Package (UNMHCP)

Because of the limited resource envelope available for the health sector, the NHP II recommends that a minimum health care package be delivered to all people of Uganda. This package consists of the most cost-effective priority health care interventions and services addressing the high disease burden that is acceptable and affordable within the total resource envelope of the sector. The UNMHCP consists of the following cluster;

- (i) Health Promotion, Disease Prevention and Community Health Initiatives, including epidemic and disaster preparedness and response;
- (ii) Maternal and Child Health
- (iii) Prevention, Management and Control of Communicable Diseases and;
- (iv) Prevention, Management and Control of Non-communicable Diseases.

This section analyses progress in implementation of the UNMHCP under the various clusters in relation to the relevant HSSIP 2010/11 – 2014/15 core indicators, lead programme indicators of focus during 2013/14 FY, annual workplan indicators (process implementation), main achievements, challenges and recommendations.

#### **3.1 Health promotion, disease prevention, and community health initiatives**

##### **Highlights of planned activities during the FY 2013/14**

- VHTs established in 2 districts including VHT sensitization of district leaders, training of trainers, community sensitization and training of VHTs.
- Social mobilization and sensitization of communities on prevention and control of diseases and disease outbreaks through the use of Film vans
- Technical support supervision of Health Promotion activities in the districts
- Meetings for capacity building of District Health Educators
- Educate the public on prevention and control of diseases through the use of mass media
- Development and Dissemination of IEC materials to the districts

##### **Main achievements**

- Conducted Training of 428 VHTs in Shuuku, Kasozi and Kagango, Bugongi, Kigarama sub counties in Sheema district.
- Field visits to VHTs carried in Rubirizi and Bushenyi districts
- Social mobilisation on Meningitis outbreak using film vans in West Nile in the districts Arua, Nebbi, Yumbe, Adjumani, Koboko, Maracha, Moyo, Zombo.

- Technical Support Supervision of Health Promotion and Education carried out in Western, South-western, West Nile, and Central region.
- Film van activities carried out on SMC, Family Planning, Fistula, Cancer screening, HIV care and treatment, EMTCT, SRHR, Adolescent health in 30 districts; Lira, Katakwi, Wakiso, Mukono, Kayunga, Mayuge, Jinja, Kamwenge, Mubende, Fortportal, Kawalo, Rakai, Kampala, Nakasongola, Bugiri, Kamuli, Iganga, Buyende, Namutumba and Luwero.
- Regional workshops on health communication targeting DHOs, DHEs, Sec for Health & DHI in 7 regions i.e. Central, Eastern, Western, Southwestern, Northern, West Nile, Karamoja region
- Workshop for DHOs, DHE and upcountry media stations
- Disseminated 17, 924 VHT registers in 54 districts
- A National VHT dialogue meeting conducted involving 40 stakeholders
- Received support for the BCC working group quarterly meetings and equipment for the secretariat from Community for Healthy Communities (CHC).

### **Performance of lead program indicators**

- Proportion of districts with trained VHTs increased from 31% to 70% by 2015
- Proportion of health facilities with IEC materials increased from 80% to 90% by 2015
- VHT registers developed and disseminated to 50% districts

### **Challenges**

- Inadequate access of budget allocated funds for implementation of planned activities.
- Inadequate funding to train VHTs in more than 1 district.
- Inadequate funding for production of IEC materials, VHT training materials and public education through the media

### **Key recommendations**

- Technical capacity for health promotion both at the centre and district need to be strengthened
- Secure funding for public awareness and education through the media
- Maintenance of the film vans used for mobilization and sensitization is a big problem due to lack of funds

### **Environmental Health**

The environmental health component aims at contributing to the attainment of a significant reduction of morbidity and mortality due to unsafe water accessibility, poor sanitation and unhygienic practices plus other environmental health related conditions. This is why the Environmental Health Division implemented both the GoU work plan and Uganda Sanitation Fund (USF) Programme work plan with emphasis put on the Kampala Declaration on Sanitation (KDS), using Community Led Total Sanitation (CLTS) and Participatory Hygiene and Sanitation Transformations (PHAST). Due to the above interventions, the National latrine coverage improved from 71.12 to 74.58% FY 2013/14, 3% up from 71.12% in FY 2012/13 and hand washing with soap stands at 32% this FY which is also 3% increase from 29% FY 2012/2013.

The Government of Uganda is committed to improving sanitation in the country. At the 2014 High Level Meeting for Sanitation and Water for All, (SWA) spearheaded by UNICEF, held in Washington

on 11th April 2014 and attended by the sector ministries including Finance ministers, the government made several commitments to support improvement of sanitation in the country. These included:

- Increased financing for sanitation and hygiene
- Improved capacity through recruitment of adequate staff, training of the staff and logistical support
- Improved coordination between relevant sectors
- Promotion of exemplary leadership and
- Enactment and enforcement of sanitation ordinances.

*Figure 12: A mound latrine on loose soil; Osudan village; Katakwi district*



*Finding local solutions:*

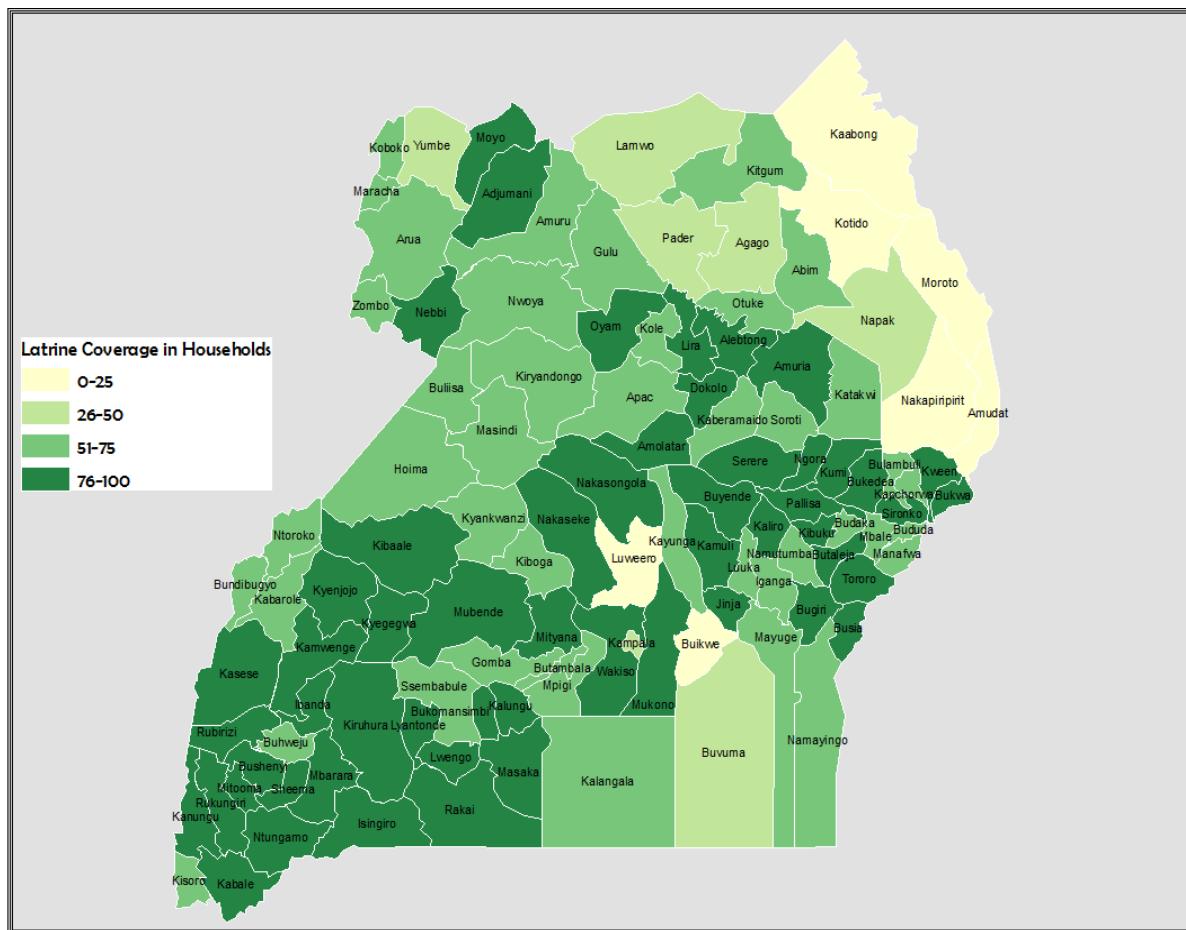
### **Core HSSIP Indicator**

- Latrine coverage attained 74% in 2013/14 FY

### **Lead programme indicators**

- Percentage of households with access to safe water; Urban 88% and Rural 67%.
- The proportion of districts implementing water quality surveillance and promotion of safe water chain/consumption increased from 30% to 50% by the year 2015.
- The proportion of households with hand washing facilities with soap increased from 22% to 50% by 2015.

*Figure 13: Percentage latrine coverage by district FY 2013/14*



## **Planned activities financial year 2013-14**

- Carry out safe water, sanitation and hygiene activities through home improvement campaigns, Community Total Led sanitation (CLTs), Participatory Hygiene and Sanitation Transformations (PHAST),
  - Follow up of the implementation of the Kampala Declaration on Sanitation +13 strategy.
  - Carry out technical support supervision and monitoring of the Local Governments on Open Defecation Free villages (ODF) & model villages, Safe Water chain, Community Led Total Sanitation (CLTs), Hand Washing Facilities with Soap (HWFs) and hygiene improvements at household level.
  - Mobilize and ensure that all Ugandan citizens commemorate the National and International Sanitation week/community days in collaboration with other line ministries and stakeholders.
  - Finalise and present the reviewed Public Health Act (2000) amendments with support from legal bodies for legal advice and input.
  - Coordinate Water, Sanitation and Hygiene (WASH) activities and collaborate with stakeholders nationally and internationally.
  - Adaptation of Water, Sanitation and Hygiene (WASH) POST 2015 activities with proposed targets and indicators for drinking water, sanitation and hygiene (Universal access to basic water, sanitation and hygiene is within reach).

### **Key output Indicators 2013/14**

- Sanitation week/ community days commemorated in all districts.
- Promotion of construction and effective use of sanitation facilities at household level
- Open defecation eliminated.
- No. of villages declared ODF and verified
- Hand washing facilities constructed and used in communities.
- Populations have quality latrines and using them.

### **Achievements Uganda Sanitation Fund (USF) programme:**

- The Uganda Sanitation fund project has been running for three years. Over that period UGX 5, 940,766,000 /USD 2,284,910 has disbursed to 15 districts (Kibuku, Pallisa, Kumi, Ngara, Serere, Soroti, Amuria, Katakwi, Dokolo, Amolatar and Kaberamaido) in the eastern region and (Bushenyi, Sheema and Mbarara) in the south west region). During FY 13/14, the project was expanded to an extra 15 districts of Nebbi, Zombo, Arua, Maracha, Koboko, Yumbe, Moyo, Lira, Albtong, Kole, Otupe, Apac, Butaleja, Budaka and Bulambuli to cover a total number of 30 districts. The MoH, which is the executing agency of the project, spent FY 13/14 preparing the new districts to meet the project requirements and they did not receive money for implementation, while the 15 original districts received UGX 2,991,999,400=, / USD 1,150,769 and a summary of their reported outputs is shown in the table 1.
- Developed the proposal for expansion of the added fifteen (15) USF districts which include: Nebbi, Zombo, Arua, Maracha, Koboko, Yumbe, Moyo, Lira, Albtong, Kole, Otupe, Apac, Butaleja, Budaka and Bulambuli.
- Continue with implementation of the Uganda Sanitation Programme Improvement Plan.
- Trained eighty (80) Environmental Health staff /sub-grantees in Community Led Total Sanitation (CLTS)
- The Environmental Health staff (EHD) in the fifteen districts were trained in Open Defecation Free (ODF) verification and revised the verification tool
- Undertook a learning journey for technology improvement of sanitation facilities – Ecological Sanitation (Ecosan) in the districts of Kabarole, Kyenjojo, Kyegegwa and Kamwenge.
- Trained the Environmental Health staff / sub-grantees at district level in ODF verification.
- Supported seven (7) districts in planning and budgeting
- Held one retreat for Environmental health staff
- Held one inception workshop for the new districts of USF programme.
- Carried out quarterly technical support supervision to all the fifteen USF districts and emergency supervisions as required.
- Fifteen districts monitored by the Programme Coordination Mechanism (PCM)
- Held weekly the USF and EHD meetings every Monday morning.
- Held Country Programme Monitor monthly meetings.
- Attended departmental meetings
- Compiled and submitted the USF semi-annual report to GSF Management.

**Annex One. Table 1: Status on monitored indicators 2013/14**

Indicator	FY 2011/12		FY 2012/13		FY 2013/14		Cum. total Achieved	5 year target	Achieved (%)
	Target	Achieved	Target	Achieved	Target	Achieved			
Villages triggered	1,025	934	1,397	1,605	957	1,441	3,980	5,827	68.3
Villages declared ODF	1,025	354	1,977	800	1,855	831	1,985	5,827	34.1
People living in ODF areas	615,000	212,400	1,186,200	480,000	1,113,000	498,600	1,191,000	3,496,200	34.1
New latrines constructed	40,000	25,685	53,580	55,656	54,711	65,774	147,115	245,473	59.9
Additional Population using latrines	240,000	154,110	267,900	278,280	273,555	328,870	761,260	1,227,363	62.0
New hand washing facilities	100,000	43,150	120,012	65,478	147,134	102,038	210,666	550,030	38.3
Households hand washing with soap	100,000	57,179	120,012	73,863	139,777	109,750	240,792	550,030	43.8
Latrine coverage (%)*	70.2	72.9	78.0	79.0	82.4	89.3	89.3	100	89.3

## Main Achievements

- The overall achievement was increased latrine coverage from 71.12% in 2012/13 to 74% in 2013/14.
- Hand washing with soap from 29% in 2012/13 to 32% in 2013/14.
- Reviewed the Public Health Act of 2000; draft copy available and has been presented to the Legal and legislative Technical Working Group.
- Carried out technical support supervision in the districts of Masindi, Hoima, Kiryandomgo, Bullisa, Bududa, Mbale, Budaka, Manafwa, Rakai, Lyantonde, Isingiro, Masaka, Buikwe, Kayunga, Buramburi, Amuru, Gulu, Bulisa, Nwoya, Sironko, ,Buhweju, Ibanda, Kamwenge and Kabarole
- Coordination of sanitation and hygiene activities internationally for example Sanitation and Water for All in Washington DC; the World Health Assembly in Geneva.
- The Global sanitation Fund programme approved the expansion proposal of the USF programme to 15 additional districts with funding of USD dollars three (3) million for grants and centrally procured activities.
- Carried out Open Defecation Free verification in the districts of Tororo, Nakaseke and Kamuli with support from Plan International and attended ODF sub county celebrations in Tororo district – Kwapa Sub County.
- Commissioned Gravity Flow scheme, Health units, houses constructed for Primary teachers in Bundibugyo district. (supported by World Vision)
- Attended the High Level meeting on Sanitation and Water for ALL (SWA) with the key sector Ministers and made commitments which included:

## An example of Sanitation promotion campaign in Kakuuto under WSDF- SW

WSDF-SW conducted a sanitation baseline survey as the first intervention in the ST/RGC to assess the general picture of the implementation area. From the analysed survey results, households without pit latrines were identified, and a sanitation action plan was made with the community leaders geared towards achieving the required basic sanitation coverage by ensuring the defaulters construct improved sanitation facilities.

The defaulting households are made to commit themselves by signing agreements as shown in the pictures below.

After the sanitation improvement campaigns, subsequent follow up on the previously defaulting households showed a great improvement in the sanitation of the house hold as shown in the pictures below;

*Figure 14: Pit latrines before and after campaigns*



*Before campaign*



*After campaign*

An end of implementation survey was carried out to confirm that the WSDF-SW basic sanitation standard had been achieved before preparing for the technical commissioning of the constructed water supply and sanitation scheme.

## Main Challenges

- Inadequate funding which has affecte transport of community extension staff environmental.
- Expensive technologies like ECOSAN, which are unaffordable by the community already burdened with many programmes.
- Delays in procurement of services, equipment and human resource.
- Inadequate skills capacity development

## Recommendations

- Provide GOU funding for USF programme to ensure sustainability
- Increase funding for environmental health sector sanitation and hygien to ensure sustainability
- Provide transport for extension staff whose work is mainly in community.

- The Ministry should increase resource allocation to environmental health sector to facilitate the implementation of their mandate, which is mainly mobilisation, sensitisation of communities, enforcement of PHA and prevention of disease.
- Therefore there is need to develop ways of capacity building, especially for the sub county staff who interface with the communities.
- There is need for the Ministry to review the non-subsidy policy to support the vulnerable households in sanitation facilities construction.
- Improve the supply of essential sanitation to the rural AH and vulnerable so that the rural households can have easy access to the facilities/technologies they want and at an affordable price for all. It may be necessary to support the rural households to access different financing, e.g. through MFIs, in order for them to construct improved sanitation facilities.

## **Conclusion**

Environmental Health Division is making steady progress towards achieving the HSSIP target (72% national latrine coverage). This is a result of combined efforts by MoH, Local Governments and Development Partners especially the Uganda Sanitation Fund. It is important to sustain good sanitation coverage and increase interventions like CLTS and PHAST in order to achieve 100% national coverage. This calls for increased funding to support district staff with transport in order to enhance their presence in the communities so as to ensure sustained acceptable sanitation practices.

## **Control of Diarrheal Diseases**

The main objective of the CDD component is to strengthen initiatives for control and prevention of diarrhea at all levels. Most diarrheal diseases such as acute watery diarrhea, cholera, dysentery and persistent diarrhea are mainly due to poor sanitation, poor domestic and personal hygiene.

### **Lead programme indicators of CDD**

- The incidence of annual cases of cholera was 1.53/ 100,000 persons. The cholera specific case fatality rate 2.3% (5,232 cases and 121 deaths).
- The incidence of annual cases of dysentery reduced to 148/100,000 persons (A total of 50,453 endemic dysentery, non outbreak type. Epidemic dysentery incidence was zero).
- Dysentery specific case fatality rate.
- Acute watery diarrhoea specific case fatality rate

## **Key Outputs**

- Communities sensitized on diarrhea prevention and management.
- Guidelines for prevention and control of diarrhoeal diseases disseminated to communities.
- Health workers trained in early diagnosis/identification and confirmation, case management of diarrhoeal diseases.
- Diarrheal disease outbreaks controlled (cholera and epidemic dysentery)

## Major challenges during FY 2013/14

- **Adverse weather conditions** resulting in population displacement, destruction of sanitary facilities and contamination of water sources. This was quite pronounced in Kasese and Ntoroko districts.
- **Inadequate operation funds** at central and district level – to support diarrheal preventive and control activities. Diarrhea can be prevented through implementation of elements of primary health care. The Primary Health Care funding at district level has stagnated yet population has increased.
- **Inadequate human resources** in most districts to implement priority interventions. Many districts have gaps in staffing levels of health inspectors, health assistants and public health nurses.

## Recommendations

- Through strengthening collaboration with other key stakeholder such as Ministry of Local Governments, Water natural resource and environment, Ministry of Education and Sports, religious leaders, private sector etc
- Advocacy for recruitment, deployment and retention of environment health staffs; additional funding for preventive activities.

## Epidemic Disaster Prevention, Preparedness and Response

**Mandate:** Prevention, mitigation and response to Public Health Emergencies

### Highlights of planned activities

The section planned to conduct the following activities

1. Daily, weekly and monthly National Task force meeting to coordinate response and mobilize resources
2. Response to public health emergencies through provision of additional support (emergency medicines, capacity building, setting standards and technical guidance) to districts reporting major public health emergencies namely: epidemics, floods, refugees, displacements etc.
3. Follow up of districts at highest risk of major public health emergencies to strengthen preparedness and mitigate the health effects of disasters.

### Main Achievements

As a result of successful implementation of the above planned activities the following achievements were registered:

1. **Resettlement of Sudanese refugees in Northern Uganda:** The sector worked with other stakeholders to resettle over 60,000 Sudanese refugees in refugee camps in Northern Uganda. These refugees are still hosted mainly in the districts of Arua, Adjumani and Kiryandongo.
2. **Control and prevention of Meningococcal meningitis outbreak:** an epidemic of meningococcal meningitis was detected, confirmed and controlled through immunization of most at risk communities in Arua and Adjumani districts.

3. **Mitigation of the deadly floods in Kasese district:** Kasese district was affected by serious floods during the month of May 2014. During this period the district was supported to strengthen preparedness against epidemics as result no disease outbreak was registered due to floods.
4. **Control of cholera outbreaks in Moyo and Namayingo districts:** During the 4<sup>th</sup> quarter of the financial year 2013/14, the two districts reported outbreaks of cholera in villages along the shores of the Nile and Lake Victoria respectively. These outbreaks were as result of poor sanitation and hygiene in these communities. Detection was quick for both outbreaks and control achieved to zero cases within two weeks of confirmation of outbreaks. A total of 78 cases and 4 deaths and 110 cases with 2 deaths were recorded in Moyo and Namayingo districts respectively. Efforts to consolidated activities to prevent similar outbreaks in future are ongoing in these districts.

### **Challenges**

1. Refugee influx constraining available resources in host districts. The new comers also come with new disease conditions such as cholera, meningitis etc
2. Inadequate enforcement of bi-laws on sanitation at district and lower levels
3. Settlement of communities in disaster prone areas eg Kilembe Mines, Bududa communities and others

### **Key Recommendations**

1. Promotion of peaceful mechanisms of conflict resolution within countries by neighboring states and regional bodies eg African Union.
2. Education of communities on hygiene and sanitation improvement
3. Additional funding to promote universal access to safe water and improved sanitation.
4. Promotion of public private partnerships in service delivery, environmental conservation etc.
5. Implementation of disaster risk reduction measures including disaster vulnerability risk mapping and resettlement of communities to safer areas.

## **3.2 Maternal and Child Health**

MCH cluster is composed of five elements: Sexual and Reproductive Health (SRH), Newborn care, Common childhood illnesses, Immunization and Nutrition. This emphasizes the link between maternal and child health and the cumulative nature of health problems through the entire lifecycle.

### **Sexual and Reproductive Health and Rights**

The right to sexual and reproductive health rights programme is important as it aims at reducing maternal mortality ratio, perinatal, and total fertility rate, and improve sexual and reproductive health of the people which are all key elements for achieving the MDGs 4, 5 and 6.

Figure 15: Variations in proportion of pregnant women completing IPT2 by district FY 2013/14

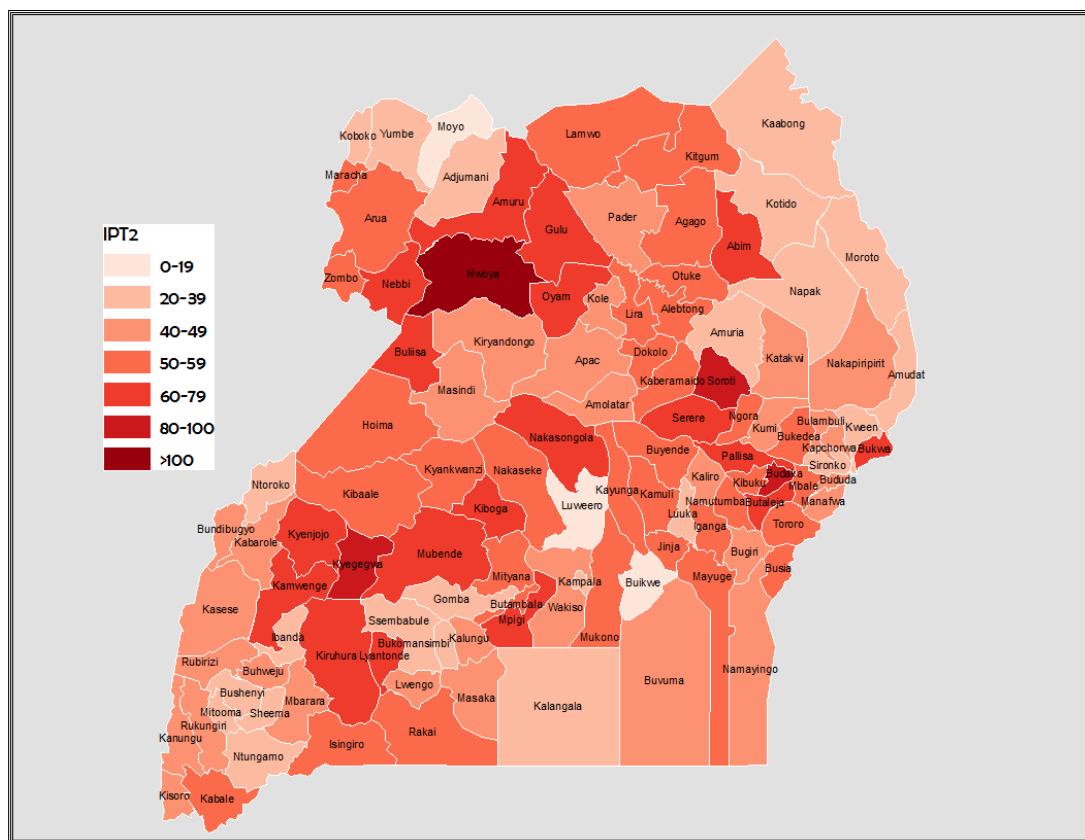
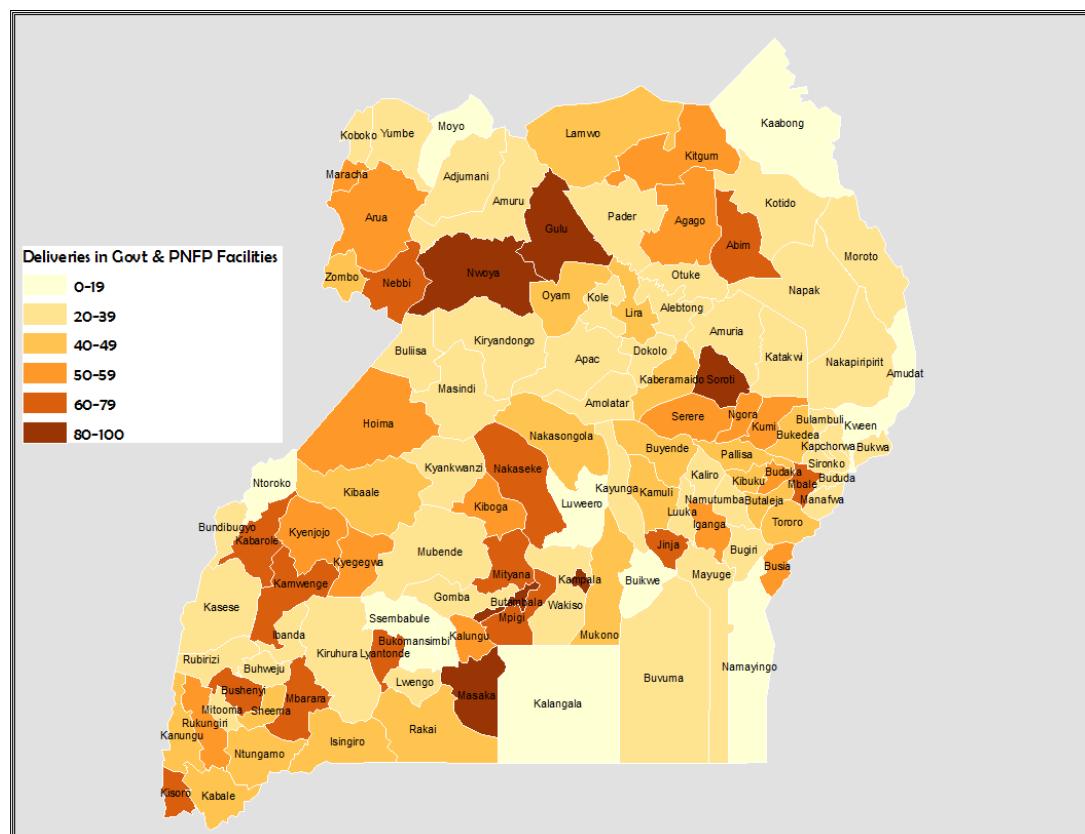


Figure 16: Variation in proportion of expectant mothers delivering in health units FY 20013/14

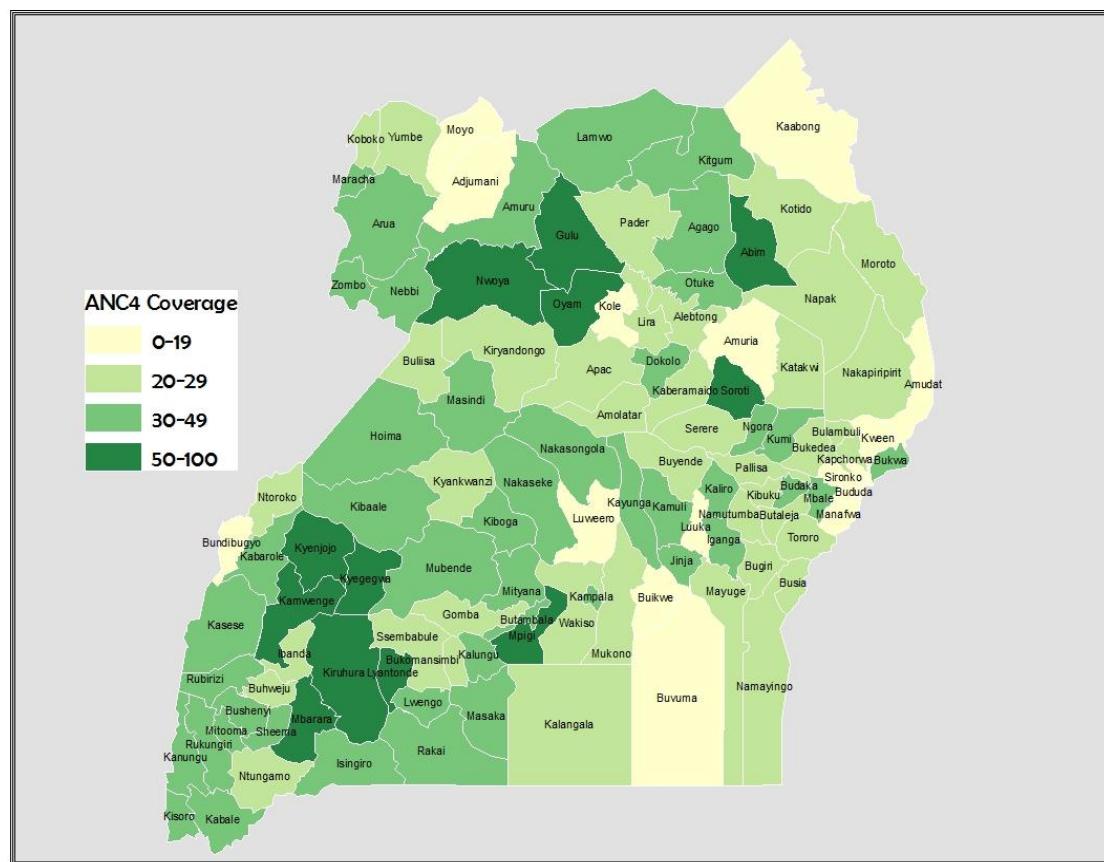


## Lead Programme Indicators

- The proportion of health facilities with no stock-outs of essential RH medicines and health supplies increased from 35% to 70% by 2015.
- The proportion of health facilities that are adolescent-friendly increased from 10% to 75% by 2015.
- The percentage of health facilities with Basic and those with Comprehensive emergency obstetric care increased from 10% to 50% by 2015.
- The proportion of pregnant women accessing comprehensive PMTCT package increased from 25% to 80%.
- The unmet need for family planning reduced from 41% to 20% by 2015.
- The rate of adolescent pregnancy reduced from 24% to 15% by 2015.

*Figure 17: Variation in percentage of pregnant women attending ANC 4th visit by district*

Financial Year 2013/14



## Main achievements

The was significant improvements in deliveries at in public and PNFP health facilities, skilled attendance at birth, contraceptive prevalence rates and reduction of unmet need of Family planning as map shown above. At least 95% of pregnant women attended 1<sup>st</sup> ANC visit making it possible to maximize several interventions including EMTCT.

This has greatly improved availability of Reproductive Health commodities including contraceptives thus reducing stock out rates at facilities. There has been increased funding especially by the Government of

Uganda from \$ 3.3 million to \$ 6.9 million. The Development Partners also increased funding for these commodities as follows: UNFPA \$ 7.5 M and USAID \$ 8 M.

Recruited additional critical cadres (196 doctors, 1,067 midwives, and 53 anesthetics officers) to offer RH services among other cadres that were recruited. 100% of hospitals offer comprehensive EmONC while all HCIIIs offer basic EmONC

A total of 474 maternal deaths and 161 perinatal death reviews were carried out in all regional referral hospitals and selected general hospitals as a quality improvement tool so that mothers do not die of the same conditions by addressing the identified gaps.

Health providers were mentored on the new technologies and new equipment on Emergency Obstetric and Newborn Care, Post abortion Care, Long Term and Permanent Family Planning Methods and scale up Maternal and Perinatal Reviews.

### **Newborn and Integrated Child Survival**

The Sector and Integrated Child Survival element is to increase coverage of high impact evidence based interventions order to accelerate the attainment of MDG 4, promote proper growth and early child development.

### **Child and Newborn Health**

Disseminated and monitored the implementation of the Child Survival Strategy (CSS)

Implemented the global “call to Action” recommendations to align the CSS with the RMNCH sharpened plan 2013-17.

- The RMNCH sharpened plan was launched in November 2013 by the Vice President.
- Printed 900 copies of the RMNCH sharpened and disseminated the plan in 34 districts through orientation meetings
- Formulation of policy frameworks and guidelines for promotion of child health interventions
- Updated IMCI computer assisted curriculum to include sickle cell and HIV
- Participated in the development of School Health Policy
- Coordination of intervention/thematic policy across child health concerned departments
- Develop the diarrhea and pneumonia prevention, protection and treatment (PPT) communication strategy and implementation framework.
- Establish and oriented Sub-Committee on Child Health Adversity
- Monitor implementation to provide corrective feedback and inform policy adjustments
- Revised by producing a more integrated child health supportive supervision checklist
- Developed newborn care quality of care indicators
- Streamlined HMIS approach to include all aspects of work assigned to VHT implementing ICCM
- Conducted 1 integrated child health district supervision visit covering 4 regions (Central 1&2, S. West and Karamoja)

Increased community access to child survival interventions and commodities

- Conducted a national ICCM program review
- Supported introduction of VHT quarterly meetings for reporting &refresher sessions in 8 districts.
- Designed a pilot for integrating iCCM medicines in the national SCM system in 4 districts
- Conducted family health days in 20 districts, child days plus in the rest of the country

Increase capacity of facility-based HWs to manage common childhood and newborn illness.

- Revised in-service newborn care HBB+ curricula to include postnatal care and extra care for sick
- In-service training for improved management & processes (triage) of severe disease 9 Facilities
- Conducted a quantification of new-born equipment and supplies for HBB plus implementation
- Conducted a Quality Improvement & technical training on the Use of Antenatal Corticosteroids during preterm birth for health facility QI teams of 7 sites in 5 districts (Mulago NRRH, Mubende and Hoima RRHs, Kiboga and Kayunga Hospitals, and Kiganda HC IV and Busaana HC III.

### **Build knowledge base on critical areas of child survival**

Conducted wave 1 of the operational research to strengthen evidence base for community and district empowerment for scale-up (CODES) to increase coverage of child survival interventions in Uganda.

### **Key challenges**

An analysis of key bottlenecks under child health include

- Inadequate staffing / access: both at the division and lower levels – most posts are not filled.
- Inadequate transport and funding for national level coordination and conducting supervision.
- Inadequate health commodities at community services level mostly ORS and Zinc; at population services level vaccines; and at clinical services level availability blood and treatment of common illnesses (e.g. ACT). Most of these are attributed to inadequate supervision to district as well as national stock-outs.
- Low initial utilisation / timely continuous coverage: utilisation bottlenecks are the most serious for child health. For example while many-intervention suggests a strong demand, there is a significant dropout. Hard-to-reach areas are being increasing covered during outreach sessions and Child Days Plus (CDP), but delays and lack of funds for outreach allowances are common. Distances that must be travelled to reach HC, staffing/skills gaps as much as demand affects the ability of the health system to regularly provide the service and ensure timely, continuous utilisation of services.
- Effective coverage: high dropout rates affects effective coverage, and is often entrenched in child care practices and expanding and ensuring regularity of outreach services alone may not be enough. A strong community link is critical to improve the timeliness of services. Across all healthcare levels data highlight a need for additional effort to scale up and maintain community health worker skills.

## Child and Newborn Health Progress FY 2013/14

The mandate of Child health is to ensure survival, development, growth and rights of children, by reducing under-five deaths to 56; infant deaths to 41; and neonatal deaths to 20/1,000 live births by 2015.

Child mortality has reduced markedly in last ten years although the current rate of reduction is insufficient to achieve the MDG4 target of under-five mortality of 56 per 1000 live births by 2015; an annual reduction of 1.8% compared to 9.1% needed. The reduction in under-five mortality over the decades is least in neonates. Over 70% of child mortality is due to malaria, pneumonia, diarrhoea, malnutrition, HIV/AIDS, and neonatal diseases (including sepsis, birth asphyxia, birth trauma, pre-term birth/low birth weight). Malnutrition and AIDS indirectly contributes to 60% and 27% of the mortality by increasing the vulnerability and severity of childhood illnesses, respectively. Previously, vaccine-preventable diseases, particularly measles, were among the major causes of under-five mortality but their impact on mortality has been greatly reduced.

*Annex One. Table 2: Status of child and neonatal health indicators*

Indicator	Status 1991	Status 2013	Target 2015
Neonatal mortality (per 1000 live births)	32	27	20
IMR (per 1000 live births)	85	54	41
UFMR (per 1000 live births)	156	90	56
Underweight among Under Fives	23%	14%	%
Stunting among Under Fives	38%	33%	%

### Focus of child survival strategy

To achieve the above objectives, the ministry developed the child survival strategy that emphasizes universal access to seven priority high impact, evidence-based interventions: 1) Newborn care 2) Infant and Young child feeding including micronutrient supplementation 3) Prevention of malaria using insecticide mosquito nets and presumptive treatment of malaria 4) Immunization including introduction of newer vaccines 5) Management of common childhood illnesses and care for HIV exposed or infected children 6) Prevention of mother to child transmission of HIV and 7) Water and sanitation

**Three delivery modes** have been selected to address child survival intervention coverage and equity gaps: family and community oriented services; population oriented services; and individually oriented clinical services

The child health division has four programs/units: Control and prevention of Diarrhoeal Diseases; Nutrition; Integrated Management of Childhood and Newborn Illnesses/ conditions and School Health. The division is currently constrained due to under staffing (0/4 PMO, 1/4 SMO, 1/2 CO, 2/3 Nutritionist), lack of transport (1 land cruiser donated by UNICEF (recently this one has been deployed to the ministry pool), 1 vehicle borrowed from PD and one rundown pickup and very old non functioning office equipment.

**Child and Newborn Survival Strategy** was developed in line with the HSSIP. The strategy is being introduced through Middle Level Managers training for Child Health and district sensitization meetings. A total of 26 managers have been trained. A quarterly child health newsletter/dialogue has been introduced to raise awareness and advocate for the strategy.

In May 2004 the MoH introduced the **Child Health Days** strategy to increase coverage of population oriented schedulable services for child health including vitamin A supplementation, immunization, de-worming of children 1-14 years and promotion of key family care practices. Uganda receives donation of 9M doses of Mebendazole a year and Vitamin A. All districts implement child health days, in April and October, but with varying degrees of performance. Current average coverage lies at 36%. However, the timeliness and quality child days' information, inadequate health worker capacity and lack of district resources to effectively assimilate CD in district activities remain a challenge.

**Newborn health and survival** the MoH has introduced an educational program aiming at equipping birth attendants with skills in resuscitating newborns - Helping Babies Breath (HBB), which impacts the three major causes of neonatal death: intra-partum-related events (asphyxia), serious infection and complications of pre-term birth. Fourteen (14) national and 18 regional HBB trainers have been developed to conduct health worker mentoring. URC/HCI is helping Uganda to roll this out in 2 districts and community HBB is being explored for hard to reach areas like Karamoja. Newborn care service standards and clinical auditing, perinatal death audit complement and address systems issues.

**Integrated Community Case Management (iCCM)** launched in July 2010 iCCM includes provision of first line anti-malarial based on rapid diagnostic tests for malaria, antibiotic for pneumonia, ORS and Zinc for diarrhea by VHTs. Training and supervision, provision of necessary commodities provides access, reduces treatment gap, and augments treatment standards for these diseases, plus routine newborn care through postnatal VHT home visits in the first week of delivery. ICCM is currently in 23 districts. UNICEF, CIDA, MC, IRC are helping Uganda to roll this out in 23 districts. There are challenges on reporting and quantification of medicine needs, ensuring availability of color-coded pre-packaged age specific medicines, suitable for VHTs.

**Integrated Management of Childhood Illness (IMCI)** is a key strategy for improving health worker skills in regard to assessment and management of common childhood illness including HIV and preventive measures like immunization, counseling on infant and young child feeding, vitamin A supplementation and de-worming all provided in an integrated manner. The 2nd and 3rd component of IMCI relate to strengthening health systems and community issues. IMCI is largely decentralized but in most districts IMCI training has seemingly stalled due to inadequate funds. The referral/hospital package for IMCI includes training on **Emergency Triage and Treatment (ETAT)**.

### **Uganda National Expanded Programme on Immunization**

The mission of UNEPI is to contribute to the reduction of morbidity, mortality and disability due to childhood diseases to levels where they are no longer of public health importance.

The programme objective is to ensure that all children and women of child bearing age are fully immunized against the vaccine preventable diseases and all babies are born protected against neonatal tetanus and fully immunized before their first birth day.

### **Highlights of planned activities during the FY 2013/14**

- Procurement of Gas cylinders and spares
- Support supervision to strengthen management of Immunization services
- Cold chain maintenance

## **Program management**

- Updated the two year coverage Revitalization plan focusing on priority activities that contributed to an improvement of routine immunization performance.
- Transferred GAVI ISS funds to all districts for two quarters to support outreach activities, support supervision visits by DHTs to health facility level, cold chain maintenance and development of REC micro plans.

## **Service delivery**

- GAVI supported accreditation of private health facilities in Kampala to inform allocation of HSS procurement as part of the process to expand service delivery beyond the public sector.

## **Vaccine supply and quality and other EPI logistics**

- Conducted cold chain maintenance in 62 Districts: Repaired 28 refrigerators from the central workshop and returned them to their respective Districts.
- In partnership with the Clinton Health Access Initiative, we conducted Cold chain inventory that highlighted the existing cold chain capacity in all Districts and gaps that will be filled after the procurement of cold chain equipment.

## **Advocacy and communication**

- The fourth Africa vaccination week cerebration in Uganda was hosted in Sheema District (21st-27th April, 2014) one of the poor performing districts. This opportunity resulted into supporting the district to develop costed community health facility micro plans that are supported by partners to improve the performance of routine immunization.
- The Immunization Communication Strategy was developed and has been rolled out to all districts for implementation.

## **Surveillance**

- Conducted AFP surveillance which is a foundation for IDSR activities in the country. At the national level polio certification indicators have been achieved non polio AFP rate of 3.15 and stool adequacy rate of 85%. With support from WHO the Stop (STOP 42 and 43) transmission of Polio teams active case search was conducted in 38 Districts, recommendations made and key activities were implemented to strengthen AFP surveillance system within the national IDSR system. In addition National STOP team missions were deployed to 43 districts with suboptimal performance.
- Surveillance review meetings were conducted in 4 regions namely Mbarara, Soroti, Arua and Masaka.
- Four sentinel surveillance sites for new vaccines continued to provide data on the burden of disease of Haemophilus influenza type b and streptococcal pneumonia while one site provided data on rotavirus.
- Provided 20,000 carbonated surveillance AFP forms to all districts.

## **Monitoring, supervision, evaluation and operational research**

- Established regional EPI/ NUTRITION support supervision teams under the regional EPI/IDSR support supervision hubs as an interface to strengthen immunization service delivery and EPI surveillances using catchment areas of regional referral hospitals. A total of 200 supervisors with an average of 20 supervisors per region were trained are currently supported by CIDA funds through UNICEF. The supervisors will be responsible for visiting all health facilities within their catchment area. This is an additional support to the already existing EPI/IDSR regional supervisors (9) housed within the regional referral hospitals who conduct monthly support supervision visits in high priority health facilities.
- Provided feedback on EPI performance for the entire country through a newspaper pullout on 27th April 2013.

## **Strengthening human and institutional resources**

- Conducted trainings of 15 tutors representing 15 schools schools & for trainers at central level and developed a draft EPI curriculum using the WHO prototype.

## **Sustainable financing**

### **Introduction of new vaccines and technologies**

- PCV10 was rolled out to 112 districts as of end of July 2014, Submitted IPV GAVI proposal and Submitted application for HPV that was successfully approved for support for national roll out in 98 districts in 2015.
- The program submitted a proposal to GAVI to request for support to introduce at least one dose of IPV as part of the polio endgame.

## **Accelerated disease control activities**

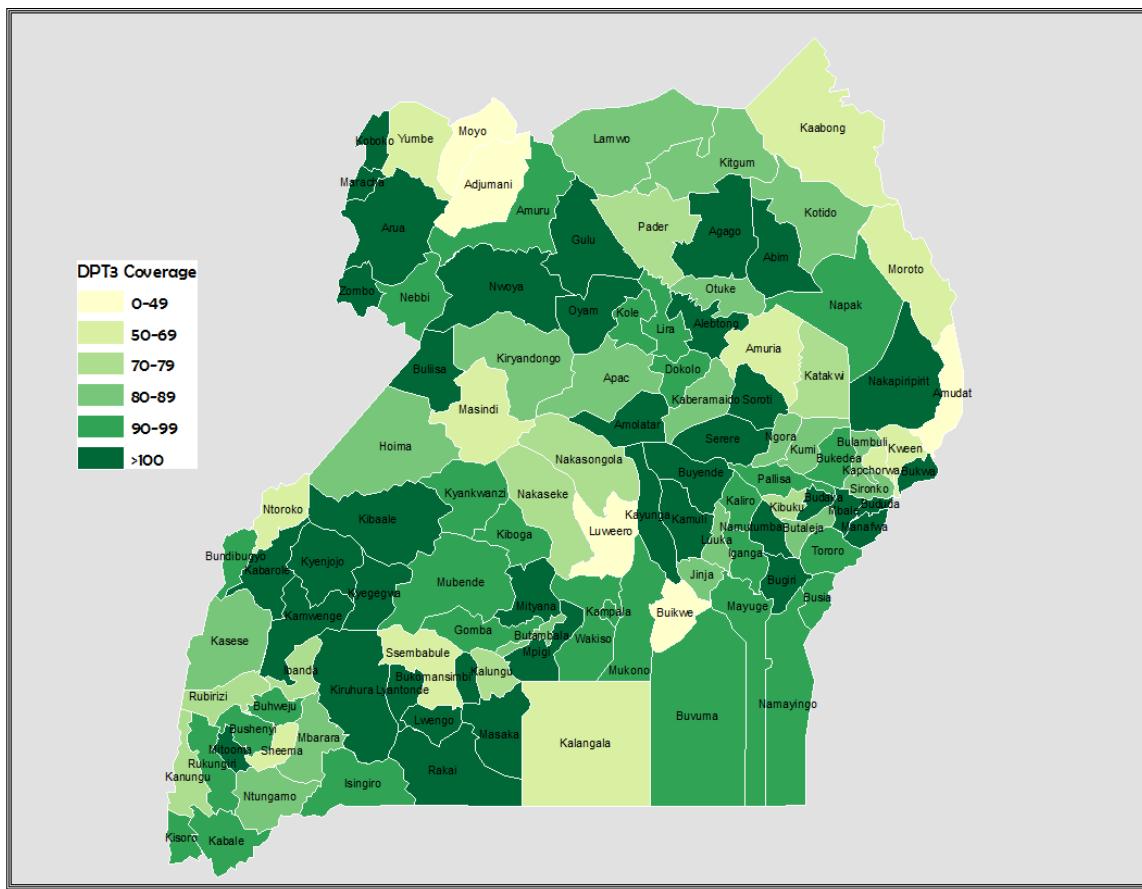
- Two rounds of polio SIAs were conducted in 37 high risk districts following a confirmed polio outbreak in the Horn of Africa. Independent monitoring coverage was above 80% for both rounds (92% for round one and 94% for round two) with 54% and 66% of the districts having achieved a coverage of >95% respectively.
- The three national polio committees (NCC, NPEC and NTF) continued to support the program to oversee the implementation of the polio eradication initiative.
- Accelerated Vaccination activities -

## **Performance of lead indicators**

### **The performance for FY 2013/14 is as below;**

- DPT3 coverage at 100.5% compared to a target of 88%
- DPT1-DPT3 dropout rate at 6.2% compared to a national target of 8%
- BCG coverage at 103.5% Compared to a target of 94%
- Measles coverage at 96.7 compared to a target 88%
- TT2+ in pregnant women of 33.7% compared to a national target of 75%

*Figure 18: Variations in performance of Pentavalent Coverage by district FY 2013/14*



## **UNEPI challenges**

- Inadequate and delayed release of funds impacting on implementation of various activities as a result of delayed submission of accountabilities.
  - Human Resource constraints at all levels in terms of number and immunization skills.
  - Lack of legislation on immunization.
  - Low stock levels of vaccines at district level due to wrong quantification and at the health facility level due to irregular last mile distribution.
  - Lack of monitoring tools like Child Health Cards, TT cards, Child Registers, Vaccine and Injection Materials Control Books and Tally sheets.
  - Influx of refugees into the country puts pressure on existing resources and is a risk of importation of Vaccine preventable diseases.
  - Lack of transport e.g. vehicles and motorcycles for EPI activities at all levels resulting from delayed procurement process of GAVI HSS funds that should have addressed this challenge.
  - Inadequate social mobilization activities for uptake of routine immunization services.
  - Lack of a budget line for procurement of cold chain spare parts and tools.
  - Operation funds for immunization program not protected at all levels.
  - Delayed submission of accountability for GAVI and other donor funds by Districts.

## **Key recommendations**

- Enhanced Implementation of the Revitalization plan 2013-2014 focusing on priority actions to reverse the trend of poor immunization performance in the country.
- Strengthen routine immunization (RI) using cost effective interventions namely: the Reach Every District (RED)/Reach Every Child (REC); Periodic Intensified Routine Immunization (PIRI) and Child health Days (CHDs) Strategies.
- Strengthen collaboration and coordination between the centre and districts for optimal utilization and accounting for GAVI and other donor funds disbursed.
- Continue capacity building for both pre - service and in-service.
- Cross border meetings and surveillance.
- Special attention to hard to reach areas and areas with large numbers of unimmunized children (implementation of RED).
- Special attention to special groups e.g. Children in refugee camps and disaster struck areas.
- Improve data quality and use for action through providing all EPI data collection tools, regular feedback, focused technical supervision and training of data management human resource.
- Conducting preventative polio SIAs in high risk areas and one round of NIDs.
- Continuous strengthening of Surveillance activities is vital.
- Continue regular support supervision to all districts but with a focus on poorly performing districts.
- Conduct measles follow up campaigns.
- Conduct an EPI coverage survey, EPI review, PEI with clear recommendations that would feed into a new cMYP.
- Continued scale up of the Reach every child strategy and development of health facility level-community immunization microplans.

## **Nutrition**

Implementation of nutrition interventions to scale up delivery of nutrition services involves the MoH and other stakeholders.

### **Core HSSIP indicator**

- % U5 children with height /age below lower line (stunting). Achieved 33%, UDHS 2011
- % U5 children with weight /age below lower line (wasting). Achieved 14%, UDHS 2011

### **Lead programme indicators**

- Maternal Infant and Young Child Feeding practices improved (Exclusive breastfeeding, Timely introduction of complementary feeds).
- Accessibility to appropriate and gender sensitive nutrition information and knowledge increased.
- Vitamin A Supplementation coverage among children 6-59 months.
- Households consuming fortified foods (Salt, cooking oil, wheat flour) increased.
- Nutrition services to health units and the community scaled up.

*Annex One. Table 3: Planned activities in FY 2013/14 as per work plan*

<b>Planned and Achieved activities</b>	<b>Remarks</b>
Held six meetings for World Breastfeeding week and participated in National commemoration of Nutrition Events on World Breast Feeding Day and African Food and Nutrition Day.	Activity carried out in Namutumba August 2013 with support from UNICEF, WFP, SPRING,USAID,WHO
Coordinated the 6 meetings; <ul style="list-style-type: none"> <li>▪ 2- Anemia stakeholders meetings</li> <li>▪ National Working Group for Food Fortification Meeting.</li> <li>▪ 3- Workshops on introduction of Micronutrient Powders in Uganda.</li> <li>▪ - ECSA meeting on monitoring of food fortification indicators at House Hold (HH) using existing surveys such as HH consumption survey by UBOS.</li> </ul>	Carried out with support from UNICEF, WFP, SPRING, ECSA
District Orientation carried out on Nutrition status and the Accelerating Nutrition Intervention carried out in all the 6 districts.	WHO ANI funding. Activity is implemented report and accountability in place.
Advocacy and awareness campaign on nutrition in South West Uganda- Bushenyi district through Nutrition Marathon done.	Activity successfully carried out with support from UNICEF, World Vision, USAID-SPRING, WFP, SAMONA, MTN, Hon. Karooro Okurut, and Minister of Gender, Labor and Social Development and other political and Administrative leadership of Bushenyi district.
Equipment and supplies procured and delivered to Bushenyi district for implementation of Integration of Management of Acute Malnutrition (IMAM) 100 Weighing scales. <ul style="list-style-type: none"> <li>▪ 100 Height boards.</li> <li>▪ 50 boxes of Plump nut – 50 boxes</li> <li>▪ F100, and F75</li> <li>▪ 5 Patients Examination beds/coaches.</li> <li>▪ 2 Delivery bed</li> <li>▪ Drugs: Dewormers 5,000 doses of (Albendazole &amp; Mebendazole.</li> </ul>	Support from UNICEF and World Vision Uganda.
To strengthen the monitoring, Evaluation and Surveillance System  Progress indicators in regard to stunting, wasting, low-birth weight, breastfeeding, anaemia and overweight were outlined from various registers of the reviewed HMIS. This was done to track the mentioned output indicators periodically using the HMIS.	Supported WHO ANI funding
Training for National stakeholders from Health, Agriculture,	Activity carried out using WHO

<b>Planned and Achieved activities</b>	<b>Remarks</b>
Academia NGO's and CSO was done in planning, budgeting, and implementation of nutrition activities	funding under the Accelerating Nutrition Interventions Project/support.
Training of Health Care Providers on Integrated Management of Acute Malnutrition (IMAM), 100 Health care workers trained on Integrated Management of Acute Malnutrition in Bushenyi	Training was successfully carried out jointly with a team from Mwanamugimu Unit with support from World Vision Uganda
Did train 30 Inspectors from MOH-Health, URA, and UNBS border point on regulatory monitoring for food fortification.	With USAID –SPRING support.
Final Draft of the Guideline for Industries and Importers to implement Mandatory Food Fortification Regulation completed.	The activity carried out successfully with support from USAID-SPRING
Drafted the Food Fortification Monitoring and Evaluation Framework in place.	Activity carried out successfully with support from USAID-SPRING
Adapted a WHO training module for planning and managing programmes to improve maternal, Newborn, Child Health and Nutrition in place.	With support from WHO funding under the Accelerating Nutrition Interventions Project/support.
Formative research has commenced on Finalization of draft package design, training materials and acceptability of the micronutrient powder in Amuria and Kanungu.	With support from WFP
Carried out Support supervision for IMAM in each of the fifteen (15) districts: Mityana, Sembabule, Mpigi, Nakasongola, Luweero, Kayunga, Kamuli, Mayuge, Kaliro, Bugiri, Kyenjojo, Kasese, Kamwenge and Kalangala.	Activity carried out successfully,
Technical Support supervision for IMAM in each of the 6 Early Riser districts (Nebbi, Pader, Kanungu, Ibanda, Oyam and Dokolo) was carried out.	Activities completed.
Carried out a 5 days joint technical support supervision on Nutrition and EPI involving National and district supervisors targeting all health care providers trained in implementation of the program.	Regional Support Supervision on Nutrition and EPI improved.
32 members were oriented and trained on the tool to assess the district capacity in implementation of nutrition activities and also map nutrition interventions implemented within the 6 WHO- ANI supported districts: (13 members from the 6 districts of Luuka, Iganga Namutumba, Masindi, Hoima and Kibaale. 20 members at national level from MoH, Academia, MwanamugimuUN agencies and NGO's).	WHO funding under the Accelerating Nutrition Interventions Project/support. Report and Accountability submitted.
A 3 Days pretest which targeting district leadership involved in implementing nutrition specific and sensitive activities at different levels was carried by 6 national members from MoH, academia, Mwanamugimu, UN agency and NGO's.	WHO funding under the Accelerating Nutrition Interventions Project/support. Report and Accountability submitted.

### **3.3 Performance of the lead programmatic indicators**

#### **Prevention and Control of Communicable Diseases**

The overall objective for the communicable cluster is to reduce the prevalence and incidence of communicable diseases by at least 50% and thus contribute towards achieving the health related MDGs.

The priority health care interventions in the cluster of prevention and control of communicable diseases include; prevention and control of STI/HIV/AIDS, malaria, tuberculosis, elimination and or eradication of some particular diseases such as Leprosy, guinea worm, onchocerciasis, trachoma, lymphatic filariasis, trypanosomiasis, soil transmitted helminthes and schistosomiasis.

#### **Prevention and Control of STI/HIV/AIDS**

The Ministry of health developed a Health Sector HIV Strategic Plan (HSHASP 2010/11-2014/15) to guide the Public Health response to mitigate the impact of HIV/AIDS through the provision of prevention, care, treatment and support services. The trend of new HIV infections (incidence) has been declining over the last three years from 162,294 in 2011 and 154,589 in 2012, to 140,908 in 2013, though this is still far from the NSP target of 71,510. HIV burden (number of people in the country living with HIV) increased from 1.2 million in 2011 to 1.6 million in 2013. The lower level health facility sites now contribute to about 59% of all enrolled ART clients in the country.

Coverage of ART treatment to mothers receiving PMTCT has improved with 96 %( 95,405) pregnant HIV positive women enrolled on ART in 2,260 sites countrywide. Improvements in retention of mother-baby pair at unified point of care is expected when the September 2013 revised ART guidelines are rolled out coupled with the use of the Mother-Child Health Passport for other SRH needs

The number of sites providing paediatric ART has almost tripled from 332 in 2011, to 834 in 2013, with at least 68% of districts having at least five paediatric ART sites. This is only 78% of the facilities providing both adult and paediatric ART; hence need to activate the remaining 240 accredited adult ART sites.

Strengthened laboratory services with the volumes of tests done doubling between 2011 and 2013, all HC-IVs and some HC-IIIs reached with Point of Care CD4 equipment and 78 laboratory hubs established to coordinate specimen referral for early infant diagnosis, Tuberculosis testing (with gene x-pert), and CD4, and soon clinical haematology.

The STD/ACP continues to provide leadership for the health-sector HIV Public health response through development and dissemination of guidelines and capacity building. This report covers four broad areas: HIV prevention, HIV treatment, care and support; Project management; Information systems and evaluation.

#### **Objectives of the STD/AIDS Control Programme**

- To prevent further transmission of the STD/HIV/AIDS epidemic
- To mitigate the impacts of HIV/AIDS through the provision of care and support to the infected and affected.
- To strengthen capacity for HIV/AIDS prevention and control at the national, district and community levels.

#### **Core HSSIP indicators**

- HIV Prevalence among pregnant women (19-24) attending ANC clinics reduced from 7% to 4%.
- The proportion of people who know their status increase from 38% to 70%.

- The proportion of people who are on ARVs increase from 53% in 2009 to 75% by 2015 among adults and from 10 to 50% in children less than 15 years of age.
- The proportion of children exposed to HIV from their mothers access HIV testing within 12 months increased from 29% to 75%.
- The proportion of pregnant women accessing HCT in ANC increased to 100%
- HCT services available in all health facilities up to HC III's and 20% of HC IIs (Proportion of health facilities with HCT services; Proportion of community structures with HCT services).
- ART services available in all health facilities up to HC IV and 20% of HC III by 2015. (Proportion of health facilities with ART services; proportion of HC IIs with ART services).
- The proportion of males circumcised increase from 25%to 50% (denominator is number of males in Uganda)
- Reduce HIV prevalence from 6.7% to 5.5% in the general adult population (15-49 years).

### **Performance against core indicators**

- The proportion of people who know their HIV status increased for women from 13% in 2005 to 66% in 2011 and for men from 11% in 2005 to 44%. (UAIS, 2011).
- The proportion of people who are on ARVs increased from 72% in 2012 to 83% in 2013among adults and from 35 % to 41% in children less than 15 years of age over the same period.
- The trend of new HIV infections (incidence) has been declining over the last three years from 162,294 in 2011 and 154,589 in 2012, to 140,908 in 2013.
- HCT services available in all health facilities up to HCIIIs and to about 30% HC IIs (38% of health facilities with HCT services). All districts are implementing community level HCT; however, this is entirely dependent on the support from partners.
- PMTCT services available in all health facilities up to HC IIIs and 20% of HC IIs (% of health facilities with PMTCT services; % of HC IIs with PMTCT services).
- All hospitals, HCIVs, over 80% of HCIIIs and 30% of HCIIIs were providing PITC by March 2014.
- The 2011 AIDS Indicator Survey (AIS) revealed an increase in HIV prevalence among adults from 6.4% in 2004/05 to 7.3% in 2011/ 2. This trend is attributed to both new infections and improved survival as more People Living with HIV/AIDS (PLHIV) access antiretroviral therapy (ART).

### **Key output Indicators 2013/14**

- The trend of new HIV infections (incidence) has been declining over the last three years from 162,294 in 2011 and 154,589 in 2012, to 140,908 in 2013, though still far from the target of 71,510.
- The proportion of those enrolled on ARVs for eMTCT increased from 52% in 2011 to 72% in 2013.
- 1.4 million Ugandans have been circumcised since the launch of SMC as an HIV prevention strategy; an achievement way above the mid-target of 1.25million men (aged 14-49) to be circumcised by the end of 2013.

- Up to 2013, 8.2 million individuals had received HCT which is more than double the 3.5 million target set for December 2013. Fewer men than women (65.4%) are going for HCT
- Access to ART services increased through accreditation of more sites. The number of health facilities providing ART increased from 407 in 2011 to 1,478 by the end of 2013
- Health workers trained in HIV Care and treatment using the new WHO 3013 guidelines
- Laboratory support for HIV/AIDS care strengthened
- Annual Antenatal HIV surveillance conducted.
- Reduced the number of health facilities reporting stock out of HIV commodities (HIV Test kits and FDC ARVs for eMTCT) from 50% in July 2013 to less than 3% in June 2014.

### **Behavioural interventions**

The focus of behavioural interventions is to create demand and promote sustainable desirable preventive behaviours. STD/ACP finalized and implemented the Comprehensive HIV/AIDS communication Strategy, campaigns on the Elimination of mother to Child Transmission of HIV, Counseling and Testing in Kampala and Talk-shows conducted country wide. These interventions have greatly improved HCT and eMTCT uptake.

The STD/ACP also participated in national events such as Philly Lutaaya Day on October 30th 2013, the Candle light day held in Luwero, World AIDS day in Mbarara district in December 2013 which included dissemination of valentine HIV prevention messages in the print media. The National Condom Strategy was also finalized and disseminated. The strategy is aimed at increasing demand for male and female condoms, improving access to and utilization of condoms, strengthening the condom supply chain management and monitoring and evaluation. Overall the strategy will guide condom programming at the different levels.

### **Biomedical Interventions**

The biomedical interventions include Safe Male Circumcision, condom promotion, eMTCT, STD and Post Exposure Prophylaxis (PEP).

### **Achievements**

- Conducted Pilot couple counseling and testing using the VHT promotion Approach in Kamwenge and Amolatar districts with support from PEPFAR through Baylor & NU-HITES respectively.
- ToTs and training of health workers in the revised ART guidelines including the eMTCT revised service delivery model, Mother-Baby Care Point was conducted with support from Baylor,
- Data quality assessment for eMTCT was carried out in selected districts of Rakai, Ntungamo, Kaberamido and Arua with support from MEASURE
- District coordination and data quality meetings were organized and held with district managers from the South Western districts.
- Partners were coordinated through eMTCT National Organizing Committee meeting, M&E Subcommittee meeting, and weekly Option B+ meetings.
- Launched eMTCT campaigns by the First Lady and Champion of EMTCT in Uganda in 6 of the 10 sero survey regions.

- Established a real time reporting mechanism for tracking option B+ progress in Uganda under Public Health Emergency Operations center (EOC).
- Conducted two DQA for the PMTCT program during the period
- Rolled out the new PMTCT guidelines in line with option B+ in the entire country
- Finalized the longitudinal ANC register
- A total of 730,000 men were circumcised over the reporting period.
- The national action plan for sex work setting which was developed and has been disseminated and is being implemented.
- In the reporting period, revised PEP guidelines were disseminated.
- Infection control mentoring was conducted in 6 hospitals and 10 health centre IVs.
- A total of 80 health facilities received on site auditing of universal precaution guidelines.
- Scaled up the provision of STD services to target populations in Kampala city where over 4,000 Female Sex Workers (FSWs) received a comprehensive prevention and care package for STI/HIV services through outreaches.
- PEP guidelines reviewed and printed and are awaiting dissemination.
- Carried out mentoring and coaching of health workers in infection control including Post Exposure Prophylaxis in 5 hospitals in Kampala
- Developed the infection prevention and control manual and awaits stakeholder review.

### **Major challenges and constraints for HIV prevention**

- Condom fatigue coupled with complacency;
- Limited use of condoms among married couples
- Limited supply of condoms e. g for this year 2014, the need is estimated at 480 million but the commitments are less than half.
- Low demand and acceptance for the female condom
- Poor linkages between services including, PMTCT, Pediatric HIV services and ART
- Lack of proper follow up mechanisms for HIV positive mothers and their babies.
- Delay in reporting and poor reporting from some districts.
- Inadequate funding for HIV prevention and implementation of activities the country.
- Loss of funding from PEPFAR has slowed the implementation of some planned activities
- The perception that non-branded condoms are of poor quality.
- The need to increase the pace at which post shipment testing is done to allow clearance and prompt distribution of condoms from the ware house.
- There is limited coordination for HIV prevention at national and district levels.
- Shortage of IEC materials in both public and private health facilities.

- Inadequate STI drugs in most public facilities.
- Limited local community involvement in HIV prevention efforts.
- Irregular supply of HIV test kits.

## Treatment, Care and Support

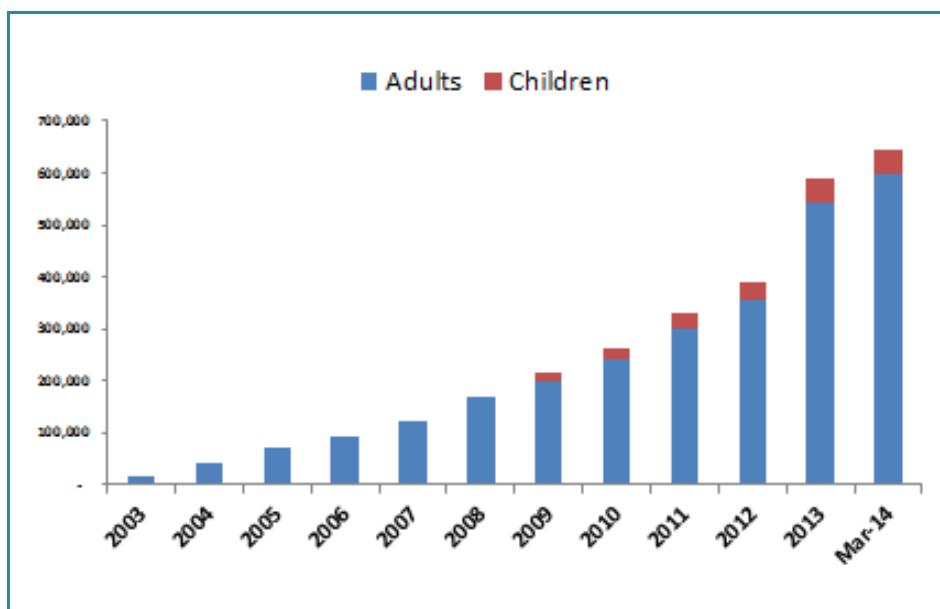
This component contributes towards improving the life of people living with and affected by HIV and AIDS for a healthy and productive life, this includes treatment of adults and children home based care and support for improved quality of life.

## Achievements

### Treatment

About 680,514 out of 821,721 people (Adults and children) are on ARVs by March 2014 representing about 83% of those eligible based on the 2010 WHO guidelines. However based on the revised ART initiation criteria, the current coverage for ART is 48% for all individuals (1,405,268) and 41% among children 0-14 years. This drop in ART coverage despite the increase in number of clients on ART is attributed to the change in eligibility criteria, and thus increased number of eligible clients.

*Figure 19: Number of active ART clients in the country: 2003 – March 2014*



- The number of facilities providing ART services increased from 735 by end of 2012 to **1,579** at the end of 2013. These facilities include two national referral, 13 regional referral and 110 of 140 general/district hospitals (79%), 187 of 206 (91%) HCIVs, and 999 out of 1309 (76%) HCHIs, and 236 out of 2777 HCII as well as 32 specialized HIV clinics. The number of facilities providing paediatric ART increased from 711 in June 2013 to 869 sites (December 2013).
- The percentage of estimated HIV-positive incident TB cases receiving both TB and HIV treatment improved from 34.2% in 2011 to 53.5% in 2012 (NTLP Report) and 60% between January and June 2013. However, the NSP target for 2014/15 is 80%.

### **Challenges:**

- Despite improvements in geographical coverage for ART, persistent disparities in sex, age and distribution of ART coverage remains.
- Low Paediatric ART coverage of only 41% of the estimated need is a challenge. This is due to limited capacity in many facilities especially the peripheral units for Paediatric care and treatment, frequent stock outs and loss to follow up.

### **Home Based Care**

- Initially in 85 districts covering mainly the CDC supported districts, the project expanded over the reporting period to include all districts benefiting from PEPFAR support and to date the BCP is being distributed in 99 districts in 334 care and treatment facilities which include facilities under new partners like STAR SW, STAR E, STAR EC, SPEAR and NUHITES. Overall 92,512 new HIV positive persons were reached with the Basic care package. By the end of December 2014, the PLP will have reached a total of 414 facilities across 103 districts.
- Support supervision to assess implementation progress of the Positive Living Project (PLP) was done in the districts of Kalangala, Mbarara, Ntungamo, Kabale, and Kisoro. This was mainly done in preparation for the integration of the PLP in the district-led programming to enhance government ownership. The overall goal of the project is to improve the health status of people living with HIV/AIDS in Uganda through provision of Basic Care Package (BCP) and promoting a positive living life style.

### **Nutrition Management**

- 100 Trainers of trainers in Nutrition Assessment Counseling and Support (NACS) trained.
- Developed IEC Materials for NACS
- Nutrition data elements mainstreamed in HMIS to enable tracking of malnutrition in the general population.
- Oriented staff in 6 districts in the revised HMIS tools for nutrition.
- Conducted 2 lessons for Partnership for HIV Free Survival (PHFS)
- Conducted monthly coordination meetings for the partnership
- Conducted M & E meetings for the partnership
- Reviewed package for the baby friendly health facility initiative (BFHI)
- Worked with NUHITES and IBFAN to support 50 facilities to attain baby friendly status.
- Conducted a rapid nutrition assessment in the private sector and disseminated the report, staff at these facilities have been trained in NACS.
- Plan is to ensure integration of nutrition intervention in the their facilities

### **Challenges**

- There is high staff attrition and internal redeployments.
- Limited resources to roll out the programme to all districts in the country.

## **Programme Management**

Programme management aims at entrenching effective leadership and management system in the programme. This entails improving the structure of STD/ACP, coordination and the supply chain management.

Following the restructuring process, all staff who were being supported by the CDC CoAg. were interviewed by the Health Service Commission and have been appointed by the Ministry to continue supporting the programme.

Quarterly coordination meetings were held by the different programmes to address the critical gaps and design action points. Meetings were held for condom programming, IEC/BCC, HBC, Strategic Information, ART and infection Control.

ACP Completed the Costed Extension application for Global Fund for July 2015 – May 2016; worth USD 75m, with focus on Commodities. Now the programme is the final process of writing a Standard HIV and TB Global Fund Application which will be submitted in October 2014.

The STD/ACP coordinated the costing of the remaining 2 years of the National Prevention Strategy with support from the World Bank and report produced (NPS-2013/14 and 2014/1) indicating a funding need of -\$685 million).

Using the same support, an implementation manual for implementation of Combination HIV Prevention (CHP) developed. The manual will guide implementers on how to undertake an institutional and population based assessment in preparation for planning; how to plan for implementation of CHP; how to implement CHP; and how implementation of CHP can be monitored and evaluated.

## **Information Systems and Evaluation**

The generation of strategic HIV information is critical for any effective programme. This involves routine programme data and that through special studies.

## **Achievements**

During the reporting period the following were achieved:

- The STD/ACP successfully costed the remaining two years of the National Prevention Strategy (NPS) with support from DFID through the World Bank. Through the same support the programme also completed the development of the Implementation manual for the NPS to guide districts and other Implementing partners in planning and implementation of combination HIV prevention. These documents are ready for printing and dissemination.
- The STD/ACP successfully implemented the 2013 round of sentinel surveillance. This implementation included the training of sentinel staff, provision of laboratory consumables, and provision of facilitation for sentinel staff, sample and data collection, supervision of field teams.
- The Mathematical data modelling process for making the 2013 non-HIV-prevalence estimates was finalised. This was preceded with a preparatory meeting conducted in South Africa and the Strategic Information unit was represented.
- A report for an HIV Sero-Behavioural Survey among fishing communities in Kalangala district was compiled and disseminated revealing an HIV Prevalence of 37.1%
- The STD/ACP programme attended an International Forum on Quality Improvement in London held in April. 3 Officers in ACP, 2 Officers in QA and 1 from META attended Forum. The QI Forum provides vital information sharing to improve service quality

- A national Quality Improvement conference was successfully conducted and over 1000 participants attended.

## **Constraints**

- Limited resources for special studies
- Long process of securing IRB approvals
- The withdrawal/suspension of CDC funding to the ministry affected the programme performance. This impacted on the staff moral in addition to affecting the planned coordination activities which could not implemented because of lack of funding.

## **Conclusion**

Overall the current interventions are consistent with four stipulated goals of the Health Sector HIV strategic Plan. The interventions implemented contributed to reduced HIV infections, improved quality of life to PLHIV, improved HIV response leadership and updated HIV strategic information. There is need for the MoH to fast track the implementation of the HIV and AIDS Prevention and Control ACT 2014 which will provides for the creation of an HIV trust Fund that will help leverage addition funding for the national response.

*Figure 20: Honourable Janet Kataha Museveni participating in a health check f to support eMTCT*



*Source: Ministry of Health photo-library*

### The district-led HIV/AIDS programming in Uganda:

#### ***Tapping on project support for Local Ownership, Better Coordination, Effectiveness and Efficiency in addressing health problems.***

Uganda has battled with the HIV epidemic for over 30 years now and there were significant gains over the years. There was a drastic reduction of the prevalence of the disease from 30% to about 6.4% in 2005/6. These gains were mainly achieved because of strong leadership and a multi-sectoral response that was driven by the government. In response to a global outcry for support to improve HIV response, PEPFAR I and the other G8 heeded to this call and increased spending on HIV leading to a rapid scale up of HIV services including provision of ARV's. As a result, there was a proliferation of vertical HIV programming supported by the AIDS development partners (ADP's) that was largely led by implementing partners.

The numerous implementing partners at the districts if not well managed lead to a lot of duplication of efforts at the facilities and districts. Although the partners have played an important role in supporting the districts in conducting some of its core roles; this has not been to a sufficient level. To mitigate this, the AIDS Control Program (ACP) has attempted to develop a rationalization process and strengthening its coordination roles at the national level. The latter however has not been replicated at the district level particularly the DHO's office because the districts have limited resources to discharge their mandate.

With the coming of PEPFAR paradigm shift, moving "contribution" and a ownership. Where means that the should be able to plan priority areas, oversee programming process, implementation and the M&E of finance the health sector the needs of the what is referred to as the **programming**.

Under the District led partners will have to declare the in the decentralized response at that common work plan and budget. For the by accessing the much needed "off medium term expenditure" on HIV through non Budget/project support. This information will be transmitted to the MoH in the bottom-up planning process. All the partners in the district will be mapped including their areas of support or intervention to avoid overlap and duplication of services. This will be aimed at further enabling the MoH achieve its objective of ensuring equity and universal access to quality comprehensive HIV/AIDS services by all people in the district and improving efficiency of resource utilization. This integrated approach to the delivery of public service will strengthen collective action. For the CDC funding, each of the parties will have clear roles and responsibilities clearly stipulated in the proposed District Operational Plan (DOP).

This will therefore lead to the full realization of country ownership; it will empower the districts to coordinate the HIV response, lead the process of joint planning with guidance from the AIDS Control Program and identifying district priorities to be supported other than those of partners, supervise and monitor the response and ensure that transparency and mutual accountability is achieved. CDC plans to support 53 districts with grants for the DLP and will work in partnership with the MoH and the Ministry Of Local Government. The funding through CDC should enable districts coordinate joint planning in a manner that is transparent and reduce on the potential for duplication through guidance of the AIDS Control Program.

*Country ownership means that the government entity should be able to plan for the country's priority areas, oversee and lead the programming process, manage and lead the implementation process, the delivery and the M&E of services as well as finance the health sector that is responsive to the needs of the population. This is what is referred to as the **District led programming**.*

II support, there was a away from "attribution" to major focus on country country ownership government entity for the country's and lead the manage and lead the process, the delivery services as well as that is responsive to population. This is **District led**

programming (DLP), all resources they intend to invest

level and this will be captured in a first time, the district's shall plan better by accessing the much needed "off medium term expenditure" on HIV through non Budget/project support. This information will be transmitted to the MoH in the bottom-up planning process. All the partners in the district will be mapped including their areas of support or intervention to avoid overlap and duplication of services. This will be aimed at further enabling the MoH achieve its objective of ensuring equity and universal access to quality comprehensive HIV/AIDS services by all people in the district and improving efficiency of resource utilization. This integrated approach to the delivery of public service will strengthen collective action. For the CDC funding, each of the parties will have clear roles and responsibilities clearly stipulated in the proposed District Operational Plan (DOP).

## Tuberculosis Tuberculosis and Leprosy Control Performance

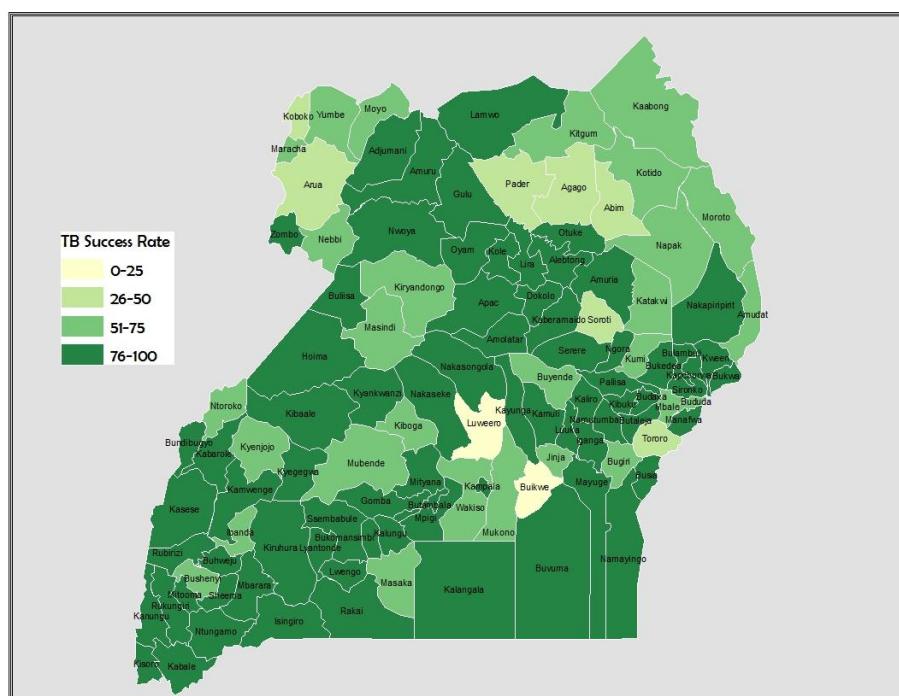
The NTLP has in the past conducted two comprehensive reviews that generated recommendations for programme improvement. The 2005 review focused on setting systems for strategic planning, resources allocation strengthening programme capacity for diagnosis and providing adequate treatment and control of TB in the country. The 2013 review recommendations focused on emergency action to strengthen systems for adequate treatment and control of TB to prevent escalation of multi-drug resistant TB (MDR-TB) in the country.

In the review period, the programme's priority focus for TB and leprosy prevention and control was addressed through the following objectives and corresponding interventions.

#### **Planned activities and achievements**

- Strengthen and scale-up services for prevention, diagnosis and treatment of all forms of TB including paediatric and drug resistant TB (MDR-TB: the NTLP conducted assessment of infection control practices and established MDR-TB management in 5 hospitals.
  - In liaison with the ACP, the NTLP developed guidelines for IPT. The guidelines are yet to be disseminated for use in enrolling HIV cases on IPT. The programme set-up a system for improving TB ICF in 550 TB Diagnostic and Treatment Units (DTU) health facilities in 40 districts, representing 46% of DTUs in 36% districts; this was aimed at increasing TB case detection and notification rates in the selected districts.
  - To improve access to quality TB diagnosis the programme established 46 centres with Gene X-pert machines for diagnosis of TB – MDR-TB in particular. The programme developed and distributed to all TB diagnostic health facilities algorithms and guidelines for new diagnostic tests, smear positive and negative pulmonary, extra-pulmonary, paediatric and DR-TB to facilitate diagnosis and notification of TB. *Establish and build capacity for 5 new treatment initiation centres for drug resistant TB (DR-TB):* this was implemented in 550 DTUs. See Figure 21 below.

*Figure 21: Variations in TB success rate by district FY 2013/14*



- Improve access to HIV diagnosis and treatment services for TB patients: in collaboration with ACP, tools for TB/HIV collaborative interventions were developed and distributed to implementing facilities. The lack of capacity to provide comprehensive HIV/AIDS care and treatment has left out some DTU from providing ART to TB/HIV co-infected patients.
- Empower communities, community support groups and social networks to prevent TB transmission and support case finding and treatment of TB patients: the planned expansion of community-based directly observed therapy (CB DOT) through civil society organisation and community-based organisations (CBO) was not implemented due to inadequate budget provided for the CSOs/CBOs under the Global Fund TB Single Stream Funding. The identified CSOs/CBOs withdrew their participation due to lack of costs for administrative and human resources for CB DOT implementation.
- Improve the quality, efficiency and effectiveness of delivering TB and leprosy services at all levels of the health system: the NTLP conducted an external comprehensive review of effectiveness of interventions in control of TB in the country. The recommendations of the review have been used in the Phase II TB Single Stream Funding (TB SSF) application to the Global Fund, and the revision of the NTLP Strategic plan for the next HSSIP period.

*Annex One. Table 4: Tuberculosis control indicators*

Indicator	HSSIP Baseline	2010/11	2011/12	2012/13	NTLP 2013/14 target	Actual performance	2014/15
TB CNR increased	-	79.0%	78.2%	75.4%	No data	70.2%	No data
TB CDR increased	57.3%	39.8%	39.2%	38.6%	61.0%	36.6%	70%
TB CR increased	32.0%	30.0%	31.6%	33.2%	42.0%	NA	80.0%
TB TSR	-	68.6%	69.8%	71.3%	77.0%	NA	85.0%
TB death rate	4.7%	4.7%	4.6%	4.6%	4.0%	NA	2.5%
% of TB cases on DOT	48.0%	35.7%	40.7%	46.0%	50.0%	49.5%	100%
% of smear positive relapses done DST	-	86.0%	84.0%	89.0%	72.0%	88.0%	75%
% false negative tests DTUs reduced	-	13.0%	11.0%	9.0%	5.0%	9.0%	< 5%
% of TB patients tested for HIV	71.0%	79.8%	83.7%	87.8%	90.0%	93.9%	100%
% TB/HIV patients started on CPT	88.0%	92.6%	92.8%	95.1%	96.0%	97.5%	100%
%TB/HIV patients started on ART	18.5%	27.9%	40.0%	56.4%	45.0%	74.2%	50%
% DR-TB patients enrolled on treatment	-	6	23	96	60.0%*	219	100%

From the table above, the programme surpassed performance targets set for 2013/14 period on the indicators for drug sensitivity testing (DST), on smear positive relapse patients, testing TB patients for HIV, enrolment of TB/HIV co-infected patients on co-trimoxazole prophylaxis and ART.

The programme achieved close to set target on indicator for patients on supervised DOT. Major improvements from the 2012/13 were recorded on the indicators HIV testing and enrolment on ART.

As the outcome of treatment is evaluated after completion of treatment, data on cure, treatment success and death rates will be available early 2015 when cohorts enrolled in the last half of 2013 will have completed treatment and evaluated for outcome.

The programme needs to sustain performance achieved on the indicator for DST which has surpassed the HSSIP target. However, more effort is needed to improve interventions contributing to the indicators that fall below the HSSIP targets.

### **Leprosy control**

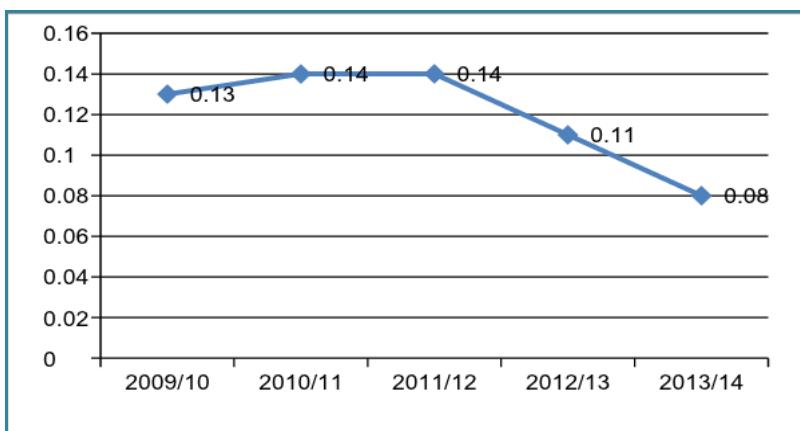
To-date, leprosy still shows a significant presence on the epidemiological profile of Uganda. During the review period, 65 districts reported at least one case of leprosy, totalling to 246 patients that were identified and enrolled on treatment in the last quarter of the fiscal year. The proportions of Paucibacillary (PB) and Multibacillary (MB) leprosy, the species of Mycobacteria leprae in Uganda changes over the year; however, as at 30th June 2014, 92% of the 382 leprosy patients on treatment were MB.

Contact surveillance and constant sensitisation of health workers about early detection of leprosy were the two core activities implemented in the review period. For every index case diagnosed with leprosy, at least six household contact members are assessed for leprosy. Integration of sensitisation of health workers in the leprosy affected districts raises high suspicion index to promote early detection of cases. The programme planned to conduct one "**skin clinic once weekly in each health sub-district nationwide**" to enhance screening and detection of patients with symptoms suspect of leprosy. However, logistics were not available to conduct this activity, and it has not been implemented during the HSSIP period. Nonetheless, case detection and treatment completion data is a good proxy measure for the indicator on once weekly skin clinics. Over 90% of the leprosy patients were identified through examination of suspects within the general PHC facilities.

***Annex One. Table 5: Performance on key indicators for control of Leprosy***

Indicator	2010/11	2011/12	2012/13	NTLP 2013/14 target	Actual performance	2024/15 target
Registered cases	460	479	391	-	295	-
Ref. population	31,962,600	33,203,900	34,131,400	-	35,357,000	-
Prevalence rate/100,000	1.4	1.4	1.1	-	0.8	< 1/100,000
% Grade II disability in new cases	18.0%	25.0%	24.0%	14.0%	33.0%	< 5%

Figure 22: Trend of leprosy prevalence rate/100,000



Worldwide, it was agreed that a country is declared to have "Eliminated leprosy as a public health problem" if it attains a prevalence of <1 case/ 10,000 population. Uganda attained this status in 2004, and it has sustained the achievement to-date. The downward trend is influenced by the strategy used in treatment of leprosy patients. Following observation that when patients of leprosy are kept on treatment longer than the recommended time, higher complete cure rates are obtained, reducing transmissibility of the disease. If this guideline is followed, the rate will be even lower towards zero cases soon.

Figure 23: Proportion of leprosy cases with Grade 2 disability

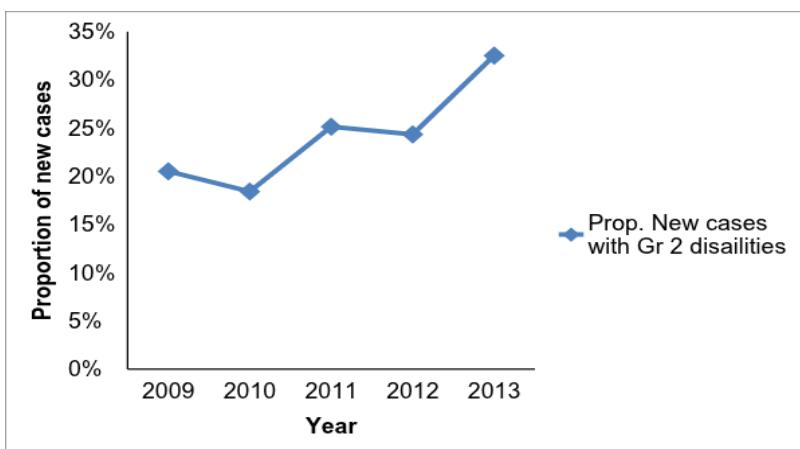
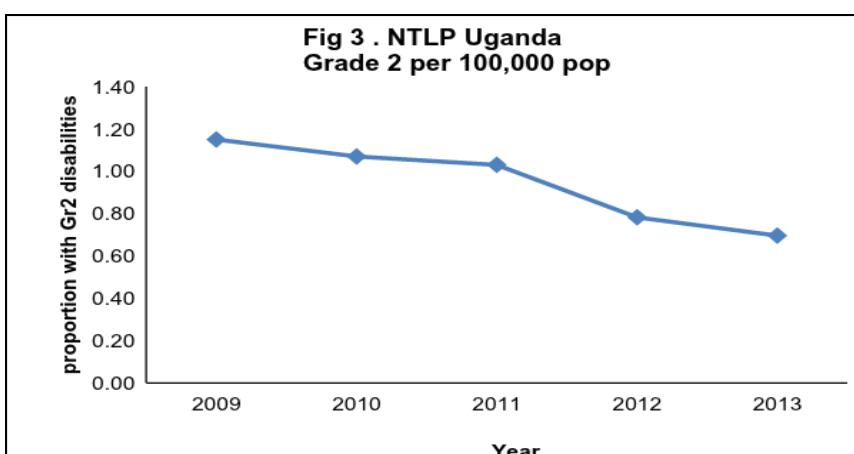


Figure 24: Contribution of Grade 2 disability to overall disability in the population/100,000



Grade 2 disability measures promptness of detection and enrolled of new leprosy patients on treatment. Grade 2 disability increased over the review periodas in Figure 22. This result indicates that most cases of leprosy are diagnosed late, and raises the need to institute further measures towards enhancing early detection of leprosy cases. However, overall contribution of leprosy-related disability in the general population has been declining (Figure 23).

**Annex One. Table 6: Major challenges to TB/Leprosy control and mitigation measures**

Challenge	Proposed/planned mitigation measures
<ul style="list-style-type: none"> <li>1. Unknown actual burden of TB in the population: efforts to increase identification and enrolment on treatment have not been successful in attaining the set targets for TB case notification and mortality. There is evidence that TB burden may be less the figures used for projections of the targets. The WHO report of 2013, which reflects the status in 2012 shows that Uganda, attained the MDG targets of halving prevalence, incidence and death rates due to TB.</li> <li>2. Inadequate resources allocated to implementation of supportive activities for TB/leprosy control.</li> <li>• TB control was largely planned on the Global Fund TB Single Stream Fund (SSF) grant. In November 2012 when the Principle Recipient (Ministry of Finance, Planning and Economic Development) and the Global Fund agreed to in-kind commodity funding, funds for supportive interventions were withdrawn at the time when Government of Uganda had not allocated its own funding.</li> <li>• Inadequate budget allocation for CB DOTS:</li> <li>3. Inadequate planning for community-based DOTS (CB DOTs): the budget provided to TASO to coordinate CSO/CBO that was tenfold less than the budget requests made by three CSOs selected to implement CB DOTs. The CSOs requested for administrative and human resource costs that had not been budgeted. All the selected CSOs withdrew their participation; as a result, CB DOTs activities were not implemented to-date.</li> <li>4. Building capacity for nationwide rollout of programmatic management of MDR-TB: this involves training of health workers in technical aspects and infection control of MDR-TB, and establishing a system for recording and reporting high quality data. These supportive activities for MDR-TB roll-out were planned squarely on Global Fund grant. The withdrawal of funding for supportive activities has stagnated roll-out and setting systems for MDR_TB management.</li> </ul>	<ul style="list-style-type: none"> <li>• The NTLP will conduct a TB disease prevalence survey in 2014 – 2015 period. This will provide actual burden of TB in the population, on which basis future TB control interventions will realistically be made.</li> <li>• Advocate prioritising resources allocation to leprosy control, not only for treatment of the disease but for prevention of life-long disability resulting from leprosy.</li> <li>• Discuss with implementing partners to identify resources to bridge the gap in funding for supportive interventions caused by the change in Global Fund funding.</li> <li>• The NTLP is in the process of withdrawing the funds disbursed to TASO, to make direct implementation through districts. This will offset the administrative and human resource needs of the CSOs that raised the budget, and make implementation through partnerships impossible.</li> <li>• The NTLP mobilised resources from implementing partners with which it rolled-out MDR-TB management to all Regional Referral Hospitals (RRH). However, further resources are need for establishment and building capacity of health facilities to provide follow-up treatment after 6 months of intensive treatment from RRHs. The programme will lobby partners for additional support for roll-out of the intervention.</li> </ul>

Challenge	Proposed/planned mitigation measures
5. Sustaining awareness about the detection of leprosy among health workers and communities, and active search through screening of contacts with index cases in the households and community are the mainstay method for early detection, prevention of disability and further infection spread by isolation of cases. This requires additional resource allocation for leprosy control.	<ul style="list-style-type: none"> <li>• Currently, the NTLP has integrated sensitisation activities into the quarterly review meetings, but these are limited to the Zonal and District TB/Leprosy Supervisors (ZTLP &amp; DTLS, respectively). The NTLP will also strengthen quarterly planning to further integrate leprosy control activities within existing community-based health services; this may be challenged with lack of partner mandates that do not focus on leprosy.</li> </ul>
6. Management of the supply chain for anti-leprosy medicines with unpredictable incidence. Though medicines are available, it has proved difficult to anticipate incident cases and project quantities of medicines required. Consequently, delivery of medicines to sites that have identified cases is delayed; adding to delayed identification, this contributes significantly to progress to disability.	<ul style="list-style-type: none"> <li>• The programme will identify partners who support leprosy and lobby for more funding.</li> <li>• A mini stock of the medicines may have to be kept at the district health offices to be able to quickly supply the medicines facilities that have identified a case.</li> </ul>
7. The long insidious onset of systems makes early detection and prevention of disability due to leprosy difficult. This is worse with MB leprosy where nerve involvement sets in late. As a result, patients and health workers recognised leprosy late, often when the disease has progressed to irreversible disability.	<ul style="list-style-type: none"> <li>• Community awareness through education programmes needs to be created in endemic districts to raise suspicion of any skin lesion as leprosy; this way, early seeking behaviour will promote early detection and treatment of cases.</li> </ul>

## Malaria

The NMCP implements a combination of proven cost effective interventions against malaria with emphasis on both prevention and prompt treatment to prevent deaths and minimize the social and economic losses attributable to malaria.

### Lead program indicators

- Reduce the prevalence of malaria among the under fives from 44.7% to 20%.
- The percentage of under-fives and pregnant women having slept under an ITN the previous night increased from 32.8% to 80% and from 43.7% to 80% respectively.
- Proportion of households sprayed with insecticide in the last 12 months increased from 5.5% to 30% by 2015.
- Proportion of households with at least one ITN increased from 46.7% to 85% in 2015.
- The case fatality rate among malaria in-patients under five reduced from 2% to 1% by 2015.

## **Key planned Outputs FY2013/14**

- Hold general staff meetings, planning and review meetings
- Procure anti malarial commodities including ACTs and RDTs
- Commemorate important international and national malaria days/events
- Distribute Long Lasting Insecticide Nets (LLINs) to achieve Universal Coverage
- Conduct operational research on efficacy and safety of mosquito larvicides
- Carry out Indoor Residual spraying in 10 districts in Northern Uganda and 2 in eastern Uganda
- Carry out cross cutting supporting interventions for malaria prevention and control

## **Main achievements**

- Procured 21 Million Long Lasting Insecticide Treated Nets (LLINs) for distribution to achieve Universal Coverage. Distribution was completed in 106 districts with approximately 19.5 M LLINs distributed.
- Indoor Residual Spraying (IRS): Two rounds of IRS were conducted in 10 districts of Northern Uganda. Approximately 850,000 houses were sprayed twice protecting more than three million people.
- Conducted susceptibility studies on 4 classes of insecticides used for Indoor residual Spraying
- Mosquito Larval Control: Small scale efficacy and safety trials of 3 candidate larvicides was conducted in Wakiso district. Large scale trials commenced in Nakasongola district.
- 70,000 torches and 280,000 batteries were procured and distributed to VHTs to facilitate their work and as a motivational package. The beneficiaries were VHTs who are active in Home Based Management of Malaria.
- Malaria Case Management: Training of health workers in integrated management of malaria was conducted countrywide.
- Support supervision was done in selected health facilities in all the districts of the country.
- Cross cutting supporting interventions including advocacy, social mobilization and behavioural change communication, monitoring and evaluation, drug efficacy studies and drug resistance monitoring were conducted.
- Conducted a Midterm review (MTR) of the 2010-2015 National Malaria Strategic Plan
- Developed of a Malaria Reduction Strategic Plan (UMRS) 2014-2020 costed at 1.36 Billion USD
- Developed and submitted a Concept Note for malaria funding under the GF New Funding Model totalling 191 million USD
- Finalized a malaria private sector case management strategy
- Completed and submitted a proposal to DFID for co-paid ACTs in the private sector. - DFID approved a proposal of 17.8 M USD for co-paid ACTs for the private sector

**Annex One. Table 7: Summary of Program Indicators that showed good progress**

<b>Key indicators from routine data</b>	<b>2011/12</b>	<b>2013/14</b>
OPD visits attributed to malaria in children under 5 (Public and PNFP facilities)	48%	13.7%
The percentage of OPD visits attributed to malaria in individuals 5 years	40%	29%
In-patient malaria mortality	3.5%	0.72%
Proportion of suspected malaria cases tested	25%	58.8%
Percentage of women who received 2 or more doses of IPTp	42%	50%

*Source: MTR, Pg 62*

### **Challenges**

- Inadequate staffing – 4 officers have died, retired or transferred without replacements. Two other officers are on interdiction. The officers should be replaced by filling in the vacant posts.
- Office space is very limited. The programme should be given more working space.
- Delayed procurement processes. The MOH Budget Committee should frontload funding for high cost procurements like Insecticides and larvicides.
- Vehicle fleet is very old and expensive to maintain.
- Inadequate funds for programme running. Funding for priority interventions like IRS should be ring fenced.
- Emergence of Insecticide resistance especially Pyrethroids.

### **Key Recommendations**

- Timely disbursement and front-loading of funds for seasonally related activities such as IRS and Larviciding.
- Fill in vacant staffing positions at the NMCP.
- Increase domestic funding for malaria control activities.

*Figure 25: President Yoweri Kaguta Museveni at a ceremony to end net distribution in Uganda*



*Source: Uganda Village Project*

*Annex One. Table 8: Progress on indicators as per performance framework*

<b>Indicator</b>	<b>Baseline and Target Values</b>	<b>Year 1 - 2011</b>	<b>Year 2 - 2012</b>	<b>Year 3 – 2013</b>	<b>2013 Target</b>	<b>Sources</b>
Malaria cases (per 1,000 persons per year)	403	349.26	405.79	460.04	320	HMIS
Confirmed malaria cases (microscopy or RDT) per 1,000 persons per year	210	49.6	78.3	150.5	180	HMIS
Malaria test positivity rate. i.e. Proportion of malaria suspected cases confirmed to be positive among children below 5 years (Malaria Test positivity rate)		44.30%	58.20%	44.20%		HMIS
Inpatient malaria cases (per 1,000 persons per year)	14	14.89	17.19	20.9	5	HMIS
Percentage of women who received 2 or more doses of IPTp	18	42		50	80	HMIS
Percentage of OPD visits (Public & PNFP) attributed to malaria (Proportion of patients suspected of having malaria) Under 5 years	51.7% (2010)	48.40%	14.38%	13.71%	25%	HMIS
Percentage of OPD visits (Public & PNFP) attributed to malaria (Proportion of patients suspected of having malaria) 5 years and above	30% (2010)	40.10%	28.97%	29.28%	15%	HMIS
Malaria Case fatality rate	2% (2010)	3.50%	1.09%	0.72%	1	HMIS
Proportion of clinical malaria cases that are confirmed by microscopy/RDT at health facility level (%)		35.40%	43.01%	58.80%	80	HMIS
Proportion of outpatient malaria cases that received an appropriate antimalarial treatment according to national policy	-		64.5	64.5	85	HMIS
Proportion of children under five years old with fever in the last two weeks who received treatment with ACTs according to national policy within 24 hours of onset of fever	14	42.50%	42.50%	42.50%	60	MIS, UDHS
Percentage of suspected malaria cases tested using microscopy or RDT in private and public sector	26	42	43.00%	58.80%	80	HMIS reports/HF SURVEY

### **3.3.1 Diseases Targeted for Elimination.**

#### **Uganda Guinea Worm Eradication Programme (UGWEP) FY2013/14**

##### **Highlights of planned activities during the FY 2013/14**

The main actions this year were centred on the announcement and promotion of new reward system:

- Intensification of surveillance for guinea worm disease.
- Increasing coordination of surveillance and control of epidemic guinea worm and diseases of importance with neighbouring countries and Ugandan health authorities.
- Hold Inter district coordination meetings.
- Investigate guinea worm rumours as they emerge.
- Close technical support supervision.

##### **Main achievements during this year**

- Printed and distributed Guinea worm new reward system announcement posters to 80% of districts in the country.
- Promotion of the new cash reward system was promoted by holding 12 radio announcements in languages of Alur, Lugbara, Luo, Madi, Kakwa, Ngakarimajong, Lugisu, Lusoga and Runyakitara.
- Held one cross border meeting in Nairobi with Counterparts in the region (Sudan, South Sudan, Ethiopia and Kenya).
- Held on Inter district coordination meetings between district UGWEP and IDSR focal persons in the formerly endemic districts in Gulu.
- All rumours were investigated.

##### **Performance of Lead Programme Indicators:**

- Maintain zero transmissions status following certification of guinea worm eradication
- To contain 100% of any Guinea worm case that may be reported

##### **Achievements**

- Zero cases reported in the country
- 100% of rumour investigated and found negative

##### **Challenges**

During the last one year, the following bottlenecks have continued to affect the operations of the programme.

- The current level of funding is basically for office maintenance and supervision. The programme is unable to promptly respond to rumours and precarious situations.
- The renewed influx of refugees from South Sudan complicated the situation as the potential to import cases is now stronger than ever before.

## Recommendations

The programme will continue to consolidate the implementation of the core post certification interventions especially in at risk villages and districts. It will thus:

- Intensify the surveillance system in the districts especially those bordering S. Sudan that are also providing reception centres and camps to the Sudanese refugees.
- The programme will continue with its Orientation plans for HWs and VHTs in the camps on GW surveillance.
- Will continue with popularization of the new reward system with the help of mass media.
- Carry out active search for cases in the refugee camps.
- Produce and supply rumour registers where they were missing as was reported in the inter-district meeting.
- Continue to support and participate in integrated surveillance with other programmes like IDSR, Onchocerciasis and Polio.
- Intensify technical support supervision for both the programme and the National Certification Committee.
- Encourage development partners to increase safe sources of drinking water in the refugee camps.

### **3.3.1.2 Nodding Disease Syndrome**

#### **Planned activities:**

##### **Implementation of the action plan on nodding syndrome:**

- Continue with case management.
- Conduct Health education to the public in affected areas.
- Carry out disease surveillance.
- Conduct further research on the cause of nodding syndrome.
- Monitoring and evaluation of the interventions.

#### **Key outputs**

*Annex One. Table 9: Static treatment centers for nodding disease increased from 7 to 17.*

Kitgum	Pader	Lamwo	Gulu	Lira	Amuru	Oyam
Kitgum General Hospital	Atanga HC III	Palabek Kal HC III	Odek HC III	Aromo HC III	Atiak HC III	Otwal HC III
Okidi HC III	Pajule HC IV	Palabek Gem HC III				
Pajimu HC III	Lapul HC III	Palabek Ogili HC III				
Kitgum Matidi HC III	Laguti HC III	Padibe HC IV				
		Awere HC III				

- Health workers continued to provide outreach services to areas far from the health facilities.
- Anticonvulsant medications have continued to be supplied from NMS on bi monthly basis with no stock out.
- No new cases have been reported, only re-attendants are being seen in both outreaches and static centers.
- Health workers have continued to provide health education through radio talk shows and during the outreaches trough out the seven districts.
- VHTs have continued to support the disease surveillance and reporting through the nearest health facilities.
- Research on socio economic impact of Nodding syndrome, attitude perceptions and health seeking behavior and clinical studies were completed. Post mortem specimen were shipped to the US for analysis and the planned genetic study commenced with one family from Abam Village being taken to NIH in Maryland Bethesda.
- Ministry of Health core team continues to monitor and evaluate the implementation of activities while building the capacity of Gulu regional referral hospital staff to take over a leading role in supervision.

## **Financing**

*Annex One. Table 10: Funds received against funds projected*

No.	Item Description	Credit (Ug Shs.)	1st QTR	2nd QTR	3rd QTR	4th QTR	Total Expenditure (Ug Shs.)	Budgeted Funds
1	Funds from GOU	45,527,131	-	-	-	-		63,392,000
2	Funds from GOU for UNAS	600,000	-	-	600,000	-		-
3	Funds from WHO	33,462,304	-	33,462,304	-	-		178,862,000
4	Allowances	-	1,739,766	-	1,739,766	1,631,758	5,111,290	
5	Welfare & Entertainment		1,147,725	-	1,147,725	375,469	2,783,450	
6	Printing, Stationery, photocopying & binding services		997,440	-	997,440	810,260	2,805,140	
7	Small office equipment		-	-	-	-	-	
8	General supply of goods & services		580,488	-	580,488		1,160,976	
9	Travel Inland		6,372,248	-	6,372,248		17,335,448	
10	Fuel, Lubricants & Oils		3,659,378	-	3,659,378	4,590,952	8,558,073	
11	Maintenance - Vehicles		2,745,180	-	2,745,180	1,239,317	5,584,754	
12	Maintenance Other		-	-	-	-	-	
13	Workshops and Seminars		850,000	-	850,000	488,000	2,188,000	
14	Health worker Training		-	-	-	-	-	
15	NCC Monitoring		-	-	-	-	-	
		<b>18,092,2</b>						
<b>Total</b>		<b>79,589,435</b>	<b>25</b>		<b>18,092,225</b>	<b>9,230,150</b>	<b>45,527,131</b>	<b>242,254,000</b>

## **Lymphatic Filariasis**

The aim of the lymphatic Filariasis program is to reduce and ultimately interrupt transmission of the disease in all endemic communities through the use of chemotherapy with Ivermectin and albendazole.

### **Lead Program indicators for Lymphatic Filariasis**

- Therapeutic coverage for the affected people with single annual dose of Ivermectin and Albendazole maintained.
- Geographical coverage for the affected communities with single annual dose of Ivermectin and Albendazole.
- Mapping of areas with lymphatic filariasis in all endemic districts completed by 2011/12.
- Morbidity and disability associated with lymphatic filariasis reduced

## **Veterinary Public Health 2013/2014**

### **Veterinary public health in charge of:**

Zoonotic diseases investigations, prevention & control (Rabies, brucellosis, cysticercosis, influenza, anthrax, etc). Training and capacity building.

Policies, laws, guidelines, plans and strategies for prevention and control of zoonotic diseases developed. Technical support, monitoring and evaluation of diagnostic and treatment capacity for brucellosis

### **Planned activities**

- Undertake Zoonotic diseases investigations and advocacy in high risk districts for rabies, Influenza, brucellosis and other zoonotic diseases in Uganda
- Develop, print & disseminate IEC materials on rabies and other zoonosis
- Districts technically supervised on control of zoonotic diseases and promotion of multisectoral collaboration under One Health Approach

### **Achievements**

- Investigation and response to Rabies outbreak in Kisizi, Gomba district and to oversee pre and post exposure prophylaxis together with community sensitization
- Response to Crimean Congo Hemorrhagic fever (CCHF) outbreak in Wakiso/Kampala area
- Participated in a multi-sectoral training and orientation of select staff/focal persons on One Health from the Ministry of Water and Environment, Ministry of Health and Ministry of Agriculture, Animal Industry and Fisheries and staff from Hoima district local government
- Developed a framework document to strengthen the “One Health Approach” to management of zoonotic & other emerging diseases. Draft circulated to key stakeholders for input.
- 33 districts of, Mpigi, Wakiso, Mukono, Kibaale, Kiboga, Hoima, Kyegegwa, Mubende, Ntoroko, Bundibugyo, Kyenjojo, Mityana, Kyankwanzi, Buliisa, Kabarole, Masaka, Lyantonde, Kiruhura, Mbarara, Ntungamo, Rukungiri, Nakaseke, Nakasongola, Masindi, Luwero, Ibanda, Bushenyi, Sheema, Mitooma, Bulambuli, Sironko, Kween & Kapchorwa were technically supervised and evaluated on diagnostic and treatment capacity for rabies, influenza, snake bites, food-borne parasitoses and brucellosis.

## **Challenges**

- Insufficient funds allocated for planned activities.
- Inadequate stocks of human rabies vaccine and hyper immune sera for rabies post exposure prophylaxis.
- Brucellosis is over diagnosed in the private health facilities because the test used is Brucella Agglutination Test which is a screening test and no confirmatory test is done.
- Frequent stock-out of brucella testing reagents in hospitals.
- Lack of sufficient stocks of anti-snake venom for management of snake bites.

## **Recommendations**

- Ministry of health particularly Central Public Health Laboratories should build capacities of the regional and hospital laboratories so that they can be able to confirm brucellosis.
- Districts and hospitals should request National Medical Stores to provide adequate stocks of rabies vaccine and hyper immune sera doses, anti snake venom and reagents for diagnosis of brucellosis.

### **3.3.2 Prevention and Control of Non-communicable Conditions**

The changing life styles have resulted in an increase in the prevalence of non communicable diseases like Diabetes mellitus, cardiovascular diseases, chronic respiratory diseases, cancer Chronic Obstructive Pulmonary Diseases and sickle cell disease.

#### **3.3.2.1 Highlights of planned activities**

The program planned for the following activities.

- Carry out national NCD Survey.
- Carry out 2 cancer camps.
- Carry out 2 supportive supervisions in Regional referral Hospitals.
- Commemorate 4 international NCDs days including World Diabetes day,World Cancer day, World Heart day and World Sickle Cell day.
- Develop draft NCD policy.
- Develop draft NCD strategic plan.
- Develop NCD training materials for Health workers.
- Develop Patient Education materials on NCDs.
- Carry out patient education sessions.

## **Main Achievements**

- The NCD survey data collection was done, awaits analysis, report writing and dissemination.
- Three cancer camps were carried out in Arua, Bushenyi and Mityana districts. Cancer screening sites have also increased to 60 with support from partners.

- Two supportive supervisions were carried out covering Kabale, Mbarara, Masaka, Fortportal and Mubende Regional Referral Hospitals.
- One international day commemoration i.e World Diabetes day commemoration was done in the district of Kabale.
- The NCD draft policy and strategic plan were developed with support of World Diabetes Foundation (WDF) support.
- Health work training materials were developed and two trainings carried out in Mbarara and Kabale Regional Referral Hospitals with WDF support.
- Patient Education materials were developed and 4 patient education sessions carried out with WDF support.

### **Lead program indicators**

- Public awareness on diabetes and risk factors increased by 5% by 2015.
- Percentage of HC IVs and hospitals equipped to diagnose diabetes increaseby 5% by 2015.
- Standard diabetis files utilized in 30% of health facilities (HC IVs and hospitals).

The lead program indicators need periodic population based survey to measure progress. The ongoing NCD survey will give us baseline measurements.

### **Challenges**

- Late release of funds
- Inadequate funding
- Shortage of staff at headquarters and in health facilities
- Long procurement processes

### **Key Recommendations**

- Increase funding to NCD program
- Increase staffing both at headquarters and in health facilities
- Prioritize NCDs at all levels

### **Injuries, Disabilities and Rehabilitative Health**

The Disability Prevention and Rehabilitation section has the following program areas:

- Visual impairment and blindness
- Hearing impairment and deafness
- Physical disabilities
- Injury prevention and control
- Production and provision of assistive devices for Persons with Disabilities.
- Health care for older persons

## **Planned Activities**

- Advocacy for disability prevention:
- Capacity building
- Provision of assistive devices to Persons with Disabilities
- Conduct support supervision on rehabilitation health care services

## **Main achievements**

Advocacy for disability prevention included:

- Commemoration of international Disability days (Older persons day, World sight day /White cane day, Disability day)
- Production and dissemination of Disability IEC materials (Eye Health and Refractive Errors)

## **Mental Health and Control of Substance Abuse**

### **Programme indicators**

- Mental Health Law enacted by 2011/12
- Mental Health Policy finalized and operationalized by 2010/11
- Operationalize Mental Health units in all RRHs by 2010/11
- Community access to Mental Health services increased from 60% to 80%
- A community strategy for prevention of Mental Health problems developed by 2013/14

### **Planned output 2013/14**

- Celebration of; World Mental Health Day on 11th November 2013, World No Tobacco Day on 31st May 2014 and the International Day against Alcohol and Drug Abuse 25th June 2014.
- Finalize drafting of the Drug Control Mater Plan
- Finalise the Strategy for Control of Harmful Use of Alcohol
- Development the Mental Health Strategic Plan
- Supervision of Mental Health services at Regional Referral Hospital Mental Health Units
- Respond to psycho social and psycho trauma needs of people in disaster and conflict affected areas.
- Coordination of stakeholders providing services for mental, neurological and substance use disorders.

## **Main achievements**

- Mental Health Bill has been gazetted and ready for presentation to cabinet.
- In service training of Primary Health Care workers in mental health using the mental health gap interventional guide with support from World Vision and WHO.
- Drafted the five year Mental Health Strategic Plan 2014/15 – 2019/20

- Conducted community sensitization through public education during celebration of World Mental Health Day (Theme: Mental health and Older Adults) and World No Tobacco Day (Theme: Raise tobacco taxes reduce deaths).
- Developed information, education and communication materials for various mental, neurological and substance use disorders.
- Developed the child and adolescent mental health policy guidelines.
- provided Support supervision to seven Regional Referral Hospital Mental Health Units (Fort Portal, Lira, Mubende, Hoima, Jinja, Soroti and Mbale)
- Chaired the tobacco control stakeholders coordination meetings

### **Main challenges**

- Gross underfunding of the programme in relation to the mandates
- Lack of progress due to multi sectoral nature of activities e.g. Mental Health Bill drafting
- Programme is understaffed

### **Recommendations for annual plan 2014/15**

- Increase funding to the programme in order to complete consultation processes for Alcohol Control Policy and Drug Control Master Plan
- Strengthen inter sectoral collaboration through consultative meetings to hasten process of policy development and implementation
- Implement the proposed restructuring to increase staff in the Mental Health Programme

### **Key priorities 2014/15**

- Finalise process of presenting the Mental Health Policy and Mental Health Bill to Cabinet and Parliament respectively.
- Intensify public sensitization about mental health through but not limited to celebration of the World Mental Health day, World No Tobacco Day and International Day Against Alcohol and Drug Abuse
- Support Supervision to strengthen functionality of Mental Health Units at RRHs.

### **Oral Health Community Oral Health**

Dental problems are important public health problems because of their high prevalence. According to the information from a rapid assessment done in 2004/2005 the estimated oral conditions found in the community were dental caries affects (93.1%) pain (82.1%), tooth loss (48.3%), bad breath (43%), oral HIV lesions (29%), tooth bud extractions (17%), jaw fractures (14%) tumors (3.4%) and Noma (2.8%)

In Uganda dental caries and gum diseases are the most prevalent of all diseases among children. Dental caries is the major cause of early loss of primary teeth. The number of dental health care workers in the districts is limited and some times absent hence the need to incorporate other health care workers in offering oral health care advice to mothers and the children.

### **Highlights of planned activities**

- Re-orientation of oral health workers towards community oral health care instead of concentrating only on their usual clinical practice.
- Sensitizing some non-dental health workers in the Health Sub districts on public oral health and hygiene.
- Printing of guidelines for teachers in nursery and primary schools on oral health care.
- Monitoring and support supervision of districts on community oral health care.

### **Main achievements**

- Sensitization of district health teams on oral health care in the community has been done.
- The guide for teachers in nursery and primary school teachers on oral health care was produced and disseminated.
- Monitoring and support supervision of districts has been done.

### **Challenges**

- Many schools in the country compared to the guidelines we are able to print and disseminate.
- Inadequate transport and facilitation in the districts to carry out community oral health care

### **Recommendations**

- There is a need to foster collaboration with the Ministry of education and sports on oral health care in schools.
- All health care workers involved in PHC activities should be sensitized on oral health care in the community.
- There is need to recruit oral health workers in the new districts to handle oral health care activities

## **3.4 Central Public Health Laboratories**

### **Planned activities**

- Launching of 59 new specimen transportation hubs and supervision of the already existing 19 hubs
- Mentoring of laboratories that were recruited into the SLMTA process
- Facilitation of the 14 regional laboratory coordination committees to conduct coordination meetings and supervise peripheral laboratories
- Facilitate the National Health Laboratories Technical and Advisory Committee to conduct coordination meetings and monitor implementation of the National Health Laboratory Services Strategic Plan

## **Achievements:**

### **1. Follow up visits to laboratories under the SLMTA stepwise accreditation program:**

SLMTA trainers and mentors visited the 55 laboratories that had been initiated into the SLMTA process during quarter 3 to support implementation of improvement projects by the trainees and identify training needs for the next training workshop.

### **2. Supported activities of the National Health Laboratories Technical and Advisory Committee**

**3. Launched new specimen referral hubs and coordinated their activities:** A total of 21 new laboratory hubs were launched and the existing 19 hubs officially handed over to implementing partners to coordinate their activities. During the hand over, GSM printers for real-time transmission of test results from CPHL to the hubs were installed and personnel trained in their use. District and facility officials were also oriented on operations of the hub based specimen referral system during the hand overs. The number falls short of the planned 78 hubs because implementing partners received funds for hub operations rather late, leading to delays in implementing critical activities most notably the laboratory physical infrastructure improvement

- CPHL provided guidance on the physical improvement designs. Facilities visited were those supported by Mildmay including Mityana Hospital, Kassanda Health Centre IV, Lyantonde Hospital as well as facilities under NUHITES.

### **4. Engaged Ministry of Health Top Management and Parliament in the supervision of laboratory services throughout the country:**

- As strategy for improving advocacy for laboratory services and increasing their uptake by clinicians, CPHL worked with the Ministry's Top management including the Honourable Minister of Health, the Director General and Commissioners as well as members of the National Assembly (parliament) in the supervision of laboratory services throughout the country. These activities were organized to coincide with the country's 51<sup>st</sup> Independence celebrations. To ensure full engagement of the clinical staff, the visiting teams conducted ward rounds alongside the facility personnel in addition to working in the laboratories. This helped not only evaluate the status and challenges within the laboratories, but also understand the clinicians' perceptions of the laboratories and helped improve the clinician laboratory interface. All National and Regional Referral Hospitals were visited.

### **5. Supported the Regional Laboratory Committees to conduct coordination meetings and supervisory visits to peripheral laboratories:**

The 14 Regional Laboratory Coordination committees were constituted by the Director General in 2011 and are composed of Regional Referral Hospital Directors (Chairs), Regional Referral Hospital Laboratory Principal Technologists (as secretaries), District Laboratory focal persons as well as some of the District Health officers. They provide technical and managerial oversight to laboratory services in their regions. CPHL disbursed funds to each of the committees to enable them hold coordination meetings and conduct support supervisory visits to the laboratories. The activity is ongoing and reports generated from it shall guide future implementation.

## **Challenges:**

1. A high turnover of personnel affects outcomes of training and mentoring: A number of personnel trained in quality systems under SLMTA changed laboratories and as such the laboratories failed to attain the SLMTA targets

2. The low number of SLMTA trainers and mentors limited ability to effectively implement the program
3. Delays in receipt of Hub support funds by the implementation partners led to delays in implementation of hub activities, around which most of the current laboratory improvement strategies revolve
4. Delayed approval of supplementary budget led to delays in some of the implementation

**Planned activities for Quarter 1:**

1. Finalize the launch of the hubs and supervise their operations
2. Continue mentoring and supervision of the SLMTA sites
3. Finalize the e-LIMS strategic plan and fast-track its implementation

### **3.5 Nursing**

**Mandate**

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

**Key output Indicators 2013/14**

- Proportion of planned technical support supervision visits to identified health facilities conducted
- Proportion of planned integrated technical support supervision (with support from UNFPA) done
- Proportion of planned capacity building workshops (leadership, management and skills building in clinical area) for nurses and midwives conducted.
- Development of nursing policy
- Collaboration and coordination meetings with national and international bodies attended/conducted.

**Planned activities**

- Hold 3 meetings with nurse leaders from RRH, and general hospitals, UNMC and other stakeholders
- Carry out Technical Support Supervision visits to 8 RRH, 2 NRH and 15 GH to ensure quality of nursing care in accordance with set standards and strengthen managerial committees
- Review of nursing standards
- Re enforce ethical code of conduct
- Maintain Welfare and entertainment
- Review standard guidelines for nurses
- Carry out vehicle repairs and fuel for maintenance
- Travel abroad
- Procurement of furniture

## Achievements

- Conducted 8 technical Support supervision visits to 7 RRHs, 9 General Hospitals and 3 HC VsHC 1Vs; Lyantonde, Luuka, Kaliro
  - Ethical code of conduct re enforced
  - Nurses and midwives addressed on issues of absenteeism, attitude and discipline
  - Uniform is being distributed by NMS
  - Roll call registers have improved on late coming and absenteeism
  - 10 facilities are implementing the concept of 5s and are organized and clean
- Conducted 2 integrated technical support supervision in UNFPA supported districts Kibaale, Bundibugyo, Arua, Yumbe, Nebbi, Lira, Oyam districts
  - Professional development discussed,
  - strengthened RH services
    - ◆ Conducted 1 nursing and midwifery interviews together with MOES
    - ◆ Strengthened Leadership Management and Governance in skills in 10 midwifery managers
    - ◆ Held two meetings with the UNMC on the Scope of Practice and department attended meetings in Zambia that effect.
    - ◆ Attended an ECSACON meeting
    - ◆ Held three meetings with nurse leaders and formed research committee
    - ◆ Held a meeting with Assistant District Health Officers on performance of nursing services.
    - ◆ Reviewed the scheme of service through the steering Committee.
    - ◆ Ten midwives were trained in leadership and management skills by ARMREF
    - ◆ Verified midwifery staffing norms and retention of the project recruited midwives
    - ◆ Reviewed nursing policy guidelines TOR for consultant and consultant identified
    - ◆ Celebrated nurses International Day, Midwives International Day and International Women's Day.

## Challenges

- Low level of departmental staffing with prolonged multiple acting positions
- Department vehicles need replacement
- Uniform distribution slow
- Inadequate funds make the department unable to accomplish planned activities due to lack of funding

## Way forward

- Lobby for more funding to be able to supervise more health
- Procure new vehicles for the department
- Fill the vacant positions give chance to officers in acting positions

*Annex One. Table 11: Comparative Contribution of Hospitals to National Outputs - FY 2013/14*

Organizational Unit	OPD Total	Percent	IP admissions	Percent	Deliveries	Percent
Uganda	42,070,891	100.0%	2,269,084	100.0%	814,375	100.0%
National Referral Hospitals	528,460	1.3%	202,384	8.9%	32,957	4.0%
Regional Referral Hospitals	2,244,065	5.3%	294,160	13.0%	78,640	9.7%
General Hospital	4,474,722	10.6%	740,637	32.6%	179,907	22.1%
All Hospitals	7,247,247	17.2%	1,237,181	54.5%	291,504	35.8%
Health centre IVs	4,315,438	10.3%	424,828	18.7%	145,418	17.9%

*Source: MoH HMIS August 31<sup>st</sup> 2014*

*Annex One. Table 12: Top ten causes of hospital based mortality for all ages 2013/2014*

Data	Under 5 Mortality	Under 5 Mortality %	5 and over mortality	5 and over %	Total deaths	Total %
Malaria	2,036	19.9%	2,028	9.4%	4,064	12.8%
Tuberculosis (new smear positive cases)	97	1.0%	2,659	12.3%	2,756	8.6%
Pneumonia	1,263	12.4%	1,112	5.1%	2,375	7.5%
Anaemia	1,241	12.2%	1,105	5.1%	2,346	7.4%
Perinatal Conditions (in new borns 0 -7 days)	991	9.7%	0	0.0%	991	3.1%
Other Tuberculosis	44	0.4%	766	3.5%	810	2.5%
Injuries - Road Traffic Accidents	122	1.2%	623	2.9%	745	2.3%
Cardiovascular Diseases (Other)	72	0.7%	621	2.9%	693	2.2%
HIV Related Psychosis	22	0.2%	611	2.8%	633	2.0%
Abortions	0	0.0%	630	2.9%	630	2.0%
All Others	4,322	42.3%	11,503	53.1%	15,825	49.7%
<b>Total</b>	<b>10,210</b>	<b>100.0%</b>	<b>21,658</b>	<b>100.0%</b>	<b>31,868</b>	<b>100.0%</b>

*Annex One. Table 13: Top ten causes of hospital based morbidity for all ages 2013/2014*

Data	Under 5 cases	Under 5 cases %	5 and over cases	5 and over cases %	Total cases	Total cases %
Malaria	236,026	49.3%	101,729	16.1%	337,755	30.4%
Pneumonia	44,244	9.2%	15,476	2.4%	59,720	5.4%
Respiratory Infections (Other)	35,115	7.3%	17,341	2.7%	52,456	4.7%
Anaemia	33,834	7.1%	17,017	2.7%	50,851	4.6%
Hypertension (Old cases)	12	0.0%	40,584	6.4%	40,596	3.7%
Injuries - (Trauma Due To Other Causes)	3,932	0.8%	28,403	4.5%	32,335	2.9%
Diarrhoea – Acute	21,465	4.5%	7,412	1.2%	28,877	2.6%
Abortions	0	0.0%	28,233	4.5%	28,233	2.5%
Gastro-Intestinal Disorders (Non Infective)	7,300	1.5%	15,949	2.5%	23,249	2.1%
Injuries - Road Traffic Accidents	1,644	0.3%	19,560	3.1%	21,204	1.9%
All Others	95,470	19.9%	340,035	53.8%	435,505	39.2%
<b>Total</b>	<b>479,042</b>	<b>100.0%</b>	<b>631,739</b>	<b>100.0%</b>	<b>1,110,781</b>	<b>100.0%</b>

*Annex One. Table 14: General Hospital Outputs, Efficiency and Outcome indicators 2013/2014*

Hospital	IPD Admissions	IPD Patient Days	Attendance OPD total	Deliveries in unit	ANC Total	Postnatal attendance	Family Planning	Immunizations	IPD Beds Available	BoR	ALOS	IPD Deaths	Maternal deaths	Mat death risk 1:x deliveries	Fresh Still births	FSB risk 1:x deliveries	SUO
Iganga	20,860	60,636	171,001	6,171	13,396	1,213	1,106	40,577	104	159.7%	2.9	479	23	268	192	32	530,729
Bwera	13,783	51,988	72,110	4,361	11,085	286	2,340	28,297	110	129.5%	3.8	305	10	436	32	136	313,175
Tororo General	14,810	63,496	59,527	4,114	9,102	2,073	584	15,946	214	81.3%	4.3	522	8	514	81	51	311,316
Mityana	13,759	73,005	57,201	5,497	11,824	1,494	1,117	20,747	122	163.9%	5.3	343	20	275	109	50	302,438
Kawolo	11,829	29,529	88,042	3,728	10,284	555	1,757	21,197	109	74.2%	2.5	201	2	1,864	27	138	294,654
Angal St. Luke	15,943	89,476	33,653	2,244	5,165	306	3	17,111	260	94.3%	5.6	673	18	125	49	46	290,177
Busolwe	12,209	22,439	79,973	1,598	4,184	867	165	9,528	100	61.5%	1.8	173	5	320	27	59	275,612
Adjumani	11,731	62,579	83,953	1,695	4,099	836	302	9,656	147	116.6%	5.3	290	5	339	28	61	272,943
Kamuli	11,490	31,229	75,836	2,063	5,521	1,937	1,276	16,477	100	85.6%	2.7	108	4	516	22	94	266,163
Nebbi	12,824	40,197	51,965	2,105	7,249	571	323	20,263	120	91.8%	3.1	210	4	526	21	100	262,974
Pallisa	12,355	42,886	48,918	3,465	7,796	1,414	728	20,873	100	117.5%	3.5	125	10	347	67	52	260,712
Kalongo Ambrosoli Memorial	13,805	76,758	28,772	3,003	6,722	2,672		12,627	302	69.6%	5.6	219	5	601	22	137	258,084
Kagadi	13,544	46,264	21,966	3,304	8,608	146	108	13,270	160	79.2%	3.4	908	4	826	82	40	248,731
Yumbe	11,361	44,177	56,328	2,242	4,301	846	1,214	20,658	116	104.3%	3.9	253	5	448	29	77	245,265
Kayunga	10,317	30,757	69,956	2,565	5,057	335	1,006	19,626	104	81.0%	3.0	291	9	285	68	38	244,660
Itojo	11,443	45,245	51,914	2,231	3,777	1,793	166	8,199	165	75.1%	4.0	140	5	446	67	33	239,922
Entebbe	8,845	30,303	62,256	5,046	16,247	1,325	399	37,095	149	55.7%	3.4	185	3	1,682	55	92	236,566
Kitgum	10,238	59,090	62,670	2,294	5,190	858	926	17,193	220	73.6%	5.8	199	1	2,294	11	209	234,636
Ibanda	12,576	38,926	22,903	2,281	4,960	152		11,082	178	59.9%	3.1	124	7	326	95	24	227,720
Masafu General	9,146	24,989	77,199	1,569	4,526	609	160	13,305	92	74.4%	2.7	82	2	785	32	49	227,543
Atutur	9,497	28,394	70,861	1,772	4,444	623	366	13,141	100	77.8%	3.0	75	1	1,772	27	66	227,521
Bugiri	9,621	41,181	52,159	2,556	8,968	659	1,108	15,446	104	108.5%	4.3	186	5	511	94	27	217,711
Gombe	9,680	35,265	49,724	2,759	5,441	378	354	11,655	100	96.6%	3.6	221	11	251	54	51	214,137
Kisoro	9,147	48,078	53,248	2,955	8,553	200	1,089	15,600	132	99.8%	5.3	138	3	985	25	118	213,269
Lyantonde	7,887	20,970	78,969	1,917	6,177	198	496	12,618	100	57.5%	2.7	95	11	174	172	11	212,818
Ishaka Adventist	11,359	25,121	18,225	3,099	5,909	701	1,168	20,723	104	66.2%	2.2	197	6	517	69	45	212,139
Kiryandongo	10,243	36,384	35,333	2,010	7,919	149	625	19,595	104	95.8%	3.6	157	7	287	76	26	207,294
Kilembe	10,851	51,175	24,645	2,448	3,615	398		13,351	205	68.4%	4.7	334	7	350	38	64	204,327
Apac	8,419	40,077	54,724	2,020	9,819	596	772	17,137	100	109.8%	4.8	147	7	289	25	81	200,130

*Annual Health Sector Performance Report for Financial Year 2013/14*

Hospital	IPD Admissions	IPD Patient Days	Attendance OPD total	Deliveries in unit	ANC Total	Postnatal attendance	Family Planning	Immunizations	IPD Beds Available	BoR	ALOS	IPD Deaths	Maternal deaths	Mat death risk 1:x deliveries	Fresh Still births	FSB risk 1:x deliveries	SUO
Kiboga	9,071	31,626	39,860	2,532	7,865	1,629	200	8,434	100	86.6%	3.5	158	8	317	89	28	195,119
Bududa	8,361	29,637	53,147	1,237	3,688	686	569	22,105	100	81.2%	3.5	145	3	412	28	44	191,640
Aber Ngo	8,823	33,258	36,707	2,198	8,600	2,077	-	28,394	172	53.0%	3.8	369	14	157	66	33	191,059
Kisizi NGO	8,738	55,108	30,175	2,198	8,595	-	186	21,886	260	58.1%	6.3	182	4	550	28	79	181,003
Katakwi General	8,367	33,632	44,455	1,066	3,040	767	902	10,193	111	83.0%	4.0	84	1	1,066	8	133	179,683
Masindi	7,250	25,141	36,148	3,600	12,743	896	1,483	29,830	143	48.2%	3.5	190	10	360	60	60	176,425
Kumi NGO	7,767	47,277	41,992	1,631	2,946	242	276	7,796	195	66.4%	6.1	127	4	408	34	48	169,943
St. Joseph'S Kitgum	8,468	58,641	27,553	1,764	4,602	623	-	15,703	270	59.5%	6.9	329	5	353	9	196	169,146
Kaabong	7,858	26,833	42,585	736	2,635	629	214	10,868	100	73.5%	3.4	85	6	-	15	49	168,048
Nakaseke	5,653	29,264	63,792	2,548	4,319	149	173	12,487	100	80.2%	5.2	2,098	4	637	51	50	166,145
Kapchorwa	6,688	26,774	47,022	1,736	4,887	47	998	9,586	119	61.6%	4.0	174	-	-	44	39	160,905
Kagando	8,814	47,094	17,584	1,315	3,913	220	744	10,278	272	47.4%	5.3	312	5	263	35	38	160,863
Kalisizo	6,328	17,413	47,330	2,122	6,456	198	613	14,357	105	45.4%	2.8	102	5	424	45	47	159,365
Nggora Ngo	9,565	7,219	8,586	221	118	8	-	15,726	103	19.2%	0.8	61	-	-	4	55	156,374
Kitagata	4,461	12,221	74,244	1,839	3,638	910	431	7,294	100	33.5%	2.7	45	2	920	38	48	154,302
Mutolere (St. Francis)	7,856	42,925	19,037	1,906	5,462	211	542	11,508	200	58.8%	5.5	251	3	635	121	16	151,816
Murchison Bay	2,415	5,380	107,895	794	3,907	188	712	4,187	165	8.9%	2.2	13	-	-	6	132	151,331
Matany	6,918	56,844	33,104	1,064	3,707	663	56	31,427	284	54.8%	8.2	189	23	46	21	51	150,692
Kamuli Mission	6,721	20,579	29,056	1,945	7,187	4,662	-	11,679	160	35.2%	3.1	186	3	648	62	31	147,856
St. Karolii Lwanga Nyakibale	7,641	24,824	14,109	2,401	4,315	312	3	10,808	169	40.2%	3.2	139	6	400	14	172	145,206
Bombo General Military	5,029	32,441	57,563	1,768	3,649	111	123	7,034	147	60.5%	6.5	193	3	589	33	54	145,186
Kyenjojo	5,888	11,145	39,345	1,643	3,996	131	2,716	17,975	72	42.4%	1.9	96	3	548	36	46	142,897
Bundibugyo	6,113	34,558	37,772	1,495	4,742	34	263	13,236	104	91.0%	5.7	164	6	249	42	36	142,109
St. FrancisNaggalama	6,359	27,401	32,957	1,503	4,976	189	-	10,920	100	75.1%	4.3	144	5	301	32	47	140,624
Rakai	5,609	17,570	44,773	1,486	2,986	116	128	8,622	69	69.8%	3.1	68	9	165	60	25	139,677
Moyo	4,566	17,871	57,759	986	1,527	482	262	6,025	167	29.3%	3.9	83	1	986	17	58	133,520
Kiu Teaching	7,248	31,193	18,656	755	1,891	75	363	3,824	291	29.4%	4.3	165	-	-	19	40	133,080
Nkozi	5,585	18,269	29,534	1,760	3,580	1,379	-	9,517	100	50.1%	3.3	104	5	352	38	46	126,492
St. Joseph Kitovu	6,346	28,630	21,054	1,405	2,058	211	-	7,359	200	39.2%	4.5	227	7	201	55	26	125,875
Anaka	5,017	18,999	37,328	1,028	4,236	958	425	8,981	100	52.1%	3.8	76	2	514	17	60	122,329

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Virika	6,234	18,373	18,202	1,218	2,244	157	11	12,258	207	24.3%	2.9	196	5	244	36	34	121,460
Kisubi	4,371	13,862	37,339	1,562	6,111	441	-	33,408	101	37.6%	3.2	97	-	-	22	71	120,672
Kuluva	6,276	38,390	15,859	1,003	3,527	168	357	16,271	208	50.6%	6.1	249	11	91	27	37	120,294
Comboni	5,378	15,796	32,643	671	3,003	246		7,548	100	43.3%	2.9	84	5	134	12	56	119,802
Kiwoko	5,064	26,170	26,534	2,192	5,623	479	285	12,924	197	36.4%	5.2	125	7	313	39	56	119,232
Maracha	5,706	46,960	16,677	937	1,983	423		13,967	200	64.3%	8.2	286	7	134	76	12	110,948
Kabarole	5,270	9,366	14,090	847	2,401	226	244	44,171	85	30.2%	1.8	53	6	141	17	50	107,645
Kambuga	4,168	14,413	35,084	1,188	3,426	121	583	5,992	100	39.5%	3.5	65	3	396	35	34	106,807
Buluba	4,637	18,726	29,640	915	1,558	370	-	6,462	120	42.8%	4.0	145	8	114	16	57	106,026
Bwindi Community	4,569	18,335	26,568	1,249	2,240	181	1,010	4,810	110	45.7%	4.0	64	1	1,249	27	46	104,026
Kanginima	5,959	17,438	8,588	231	1,487	230	560	10,155	45	106.2%	2.9	42	-	-	1	231	102,298
Rubongi Military	3,446	8,412	47,011	119	1,070	134	474	2,964	69	33.4%	2.4	15	-	-	1	119	100,728
Villa Maria	4,768	19,889	19,968	1,321	1,576	9	-	5,368	126	43.2%	4.2	158	10	132	43	31	99,959
Nyapea	4,934	14,631	13,692	1,326	3,503	1,013	-	11,035	139	28.8%	3.0	127	8	166	29	46	98,797
Buikwe St. Charles Lwanga	4,977	15,294	13,641	929	2,725	184	-	8,245	85	49.3%	3.1	88	-	-	21	44	96,045
Kakira Worker's	2,805	5,066	49,601	367	1,348	115	451	4,574	77	18.0%	1.8	18	-	-	5	73	95,383
Ruharo Mission	3,806	11,757	28,696	703	1,195	131	87	2,806	105	30.7%	3.1	87	-	-	7	100	90,569
Abim	3,622	13,485	29,854	510	982	346	15	3,321	120	30.8%	3.7	61	2	255	8	64	88,070
Rugarama	3,840	22,820	21,944	295	1,822	139	314	4,568	136	46.0%	5.9	110	-	-	5	59	83,070
Nakasero	2,442	9,779	37,068	755	400	85	-	12,350	68	39.4%	4.0	38	-	-	2	378	80,186
Amudat	4,085	15,460	12,900	426	1,513	777	220	6,957	113	37.5%	3.8	77	1	426	17	25	78,951
St. Francis Nyenga	2,916	12,050	21,832	558	2,997	517	35	6,791	100	33.0%	4.1	74	-	-	17	33	71,495
Dabani	3,977	8,693	4,796	403	980	518		7,938	64	37.2%	2.2	64	2	202	65	6	68,803
Rushere Community	2,998	9,085	11,625	569	3,445	457	195	13,340	92	27.1%	3.0	68	1	569	21	27	64,157
Lugazi Scoul	2,474	10,762	16,685	214	1,294	249	1,004	4,706	44	67.0%	4.4	4	-	-	2	107	57,080
Lwala	2,857	15,787	6,109	666	1,469	667	-	6,761	100	43.3%	5.5	45	3	222	28	24	54,714
Namungoona Orthodox	2,101		14,552	414	2,002	307	-	6,528	45	-	-	17	3	138	7	59	50,597
St. Anthony'S Tororo	2,533	10,355	8,221	454	1,071	159	-	5,691	163	17.4%	4.1	75	1	454	3	151	50,239
Nakasongola Military	1,597	13,441	23,243	127	756	12	184	1,561	98	37.6%	8.4	10	-	-	1	127	48,621
Nkokonjeru	1,613	5,022	13,236	540	1,950	249	18	5,173	61	22.6%	3.1	35	5	108	12	45	42,274
GuluMilitary	1,167	10,513	17,527	64	971	-	130	2,500	114	25.3%	9.0	19	-	-	1	64	36,403

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UPDF 2nd Div.	823	4,405	22,175	21	860	85	115	2,123	40	30.2%	5.4	13	-	-	-	-	35,580
Amai Community	1,666	13,065	3,438	358	2,534	234	21	6,967	79	45.3%	7.8	31	2	179	9	40	33,006
Mayanja Memorial	1,243	3,633	9,676	321	648	26	346	4,795	100	10.0%	2.9	23	-	-	2	161	31,395
Oriajini	1,437	4,951	3,172	592	1,573	192	194	6,900	48	28.3%	3.4	15	-	-	9	66	30,047
5ThMilitary Division	666	3,511	18,377	118	699	90	191	1,516	50	19.2%	5.3	3	-	-	2	59	29,750
Bukwo General	1,524	11,150		287	1,738	562	279	5,702	30	101.8%	7.3	11	1	287	10	29	26,725
Kida	1,304	2,542	2,639	358	1,143	38	78	3,045	30	23.2%	1.9	101	-	-	8	45	25,228
Galilee Community General	1,035	146	5,536	279	368	128	386	9,566	21	1.9%	0.1	5	-	-	3	93	24,810
Senta MedicareCLINIC	627	2,205	10,683	199	565	245	6	3,570	15	40.3%	3.5	1	-	-	3	66	22,205
Gulu Independent	836	3,604	5,595	56	248	7	73	12,678	81	12.2%	4.3	34	-	-	1	56	21,115
Buwenge NGO	722	2,115	3,946	631	2,393	612	871	5,179	41	14.1%	2.9	5	-	-	3	210	20,905
Saidina Abubakar Islamic	438	9,421	8,067	183	818	53	23	5,154	20	129.1%	21.5	62	-	-	-	-	17,030
Uganda Martyrs	493	1,084	5,963	255	822	42	1	2,588	20	14.8%	2.2	6	-	-	1	255	15,583
Mbarara Community	614	1,556	4,877	45	133	12	61	967	53	8.0%	2.5	4	-	-	-	-	14,608
Kabasa Memorial	753	2,658	1,662	17	659	307	154	4,668	45	16.2%	3.5	3	-	-	2	9	14,536
Bamu	703	2,113	2,382	184	271	5	24	108	66	8.8%	3.0	2	1	184	5	37	14,019
Old Kampala	173	477	6,071	45	68	14	1	9,323	20	6.5%	2.8	-	-	-	-	-	10,797
ParagonKampala	294	625	3,199	268	1,351	130	211	2,517	22	7.8%	2.1	1	-	-	3	89	10,298
Divine Mercy	185	70	1,551	1	4	-	-	0	15	1.3%	0.4	3	-	-	-	-	4,333
Bethany Women and Family	102	274	-	26	61	14	77	430	20	3.8%	2.7	-	-	-	-	-	1,822
Novik	-	-	12,505	21	1,450	11	54	389	-	-	-	-	-	-	-	-	-
St. Catherine	-	-	23,498	14	33	17		851	-	-	-	-	-	-	-	-	-
Kibuli	-	-	17,926	594	456	4		1,070	-	-	-	1	594	5	119		
Kitintale	-	-	322	11	14	7	4	330	-	-	-	-	-	-	-	-	-
Middle East Bugolobi	-	-	1,747	-	-	-	88	0	-	-	-	-	-	-	-	-	-
Ntinda	-	-	462	9	7	5	127	268	-	-	-	-	-	-	1	9	-
Mildmay Uganda	334	3,413	63,175	-	-	181	186	961	33	28.3%	10.2	27	-	-	-	-	-
Cure Children's	1,094	6,951	4,859	-	-	-	-	165	40	47.6%	6.4	17	-	-	-	-	-
Benedictine EYE	-	-	7,260	-	-	-	-	0	68		-	-	-	-	-	-	-
Benedictine Eye	1,602	6,288	-	-	-	-	-	0	68	25.3%	3.9	238	-	-	-	-	-

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Hospital	IPD Admissions	IPD Patient Days	Attendance OPD total	Deliveries in unit	ANC Total	Postnatal attendance	Family Planning	Immunizations	IPD Beds Available	BoR	ALOS	IPD Deaths	Maternal deaths	Mat death risk 1:x deliveries	Fresh Still births	FSB risk 1:x deliveries	SUO
Buliisa	-	-	2,234	-	88	-	16	0	-	-	-	-	-	-	-	-	
Hunter Foundation	-	-	43	-	8	-	-	519	-	-	-	-	-	-	-	-	
Holy Innocents Children's	3,671	8,171	17,653	-	-	-	-	2,361	55	40.7%	2.2	77	-	-	-	-	
Average	6,035	24,114	32,077	1,387	3,665	488	450	10,462	114	1	4	154	5.8	241	33	42	138,459
minimum	102	70	43	1	4	4	1	-	15	0	0	1	1	46	1	6	1,822
maximum	20,860	89,476	171,001	6,171	16,247	4,662	2,716	44,171	302	2	22	2,098	23	2,294	192	378	530,729
sum	688,024	2,724,938	3,849,271	159,460	432,427	55,124	41,804	1,286,885	13,071	61	467	17,217	449	36,589	3,493	7,402	15,230,510
count	114	113	120	115	118	113	93	118	115	113	113	112	78	77	106	106	110

*Annex One. Table 15: Outputs and Ranking of HC IVs 2013/2014*

Facility	IPD Admissions	IPD Patient Days	IPD Beds Available	Total OPD	Deliveries in unit - OPD	Total ANC	Postnatal Attendances	Family Planning contacts	Immunization	Caesarian Sections-IPD	Major operations	Blood Transfusions (Units) - IPD	IPD Deaths	Fresh Still births in unit - OPD	Maternal deaths - OPD	SUO	Rank
Mukono T.C.	6492	7194	21	43710	5225	10150	5057	1719	25683	594	704	22	11	31	-	180,815	1
River Oli	8192	16379	56	26419	3709	3387	526	40	12645	4	12	6	45	-	172,350	2	
Kabuyanda	7208	26769	49	17696	1914	2548	106	940	3131	387	432	306	44	44	2	137,809	3
Serere	6256	22024	81	29173	1700	2223	750	300	4413	231	709	448.9	60	43	5	134,032	4
PAG Mission	6365	38745	163	32988	587	1533	659	121	3636	66	215	961	148	6	1	133,282	5
Nyahuka	5671	17739	69	33387	1514	3094	52	113	2841	284	496	530	55	42	4	128,220	6
Koboko	5858	18958	95	25422	1860	3371	313	311	15928	161	234	103	85	31	2	127,775	7
Pakwach	6309	15507	65	24749	923	2114	419	322	4955	9	11	233	161	10	3	126,418	8
Luwero	4556	8220	50	44030	1952	4693	1497	133	5497	76	171	122	51	15	-	126,391	9
Rubaare	4374	28768	54	47207	1948	2802	670	861	7327	264	363	2	35	14	3	126,189	10
Bugobero	5421	18877	47	31721	922	3259	499	561	14039	90	190	313	20	10	-	122,613	11
Azur HC III	6689	12625	73	9848	1910	1505	205	386	4996	113	169	6	90	11	1	121,780	12
Kyangwali	5487	19013	32	28994	954	2308	102	525	6101	-	15	1042	128	14	1	118,757	13
Mpigi	5327	9197	43	23789	2271	4709	567	36	4904	251	359	110	15	26	4	118,686	14
Budaka	5379	9663	35	25559	1496	2566	651	67	3234	-	23	-	9	15	-	116,013	15
Kitwe	5153	11396	48	26980	1355	3957	196	205	8226	16	17	43	27	19	1	114,874	16
Omugo	4425	9600	28	34855	1042	2650	455	626	6683	-	0	-	25	11	-	109,642	17
Busia	3631	4701	34	41414	1660	5815	-	298	9904	31	38	-	23	29	-	109,216	18
Buyinja	4775	13057	27	27868	734	1769	237	298	3370	-	28	-	27	6	-	104,989	19
Midigo	4995	9641	72	21687	902	1909	739	1020	4816	38	74	177	29	14	-	103,919	20
Budadiri	4459	11810	47	25059	1628	2910	295	340	9129	54	141	87.5	34	26	2	103,682	21
Kaberamaido	3521	12253	74	41124	723	1386	127	140	2600	42	183	11	34	9	2	98,901	22
Buwenge	4613	12239	32	21667	879	1862	723	153	3814	11	21	-	6	2	-	97,389	23

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Facility	IPD Admissions	IPD Patient Days	IPD Beds Available	Total OPD	Deliveries in unit - OPD	Total ANC	Postnatal Attendances	Family Planning contacts	Immunization	Caesarian Sections-IPD	Major operations	Blood Transfusions (Units) - IPD	IPD Deaths	Fresh Still births in unit - OPD	Maternal deaths - OPD	SUO	Rank
Kakuuto	4423	17202	55	25489	505	1735	118	157	6418	55	76	443	62	15	2	96,648	24
Kumi	3220	5547	22	39864	461	2013	417	1183	6668	-	0	-	1	1	-	93,609	25
Dokolo	4116	22233	65	25398	771	1565	266	698	4269	104	253	66	73	96	4	93,111	26
Kibuku	3599	5487	33	29637	1198	2063	509	146	3953	-	30	73.2	9	6	2	91,762	27
Bishop Asili Ceaser	4260	14800	80	21169	1078	640	262		2711	488	841	741	308	52	6	91,452	28
Mukujju	3624	10222	26	29297	664	2209	1126	459	4916	-	1	-	7	2	-	89,857	29
Ogur	2190	6902	36	48970	1007	1595	197	448	6305	-	6	-	19	8	1	89,236	30
Ntwetwe	3803	8764	39	22454	1332	2748	140	612	6024	72	116	7	24	21	-	89,114	31
Kibaale (Kibaale)	4581	4556	34	13405	998	1911	180	427	3045	75	94	34	12	22	2	88,978	32
Kasangati	2662	4140	31	29987	2364	6536	484	256	14817	32	32	-	1	7	-	88,338	33
Rwashamaire	3383	13690	37	29767	1150	2294	129	520	2863	-	0	-	12	123	1	88,306	34
Wakiso	2512	3769	26	35183	1646	4296	660	641	21207	28	63	-	1	3	-	88,133	35
Mulanda	3557	10410	32	25956	965	3283	1585	1174	3735	-	0	-	22	96	1	87,904	36
Rukunyu	4150	13840	64	17739	1079	828	1077	347	4834	345	425	330	92	27	3	87,477	37
Mukono CoU	3674	9882	47	21248	1300	2333	1078	10	5397	353	584	261	74	20	3	85,648	38
Kigorobyaa	3228	6074	34	29637	910	2387	58	647	3314	-	10	8	16	3	-	84,816	39
Bwizibwera	3082	6051	32	26715	1603	2815	2630	193	3394	-	10	2	2	12	-	84,458	40
Muyembe	3669	6860	30	22217	906	2783	197	154	4201	-	0	-	23	5	-	84,189	41
Anyeke	3276	8372.4	58	26699	1028	2370	319	222	4804	85	143	85	35	14	-	83,395	42
Amuria	3380	11793	70	24058	1184	1919	719	335	4592	117	295	10	11	15	1	83,083	43
Namwendwa	3186	7658	31	25629	1156	2357	665	1085	5626	25	53	156	31	1	-	82,378	44
Busiu	3687	6412	42	19523	822	1468	140	201	2576	7	74	95	11	8	1	80,358	45
Kinoni	3558	5695	25	21008	582	1718	1384	262	2156	17	21			34	-	79,401	46
Tokora	4002	8996	34	15266	359	1115	1317	89	3183	50	54	230	53	14	3	78,988	47

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Facility	IPD Admissions	IPD Patient Days	IPD Beds Available	Total OPD	Deliveries in unit - OPD	Total ANC	Postnatal Attendances	Family Planning contacts	Immunization	Caesarian Sections-IPD	Major operations	Blood Transfusions (Units) - IPD	IPD Deaths	Fresh Still births in unit - OPD	Maternal deaths - OPD	SUO	Rank
Bukedea	3290	13320	42	19495	1309	2401	386	319	6500	-	73		13	9	-	78,243	48
Bumanya	3455	9395	32	20963	726	1860	240	283	3142	61	252		7	8	-	78,238	49
Bukomero	3005	5031	42	23249	1251	2787	113	311	6902	-	0		17	81	-	77,565	50
Rugazi	3166	6779	39	22141	1067	2101	90	163	3470	-	486	7	8	8	-	76,837	51
Nankandulo	2763	5122	37	29688	687	1620	390	1042	3253	-	0	105	8	-	76,745	52	
Magale	3805	11314	91	12426	941	1652	893		6022	71	135	319.3	76	32	-	76,683	53
ATIRIR	3106	6229	34	25363	483	1220	348	136	3040	-	13		5	3	-	75,828	54
Lalogi	2353	7981	38	35919	476	1399	242	437	3912	-	0	65	44	58	1	75,415	55
Kabwohe	2373	4503	33	28164	1736	2426	321	172	4053	99	103	90	26	15	1	74,709	56
Aduku	2948	10791	31	20547	1358	2609	337	404	4381	126	242	20	470	35	2	74,108	57
Nagongera	2550	4792	43	27180	984	2366	52	431	5945	-	0	-	4	12	-	72,964	58
Karenga	3073	10492	64	22836	265	909	326	34	3618	-	0	-	22	1	-	71,614	59
Kyabugimbi	2461	7277	30	28735	763	1975	137	559	3011	55	58	2	13	-	-	71,403	60
Pajule	3067	9942	37	18333	832	2240	600	540	3052	-	0	-	28	4	-	70,798	61
Princes Diana	3139	19561	40	18642	692	1350	458	241	2338	-	0	-	6	5	-	70,679	62
Kihiihi	2885	10722	64	21308	719	1795	128	772	2748	-	16	47	44	2	4	70,075	63
St. Paul	3565	13563	90	10123	954	1340	325	586	2830	407	655	403	85	22	4	70,060	64
Kyegegwa	2653	8992	36	22466	1063	1808	487	222	4533	120	229	102	30	18	1	69,741	65
Ruhoko	2349	6655	45	27247	1060	2149	55	232	2132	54	78	143	36	174	3	69,426	66
Butebo	2890	6697	34	16870	1035	3032	393	296	4590	10	39	114	10	15	1	68,174	67
Nakasongola	2240	4992	54	29400	682	1613	144	159	3339	-	62	37	28	2	-	68,036	68
Kiganda	2335	5128	20	22434	1415	3472	236	520	3883	132	183	-	10	46	1	67,425	69
Amach	2435	7676	52	25943	642	1245	61	354	3939		892	-	8	9		67,296	70
Kotido	2904	11523	59	19763	534	579	371	109	1307	54	55	-	19	20	2	66,784	71

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Kidera	2615	7878	30	19985	796	1899	823	237	7897	21	122	-	12	10	1	66,249	72
Alebtong	1803	9529	59	31883	807	2219	79	441	7784	5	8	-	37	11	2	65,889	73
Bufumbo	2735	7796	30	18975	595	1639	569	304	3898	-	0	-	229	59	-	65,011	74
Kangulumira	2009	3262	23	25606	1135	3191	187	596	6168	-	0	-	16	6	-	64,637	75
Obongi	2482	8132	47	24033	401	738	207	686	1445	9	79	123	138	3	-	64,373	76
Kawempe	1909	1909		23571	1485	3843	776	370	6210	15	17	-		2	-	63,368	77
Nankoma	2101	4995	25	24668	660	2517	1031	629	7172	-	0	-	7	5	-	63,006	78
St. Ambrose Charity	3201	7487	65	5391	1487	1462	114	174	4516	545	660	447	86	54	8	62,619	79
Nsinze	2253	5106	30	22028	908	1486	361	675	2288	-	0	-	11	4	-	62,082	80
Aboke	2410	5458	18	18537	935	1994	115	341	5338	40	69	-	1	8	-	61,655	81
Busesa	2018	4060	24	23102	878	2593	2934	590	3107	10	11	-	61	6	-	61,442	82
Kanungu	2392	7136	20	21303	546	1051	56	202	1391	-	0	-	5	4	-	60,846	83
Patongo HC III	1692	4232	23	29656	563	2852	177	417	5509	-	0	-	6	2	-	60,676	84
Apapai	2226	4103	23	22850	617	1262	213	97	2806	-	0	-	1	9	-	60,672	85
Mungula	2488	9153	36	20037	379	754	135	180	1542	-	0	-	18	3	-	60,095	86
Kakumiro	2098	10120	55	19255	1266	2853	111	136	4873	111	120	79	20	13	-	59,580	87
Mitooma	1236	3348	41	36226	489	1750	64	277	4318	12	12	-	9	1	-	59,120	88
Semuto	1582	2416	24	30458	574	2019	228	30	2954	-	0	-	4	73	-	58,787	89
Benedict Medical centre	1358	2955	49	33941	367	584	237		1723	88	183	35	10	6	-	56,901	90
Buliisa	2272	5126	36	18118	557	1692	102	37	4501	-	0	-	25	66	-	56,799	91
Nyamuyanja	1859	3226	24	25185	444	1193	35	583	2669	45	57	-	5	53	-	56,729	92
Bbaale	1669	4739	17	27204	370	1607	200	727	2234	-	0	113	10	-	55,803	93	
Rugaaga	1737	4190	18	25842	395	1424	105	206	4206	-	2	-	1	3	-	55,581	94
Kiruhura	1936	5222	27	22384	416	1390	134	151	4832	-	11	-	4	6	-	55,308	95

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Kakindo	2007	4642	37	18358	752	2420	300	255	5614	116	116	34	11	11	2	54,833	96
Kyarusozzi	1795	4157	30	22189	818	1617	86	562	1924	60	74	94	27	6	-	54,721	97
Bubulo	1716	2561	24	20545	780	2081	2361	525	3701	-	3	-	3	10	-	53,409	98
Amolatar	2047	5851	44	17116	617	1929	171	88	2514	-	0	-	30	3	-	52,503	99
Padibe	1763	5046	34	20581	659	968	390	646	2466	21	27	26	45	7	-	51,816	100
Kitebi HC III	-	-	-	29881	2776	9855	766	886	11194	-	0	-	-	7	1	51,753	101
Kassanda	1671	3335	8	18145	1137	3236	152	187	4202	-	0	-	1	16	-	51,523	102
Ishongororo	1696	4988.9	35	20732	664	2337	52	180	3479	16	33	-	6	11	-	51,472	103
Naam Okora	1985	5389	36	18039	481	876	186	303	2156	-	0	-	15	1	-	51,333	104
Nabilatuk	2325	5144	30	13473	368	789	289	36	2900	14	48	47	50	7	-	51,325	105
Kigandalo	1219	1916	16	26259	784	1956	154	643	4044	-	0	-	2	3	1	50,649	106
Awach	1852	5349	31	19555	447	705	182	132	2806	-	46	-	9	1	1	50,641	107
Namayumba	1133	1873	20	27693	733	2320	80	53	3175	19	59	30	19	16	1	50,215	108
Kazo	1032	2273	35	29290	537	2237	162	250	3747	-	0	-	6	2	-	49,529	109
Bwijanga	1662	4727	26	19812	577	2178	131	298	2968	-	6	-	20	7	-	49,524	110
Rhino Camp	2203	4166	30	12098	533	1263	243	173	3755	-	0	-	17	7	1	49,399	111
Kapelebyong	1592	5246	47	21714	462	1163	308	182	2980	-	0	-	1	4	-	49,327	112
Kiyunga	1573	2416	30	17980	933	2468	1200	577	2799	5	12	-	4	7	-	48,922	113
Kityerera	1146	1618	9	25887	645	2635	247	563	4413	-	0	-	-	5	-	48,907	114
Ntara	1982	5694	31	13677	682	1282	465	549	2871	152	155	112	15	12	-	48,539	115
Kaproron	2150	2477	34	13109	366	1180	423	17	1748	-	55	-	10	7	-	48,349	116
Kebisoni	1558	2477	32	20323	569	1383	200	279	1967	-	3	-	1	1	-	47,862	117
Bugembe	433	259	27	30026	1461	3638	419	691	7256	-	0	-	-	6	-	47,651	118
Ndejje	1053	2165	16	23108	930	3170	533	292	8846	1	8	-	6	2	-	47,320	119

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Toroma	1651	4991	36	18254	486	818	460	617	2431	-	0	-	6	1	-	46,883	120
Bukulula	949	1751	17	30029	173	1045	591	213	2922	-	2	70	4	1	-	46,638	121
Atiak	1673	4900	26	18985	188	860	124	985	2657	-	4	-	10	-	-	46,536	122
Bukuku	1051	1506	6	19189	954	2232	981	8611	3255	50	78	-	10	5	-	46,287	123
Lwengo	1270	3038	14	23645	337	1664	167	160	4133	-	0	11	4	-	-	46,202	124
Budongo	1327	2384	23	21316	615	1635	339	594	3078	-	0	-	-	2	-	46,196	125
Rwekubo	1325	3097	18	22182	557	954	45	276	1072	203	275	4	8	10	1	45,694	126
Nyimbwa	1474	2413	18	19456	452	1415	137	281	1939	6	18	-	4	4	-	45,130	127
Adumi	1468	5234	38	18489	462	1333	98	205	4872	3	8	-	7	15	-	44,611	128
Bugangari	879	2063	22	27501	465	1201	204	379	2670	-	0	-	1	5	-	44,437	129
Kibiito	766	1081	6	26544	705	2427	138	331	2552	19	22	-	-	7	-	43,517	130
Kalangala	603	895	41	31768	211	887	45	1216	1095	15	123	2	14	1	-	43,161	131
Kikyo	1806	2761	18	14155	238	700	71	59	1424	-	0	-	2	4	1	43,135	132
Bugono	1398	1506	20	17615	605	1150	314	659	2131	-	62	-	54	2	-	43,098	133
Wagagai	1149	1957	19	23058	328	695	772	87	1854	68	122	24	125	2	-	43,081	134
Muko	1230	2102	20	20572	411	1328	211	520	1922	3	5	-	6	-	-	42,491	135
Walukuba	-	-	-	37752	554	2054	445	367	2071	-	0	-	-	3	-	42,369	136
Orum	1314	3948	35	19349	374	867	15	216	2256	-	6	-	10	4	-	41,929	137
Chahafi	1239	2808	19	19909	407	1376	196	203	1659	-	0	-	1	-	-	41,748	138
Kalagala	1409	1296	30	16467	387	1208	234	1580	2285	8	34	-	11	5	-	41,505	139
Karugutu	1106	2138	30	22115	267	1097	42	116	3754	-	5	-	9	2	-	41,418	140
Hamurwa	1025	1847	26	21735	460	1450	85	467	1802	-	0	-	1	3	-	40,771	141
ASTU	-	-	-	39972	-	-	-	101	0	-	0	-	-	-	-	40,023	142
Shuuku	954	2704	28	21385	539	1288	105	233	2660	11	13	-	-	3	-	39,735	143

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Rubuguri	1198	3825	32	18652	413	809	72	239	1934	-	2	-	4	6	-	39,634	144
Kyazanga	967	2354	19	19577	421	1975	246	282	4667	-	7	-	3	1	-	38,372	145
Kiwangala	753	1702	13	22006	398	1412	353	294	9627	11	53	6	65	3	-	38,246	146
Buwambo	338	671	14	30335	298	943	77	193	3679	-	0	-	-	2	-	38,237	147
Madi-Opei	997	2027	33	20481	310	816	355	469	1928	-	1	3	7	1	-	38,192	148
Maddu	1124	1968	32	17204	440	1208	407	71	2525	-	0	-	14	5	-	37,612	149
Mpumudde	516	409	25	23293	618	2848	803	670	2623	-	0	-	-	1	-	36,808	150
Butenga	885	1999	21	18753	331	1503	342	134	3749	12	27	108	8	28	-	35,422	151
Rwesande	1663	4998	36	6905	314	1223	240	135	2796	86	138	-	22	6	-	34,778	152
Buwasa	408	476	12	25113	393	1108	197	677	2447	-	0	-	-	4	-	34,678	153
Busaru	1940	5866	54	1335	322	1477	157		5048	30	34	82	22	2	-	33,872	154
Rubaya	864	2430	33	17891	351	1166	127	222	1525	-	0	-	7	3	-	33,669	155
Mukwaya General Hospital	461	846	28	24517	282	461	37	47	2079	53	91	4	2	-	-	33,530	156
Ssembabule	619	1006.3	24	19683	379	2478	116	555	5138	-	0	-	-	1	-	33,465	157
Nsiika	488	820	16	24000	244	754	9	328	1502	5	5	-	-	28	-	33,386	158
Masindi Military Army Barracks	738	2077	40	21427	33	197	9	37	522	-	0	-	3	-	-	32,888	159
Ssekanyonyi	878	1901	24	15874	455	1264	241	719	2170	-	0	-	2	5	-	32,865	160
Kikuube	-	-	-	25495	1019	2836	92	328	2668	-	0	-	-	20	-	32,752	161
Mparo	980	2013	23	14664	310	663	223	600	859	-	0	-	7	-	-	31,829	162
Bishop Masereka Christian Foundation	1626	3246	18	4817	297	633	36	166	1783	139	229	-	26	1	-	31,466	163
St. Joseph of the Good Shepherd Kyamulibwa Ngo	1458	4599	73	7724	270	200	150	11	795	50	114	213	11	5	-	31,284	164
Bukwa	1412	4193	60	7748	202	645	501	68	2669	26	136	8	9	8	-	31,079	165
Kyannamukaaka	622	1088	35	20090	143	846	101	161	1826	-	0	-	-	1	-	31,054	166
Bugamba	763	1929	29	16094	318	1489	300	362	1775	-	0	-	-	-	-	30,560	167

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Buhunga	687	2103	18	17149	363	607	90	433	1653	-	0	-	-	-	-	30,165	168
Maziba Gvt	920	2535	34	13378	228	1018	103	820	844	-	0	-	10	1	-	29,457	169
Franciscan	1591	1291	20	5125	71	120	16	-	40	-	2	-	3	2	-	29,421	170
Kamwezi	430	999	30	19479	426	860	273	299	2063	-	11	-	5	-	-	29,188	171
Ntungamo	-	-	-	23084	770	2337	54	405	3638	-	0	-	-	7	-	29,060	172
Buvuma	716	1457	20	15567	329	1035	116	140	2082	-	14	-	1	40	-	29,014	173
Bushenyi	447	855	28	19223	292	1058	367	324	2900	-	0	-	1	3	-	28,843	174
Koja	318	491	23	17759	579	2138	322	1089	5474	-	50	-	4	3	-	28,293	175
Mwera	690	1797	18	14269	324	815	147	130	2088	5	9	-	-	-	-	27,203	176
Kamukira	-	-	-	25577	43	773	146	626	963	-	0	-	-	-	-	26,757	177
Ngora Gvt	316	416	20	19374	201	1249	134	186	1948	-	0	-	32	1	-	26,293	178
Kiyumba	530	890	16	15346	310	808	43	223	1300	27	30	16	1	-	-	25,643	179
Namatala	-	-	-	23542	-	2027	539	292	2728	-	0	-	-	-	-	25,517	180
Busanza	631	1558	16	13682	326	604	45	189	740	-	0	-	1	1	-	25,344	181
Ngoma	282	703	20	18491	158	958	82	110	2449	-	0	-	1	3	-	24,576	182
Luwunga Barracks	187	54	30	19914	64	324	49	201	514	-	0	-	-	-	-	23,429	183
Kyantungo	591	1136	22	12425	221	522	256	116	2041	1	1	-	8	-	-	23,250	184
Butiru HC III	-	-	-	20854	126	998	178	424	3791	-	0	-	-	-	-	23,042	185
Mbarara Municipal Council	-	-	-	14954	166	3068	4288	649	4512	-	0	-	-	2	-	20,689	186
Kataraka	1	2	-	16003	23	653	170	189	1234	-	0	-	-	-	-	16,886	187
North Kigezi	847	2100	22	2267	221	246	463	104	586	6	12	4	-	1	-	16,601	188
Bukasa	320	619	11	10708	65	253	75	78	1102	-	0	-	2	-	1	16,256	189
Kampala Hospital	-	-	-	11409	479	210	265	-	3034	-	0	-	-	3	2	14,648	190
Ntuusi	98	226.6	1	11212	116	1194	50	213	1436	-	0	-	-	-	-	14,278	191

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SAS Clinic, Bombo Road	-	-	-	6911	29	58	28	36	66	-	0	-	-	-	-	7,130	192
Nyamirami	-	-	-	6456	2	491	15	49	1430	-	0	-	-	-	-	7,030	193
Hiima Iaa (Uci)	-	-	-	5149	8	44	5	1	33	-	0	-	-	-	-	5,221	194
Women's Hospital and Fertility Centre-Bukoto	-	-	-	2913	108	266	32	-	0	-	0	-	-	-	-	3,602	195
Mbarara Municipal	-	-	-	1547	9	274	-	116	197	-	0	-	-	-	-	1,826	196
Count	181	181	179	196	194	196	193	189	196	88	196	70	161	167	49	196	-
mean general	2,347	6,219	35	21,988	748	1,810	391	409	3,864	90	77	146	29	15	2	60,270	-
Minimum	1	2	1	1,335	2	-	5	1	-	1	-	2	1	1	1	1,826	-
maximum	8,192	38,745	163	48,970	5,225	10,150	5,057	8,611	25,683	594	892	1,042	470	174	8	180,815	-
Sum	424,828	1,125,651	6,324	4,309,611	145,124	354,793	75,489	77,242	757,440	7,906	15,096	10,208	4,621	2,500	104	11,812,901	-
count non blanks	181	181	179	196	194	195	193	189	194	88	121	70	161	167	49	196	-

### 3.6 Client Satisfaction Report By Civil Society Organisation (UNHCO)

Client satisfaction is defined as the degree to which the goods, services and products provided meet clients' needs and expectations. It is measured through studies, exit polls and community monitoring of service delivery. The major drivers of client satisfaction are expectations and realities regarding waiting time, opening and closing time of facilities health workers' attitudes, availability of medicines and supplies and Human Resources for Health, functional feedback and redress mechanisms, transparency and accountability and quality of the health care.

#### Progress

Client satisfaction has not been fully tracked on a routine basis yet it influences demand. UNHCO in the year under review has implemented various initiative e.g the community score card, client satisfaction studies to assess progress and also strengthen demand. We are also advancing to an automated system to routinely conduct exit polls (subject to MoH approval) of client satisfaction. There system is already in place, there is a tool in place and there iPads to support this. For its internal project progress review purposes, UNHCO conducted a satisfaction study in 11 districts in Uganda which shows positive progress.

#### Client satisfaction with accessibility of health care

Given the diversity of CSOs, internal coordination is still a challenge although considerable progress has been made. This has resulted into increased CSOprogrammatic interface with the health sector. Increasingly, CSOs have ably advocated for policy reviews and change at HPAC, technical working groups, Area teams. For instance, our sector cooperation included development of the HSSIP, formulation of the sharpened plan/promised renewed was all inclusive, a gesture forincreased participation in policy reviews. UNHCO was assigned to spearhead the development of the community scorecard to monitor the sharpened plan implementation.

The endline evaluation of MHP by VHR/UNHCO revealed that knowledge of at least three danger signs in pregnancy and childbirth has more than doubled in all areas of maternal health project compared to the baseline 26.2%. Similarly, Knowledge on MSRH rights increased from 13% at baseline to above 81% at end line through social and media campaigns. Generally, community perception of MSRH increased from 84.4% at baseline to over 90% in the project timelines.

Integrated outreaches organized by the project have made a significant contribution to increasing access to MSRH services especially in hard to reach and underserved areas. By the final evaluation, the MHP had supported a cumulative 1388 outreaches conducted by the 41 supported health facilities. Positive engagement of VHTs in mobilization and follow up of pregnant mothers through home visits has improved compliance with ANC and PNC and a significant reduction in maternal health complications and death though the system of maternal death audits in the community is not yet functional. Community systems strengthening under the MHP have therefore demonstrated a positive trend in increasing access to MSRH services in limited resource settings.

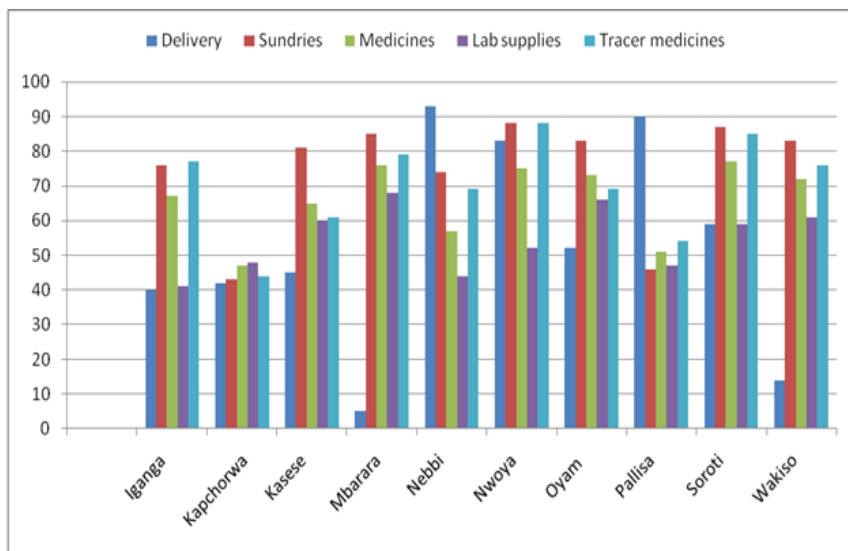
*"...It is true, there are more women coming for services yet buildings, beds and health workers have not improved to match the situation", [DHO, Soroti District]*

Limited gender empowerment and male involvement in maternal functions of women is key to access. Long distances and un-affordable travel costs to Health Centers, unemployment and reproductive health, grounded ambulatory Service across districts. All these have affected access to health services

### Client satisfaction with availability of health care

Field reports from the various districts have shown a considerable improvement in medicine availability. The client satisfaction with services in Uganda's public Health facilities' study conducted by the Medicines Transparency Alliance and Uganda National Health User'/Consumers' Organization (2014), rated client satisfaction with Health facilities at 47%; availability of tracer medicines at 79% and medicines in general at 63% laboratory supplies at 54%. The study covered 10 districts and 202 health facilities as shown by the graph below

*Figure 26: Graphical representation on availability*



*Source: Adapted from client satisfaction study Report 2014*

There was a remarkable improvement as compared to the previous financial year thus positive trend. However, this trend has not translated directly into reduced disease burden and morbidity. For instance Reproductive Health items have remained constant despite the challenging reproductive health issues e.g. contraceptive prevalence rates of 30%, unmet needs of family planning services at 34%, the percentage of women attending 4ANC visits stands at 31%. This trend in the figure above negatively impact on client satisfaction. **AHSPR2013/2014**

Emergency Obstetric care has been failed by lack of equipment, chronic absenteeism of theatre attendants and medical officers and theaters that have taken more than 10 years to build and function such as Nankandulo in Kamuli, Kyanamukaka in Masaka, Kassanda in Mubende, Kikube in Hoima, Kalenga H/C IV in Kabongo District and many more across the country. This has made the functionality of health center IVs difficult and questionable. Some have been turned into theatres for safe male circumcision contrary to the intended purpose.

### Client satisfaction with quality of health care

With support from Sida through Maternal health project, 24 Maternal Perinatal and Death Reviews (MPDR) committees from 10 districts were orientation by the Ministry of Health and Voices for Health Rights /UNHCO. Guidelines rolled out for improving the quality of maternal health services in the country. Reviews are being conducted and notifications made to the Ministry wherever cases occur in the districts.

Advocacy for increasing the PHC non wage to 63 billion from the currents 43 billion has been conducted by the CSOs together with the health committees and budget committee of parliament. This is to

improve district supervision and activation of the VHT structure for universal health coverage and quality of the information disseminated to the public.

The tobacco control bill is yet for second reading on the floor of parliament and hopeful for parliament to pass it and implement it. This will control the spread of secondary infection with TB of the citizens.

Consultation on the patients' rights bill has been carried out to effect citizen empowerment demand for quality health care across the country.

One of the greatest challenges has been the high utility bills and early this year Mulago Referral Hospital was cut off from water supply. CSOs together with the media intervened and government later responded by reconnecting the hospital. Busia Hospital and Abim Hospital have experienced similar disconnections over high utility bills and slow response has greatly undermined some clinical procedures and generally infection control.

A number of health facilities have been mismanaged by junior staff as in charges due to poor supervision by districts, poor pay, lack of incentives and motivation

Continued deliveries by Traditional Birth Attendants (TBAs) in most of the districts has greatly affected the quality of motherhood and sometimes resulting into preventable deaths and development of maternal related complications among pregnant women. A 31 year old mother of 5 from Kabong said "*I am treated better here (TBA) than in a government hospital where they were rude to me.*" *Some of these alternatives have become death traps for these mothers.*

### **Client satisfaction with accountability of health care**

As a follow up on the recommendations of client satisfaction survey, 2014, pilot project is being implemented in Pallisa and Iganga for generating an automated data base on MPDR, CSC and patient exit poll as shown in the appendix attached. Automation was completed and the Ministry of Health picked interest to institutionalize community empowerment and accountability based on the UNHCO model and to build capacity of the Maternal Health Cluster in the development of a balanced score card to monitor the "Reproductive, Maternal, Newborn And Child Health Sharpened Plan". UNHCO-OSF Report 2014

140 community monitors from 7 districts have been oriented and trained on monitoring of service delivery using the rights based approach. 65 health facilities in 20 districts have been empowered to functionalize Feedback and redress mechanisms. In Kitagata Hospital the board has resolved that no patient should stay for more than one hour at the facility while Mityana hospital have requested for a more rigorous feedback and redress mechanism to influence transparency.

Feedback and redress mechanisms were functional where other partners have supported the Health Unit Management Committees and Hospital board to participate and plan for the health care. These platforms have provided linkage between the service providers and community users (Assessment report UNASO 2014)

### **Recommendations**

1. Budget increment : Client centered budgeting for health care should be made a priority to reverse the statement by( MoFPED)*"Ill health is the most frequent cause and consequence of poverty"*
2. Health insurance scheme Bill of 2007 be legislated to allow for universal coverage of the health care and also the right to access to health services for the benefit of local consumers comprehensively legislated upon.
3. Focus and strengthen supervision by MoH , local government , Unit in charge to improve the quality of care offered to the consumers

4. Public - Private partnerships - address disparities, tap private resources for the public and increase competitiveness for improved quality
5. Continue to empower Women and men to participate, make informed choices and decisions and demand for quality health care
6. Build and strengthen mechanisms for community engagement and social accountability.
7. Regular measure and respond to client satisfaction challenges.

## **Conclusion**

There is considerable positive progress in client satisfaction. This improvement only happens, when clients are empowered to demand, constructively participate in health care planning and delivery and when there is joint action between communities and health workers. Quality improvement and thus quality health care are key drivers for client satisfaction. Good stewardship where health services are well managed, leaders get involved in improving health services and the gap between clients and the health system is properly closed, results into better healthcare.

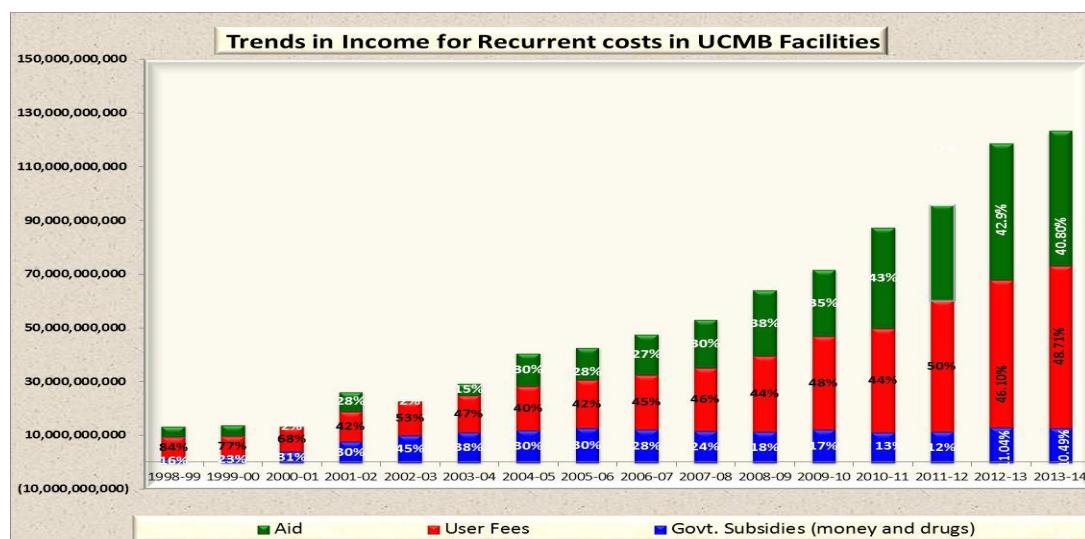
### **3.7 Uganda Catholic Medical Bureau (UCMB) performance**

The Uganda Catholic Medical Bureau (UCMB) a health department of the Catholic Church in Uganda coordinates, represents, and supports 281 accredited health facilities and 13 heath training institutions. The health facilities comprise of 32 hospitals, 5 health centres level IV, 169 health centres at level III, and 75 health centres level II

#### **Health Financing in UCMB network: 2013 / 2014.**

Total expenditure by the UCMB facilities amounted to 147.9 billion shillings in FY 2013/14 compared to 131.6 billion in FY 2012/2013. Government subsidies included the primary health care conditional grant to UCMB facilities and the MOH- DP Bursary funds for trainee beneficiaries in UCMB Health Training Institutions. Overall, government subsidies to UCMB facilities contributed 10.49% of the budget financing in the year, user fees financed 48.71% and donations contributed 40.80% (Figure 24).

*Figure 27: Trends in income for recurrent cost in UCMB network (Hospitals + Lower Level units)*



Source: UCMB

Government contribution decreased in absolute terms from 13.1b (2012/2013) to 12.9bn (2013/2014). This support includes subsidy through the PHC CG for NGO - Non Wage Recurrent and the Bursary Scheme funded by Development Partners through MoH going to some beneficiaries from hard-to-reach districts. With reducing budget support, these PNFPs have reverted to user fees.

#### **Perfomance based financing (PBF) expereince in diocese of Jinja**

New Inovations with support from Cordaid such as Perfomance Based Financing (PBF) with the aim of increasing efficiency and quality of care have been piloted in both public and private facilities in Jinja and Kamuli. Results from the pilot so far indicate increasing trends of performance as shown below in Table 17.

**Annex One. Table 16: Indicator performances for PBF supported government facilities - Kamuli district**

No	Indicators	Target	Achieved	%Analysis
1	OPD visits	260,984	325,555	125
2	ANC 1 <sup>st</sup> visit	19,507	14,865	76
3	ANC 4 <sup>th</sup> visits	6,149	5,157	84
4	ANC IPT2	7,027	8,570	122
5	Deliveries	6,997	6,507	93
6	Referral EMoNC for pregnant mothers	416	481	116
7	Post Natal Care	4,596	4,254	93
8	Family Planning new users	7,583	6,997	92
9	Child immunized	11,330	10,103	89
10	TB treatment	192	121	63
11	Caesarean Sections	792	600	76
<b>% average score</b>				<b>93</b>

Preliminary results indicate PBF as “magic bullet” to promote quality and efficiency in health service. Besides other direct investments, it has improved on HMIS data management, infrastructure improvement and facilitated community integrated health programs. Under PBF Namwendwa HC IV and Nankandulo HC IV became functional (to begin carrying out caesarean sections and blood transfusion which they had never done before).

#### **Summary of UCMB contribution to HSSIP outputs FY 2013/14**

- OPD services : New and Re-attendance slightly decreased by 4%
- IP services: Total number of admissions decreased by 4 %
- Maternity services: Total number of deliveries increased by 1.21%
- Child care: The number of immunizations decreased by 3.12%

#### **HIV Project specific performance**

The performance review of the project in the last financial year shows that the program has achieved the following:

- Provided 64,595 clients with HIV services (50% of the overall UCMB achievement) ;
- Counseled, tested, and provided results to 153,948 individuals (65% of UCMB annual achievement. 87% of those found positive have been linked to HIV care either directly in program run facilities or other facilities of their choice through a referral system.

- Provided HIV care to 64,595 patients (42% of the entire UCMB output and 42,471 currently on ART in the program supported hospitals alone).
- Under the project 20,128 men and children in reproductive age group have been circumcised as part of the combination prevention approach.
- Equipping all labs in the participating facilities with latest CD4, blood chemistry and microbiology diagnostic equipment..
- Provided OVC services to 9,800 children and their carers through its robust OVC program gave 45,000 individuals in HIV care PHDP services and did CD4 monitoring tests to 64% of all its patients (64,595) in care.
- Continuous skills development and enhancement among health workers in the areas of HIV, TB, and community services were also provided to over 600 health workers working in the project facilities.
- With funding from WHO enhanced TB/HIV co-management using the GeneXpert diagnostic technology in the districts of Tororo, Busia and Mpigi, not only serving the host hospitals of Nkozi and St Anthony's, but the entire districts.
- More than 250 patients were identified and put on treatment in addition to identifying and referring 5 MDR cases to MoH managed MDR treatment center.

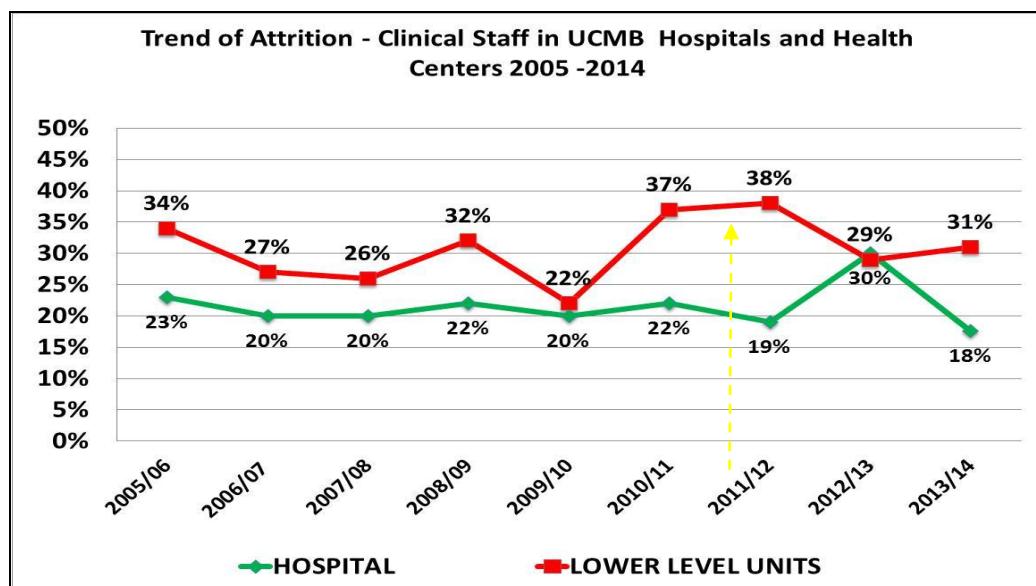
### **Human Resource for Health in UCMB facilities**

The total workforce in the UCMB networks at June 30th 2014 was 8,422 as compared to 8,225 as at June 30th 2013. This was a rise of about 4% over one year. Table 1 shows the distribution of the clinical and non-clinical staff by level of care.

Sixty five per cent of the health workers are in the hospitals and 35% are in lower level facilities. Of the total workforce 67% are employed for clinically related work and the remainder (33%) provide non-clinical support services e.g. administration, security, sanitary work etc. Of those engaged for clinical services in hospital 86% are qualified; in the lower level health facilities 89% of the clinical staff are qualified.

Human resource for health has for several years remained a major challenge to the UCMB because of the high turnover, as indicated in the Figure 25.

*Figure 28: Trend of turnover of clinical cadres in UCMB health Centers and hospitals 2005-2014*



## Reasons for the attrition

Recruitment by Local Governments (LGs) caused a shift of health workers from PNFP facilities. Majority of health workers (25%) moved to LG-public facilities seeking for better working terms. Other reasons included; going for further studies, end of contract and bonding agreement, poor performance, absconding from work and indiscipline.

## Other contributions of UCMB to the HSSIP in FY 2013/14

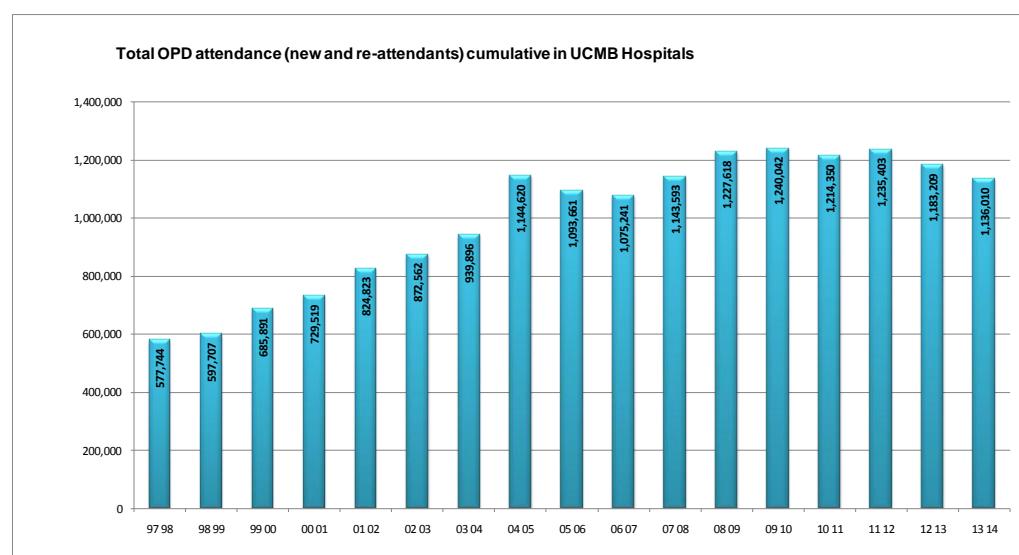
- The training of human resources for health as shown in table 4;
- A total OPD attendance (new and re-attendance) was 1,136,010 as seen in figure 26
- Total admission in hospitals for 247,203 (cumulative number) and;
- The number of deliveries in UCMB Hospitals (sample of 65% of the PNFP Hospitals) was 56,473.

*Annex One. Table 17: UCMB – Health Training Institution Performance: 2008/09 – 2012/13.*

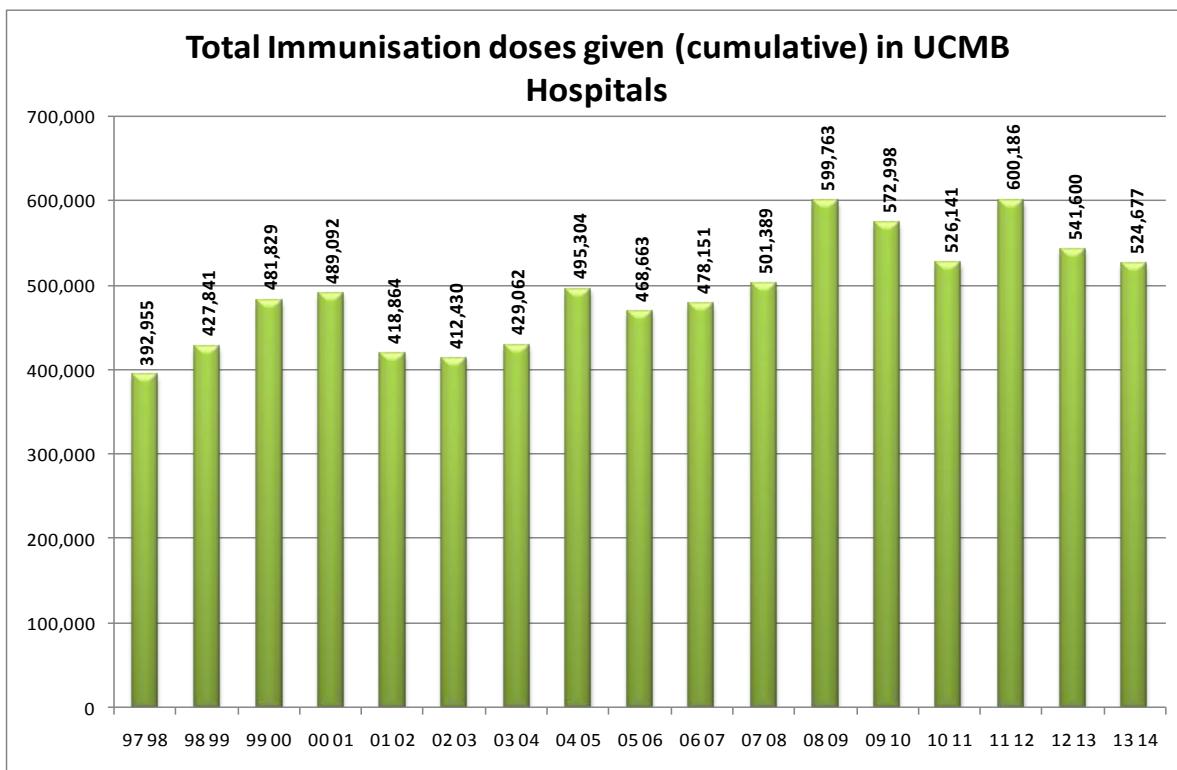
Programme Offered	2008/ 2009	2009/ 2010	2010/ 2011	2011/ 2012	2012/ 2013	Cummulative Number of Graduates	Percentage share by Programme
Certificate Nursing	101	99	80	148	176	<b>604</b>	<b>17%</b>
Certificate Midwifery	138	134	97	137	250	<b>756</b>	<b>21%</b>
Certificate ECN	177	206	255	145	131	<b>914</b>	<b>26%</b>
Certificate Clinical Laboratory	76	69	44	85	109	<b>383</b>	<b>11%</b>
Diploma Nursing	106	121	95	68	79	<b>469</b>	<b>13%</b>
Diploma Midwifery	67	71	54	62	62	<b>316</b>	<b>9%</b>
Diploma Medical Clinical Laboratory	18	14	28	22	9	<b>91</b>	<b>3%</b>
<b>Total</b>	<b>683</b>	<b>714</b>	<b>653</b>	<b>677</b>	<b>816</b>	<b>3,533</b>	

Source: UCMB.

*Figure 29: Total OPD attendance (new and re-attendance) in UCMB Hospitals*



Source: UCMB

*Figure 30: Cumulative number of Immunization doses for UCMB Hospitals.*

Source: UCMB

In general terms the performance has declined compared to last FY 2012/2013. This could be attributed to the challenges of reduced funding and human attrition among others.

### 3.8 Uganda Protestant Medical Bureau (UPMB) performance

The Uganda Protestant Medical Bureau (UPMB) is a national umbrella organization for Protestant, Adventist and Pentecostal founded member facilities. It was founded in 1957 by government by government notice no.672. UPMB is the health technical arm of the church of Uganda (CoU) and the Seventh Day Adventist Church (SDA).

The Bureau supports activities of 278 health units affiliated to the Protestant, Adventist and Pentecostal churches of Uganda. The 278 units include 18 hospitals with 10 Health Training Institutions (HTIs), 6 HC IVs and 254 Lower Level Units comprising about 31-35% of the private, nonprofit health facilities across Uganda. Accessibility to drugs and medical supplies for member units is ensured through the Joint Medical Store (JMS), founded and owned jointly by UPMB and UCMB.

#### Staffing in UPMB Member facilities:

Data obtained for the last four FYs shows an increasing trend in staffing numbers for UPMB hospitals. During the review period, UPMB received support from SDS and Mild May Uganda to recruit and also meet the staff salaries for its member health facilities. A total of 72 staff were recruited under the SDS Project and posted in 31 UPMB facilities while the Mild May Uganda supported 16 staff in 7 Health facilities. This and other factors explain the increasing trend in the staffing numbers across the different levels of care. However, the biggest challenge facing UPMB facilities is staff turnover, which the secretariat works tirelessly with other players in the sector to address.

*Annex One. Table 18: UPMB - Hospitals contribution to the HSSIP:*

Financial Year	Total Inpatient Admissions	Total Deaths	Total Inpatient days	Average length of stay	Average occupancy	Bed Occupancy
2013-2014	110,279	1,429	275,827	2.5	755.7	27.6
2012-2013	107,265	1,958	492,799	4.59	1350.1	50.0%

*Annex One. Table 19: UPMB - HC IVs contribution to the HSSIP*

Financial Year	Total Bed capacity	OPD Attendance	Admissions	Deliveries	ANC and FP	Immunization
2013- 2014	461	70,168	19,862	4,551	14,251	39,716
2012-2013	401	63,121	23,017	2,653	14,338	29,557
2011 - 2012	357	69,212	9,606	4,665	10,019	38,231
2010 - 2011	209	75,673	15,771	4,087	8,407	40,645
2010 - 2009	230	90,336	59,357	4,199	6,701	38,379

*Annex One. Table 20: UPMB - Census Information*

FY	Total Inpatient Admissions	Total Deaths	Total Inpatient days	Average length of stay	Average occupancy	Bed Occupancy
2013- 2014	19,862	348	73,649	3.7	201.8	43.8%
2012-2013	23,017	468	102,285	4.44	280.2	69.9%

### Staff productivity in UPMB hospitals (Standard Unit of Output per staff)

The indicator Staff productivity (Staff SUO) is obtained by computing the SUO for each facility and dividing it by the total number of staff available for the period under review – implying the staff SUO has a direct relationship with the hospital SUO and an inverse relationship with the total number of staff at the facility.

Figure 28 shows the SUO for UPMB hospitals for the previous three FYs. The primary vertical axis represents the SUO for the three FYs while the secondary vertical axis represents the staff SUO. UPMB hospitals registered a 0.5% increase in total SUO with a fall in staff productivity. This could be explained by the increase in staffing numbers in UPMB hospitals (Staff productivity being inversely related with the number of staff at the facility)

*Figure 31: Standard Unit of output in UPMB hospitals*

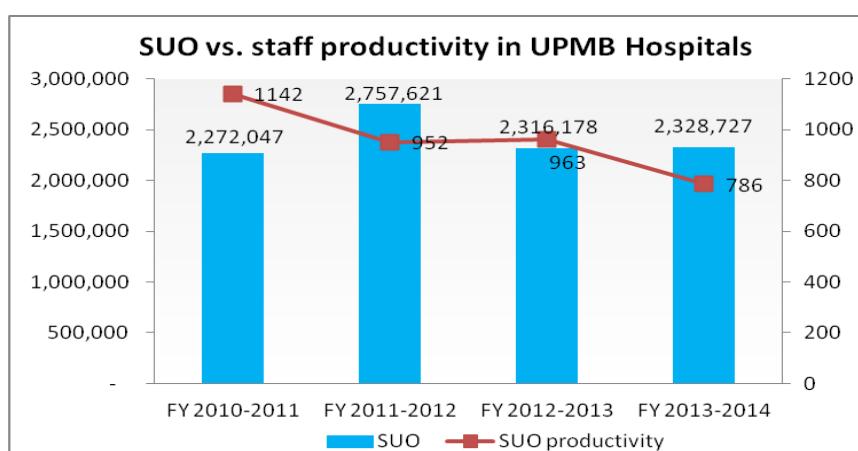
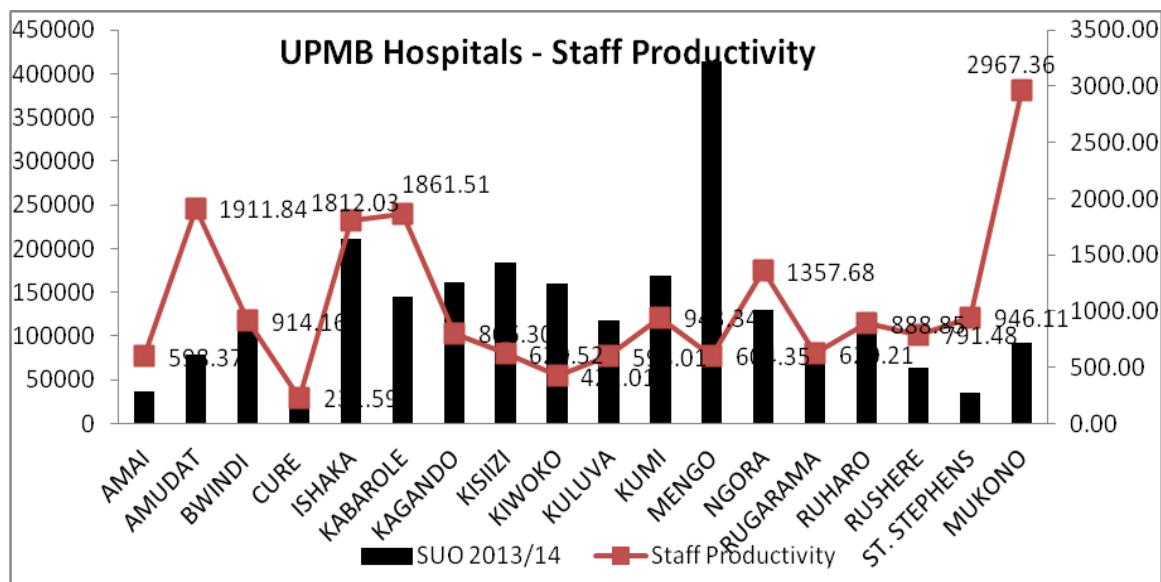
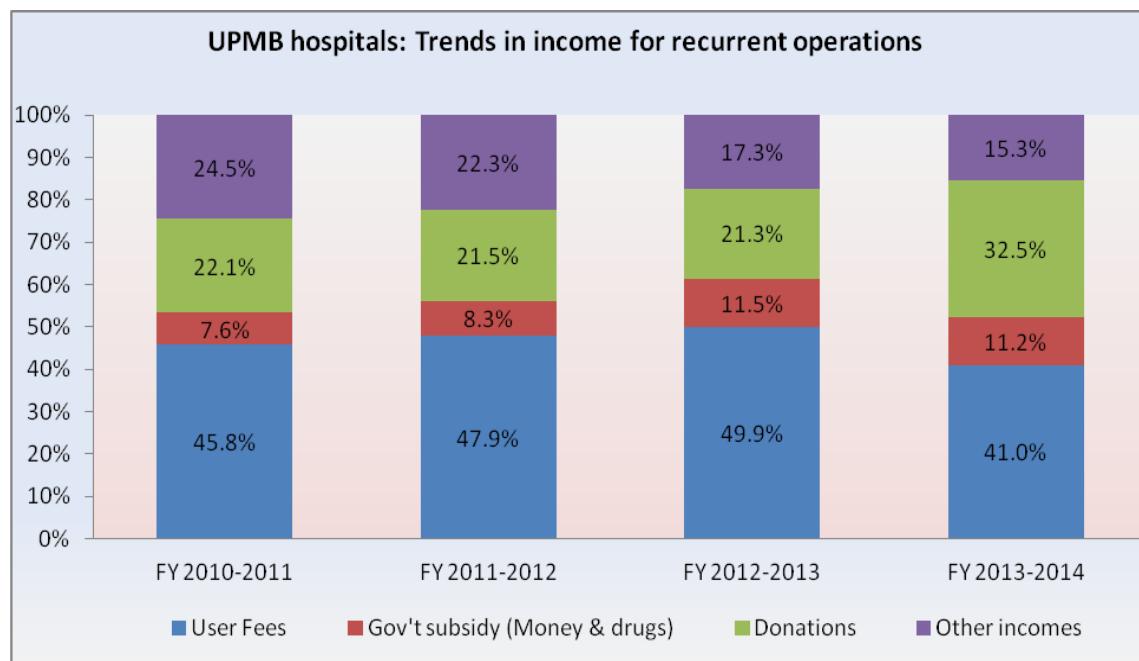


Figure 32: Staff productivity per facility during the FY



Mengo hospital registered the highest Standard Unit of Output (SUO) during the FY while Mukono COU hospital registered the highest staff productivity.

Figure 33: Trends in income for recurrent operations for the previous 3 Fys



In the 2013-2014 FY, the cash inflow from user fee collections decreased in relative and absolute terms for UPMB hospitals by a margin of over 8% in comparison with the previous year but continue to be the major source of income for the hospitals, financing approximately 41% of the overall recurrent cost incurred by health facilities to deliver quality health care. Data analyzed for the previous financial years shows that user fees are the major source for the facility. External donation both in kind and in cash contribute increased during the review period from 22.1% in 2010-11 to 32.5% in 2013-2014. Government subsidies to UPMB hospitals (these include PHC conditional grant to hospitals, PHC

conditional grant to HSD, PHC conditional grant to training schools and MOH credit line drugs from JMS and NMS) declined during the FY by 0.2%. In 2013-2014 FY, further analysis indicates that 86.6% of the government subsidy is in form of PHC conditional grant to the hospitals (increased from 80% last FY) – with only 10.2% allocated to credit line drugs – although this increased from 6.6% last FY.

*Annex One. Table 21: UPMB - Lower Level Units (HC II & III) contribution to the HSSIP:*

Financial Year	Total Bed capacity	OPD Attendance	Admissions	Deliveries	ANC	Immunization	Number of LLUs submitting complete and timely reports
2012-2013	1,716	775,632	41,586	19,434	75,208	560,885	83.8%
2011 - 2012	1,305	767,498	50,139	38,187	8,776	360,813	75.5%
2011 - 2010	951	546,186	59,357	30,192	10,683	258,490	59.7%
2010 - 2009	670	556,885	30,192	28,240	6,860	345,853	45.1%

*Annex One. Table 22: UPMB - Summary statistics for Lower Level Units (LLUs)*

FY	Total Inpatient Admissions	Total Deaths	Total Inpatient days	Average length of stay	Average occupancy	Bed Occupancy
2012-2013	41,586	274	163,482	3.9	447.9	26.1%

## **ANNEX TWO: Integrated Health Sector Support Systems**

During HSSIP 2010/11 –2014/15 the sector will focus on putting in place the necessary inputs that are needed, to ensure there is improved access to health services. These inputs relate to the human resources, infrastructure (including equipment, ICT and transport), and medical products.

### **4.1 Ministerial and Top Management**

#### **Key output Indicators 2013/14**

- Issue weekly press statements to disseminate the ministry's strategies to improve Health Care Management.
- Hold monthly press conferences to update the public on the efforts of the ministry to improve health service delivery.
- Inspect the delivery of health services in 14 RRHs and 45 GHs.
- Monitor medicines distribution, storage, allocation, records and dispensation system in districts.
- Supervision of PHC activities in 111 districts.
- Monitor the functionality of HC IVs and HC IIIIs in 111 districts.
- Support supervision of DHTs in 111 districts.

#### **Administration and support services**

#### **Legal and Regulatory Framework**

Appropriate legislation and its enforcement provide an enabling environment for operationalization of the policy and the HSSIP and are essential for an effective health service delivery system. The Health Professionals Councils are responsible for;

- Strengthening the legal and policy environment conducive for the delivery of the minimum health care package
- Promoting enforcement, observance and adherence to professional standards, codes of conduct and ethics

#### **Lead Program Indicators**

- Number of relevant international legal instruments on health that have been domesticated
- Number of law enforcers trained in new legislation and policies to ensure implementation of legislation and policies.
- An effective regulatory environment and mechanism developed.
- An adequate and functional staffing structure of Professional councils established over the next five years.
- A Joint Professional Council with decentralized supervisory authorities established and operationalized over the next five years.

#### **Uganda Medical and Dental Practitioners' Council (UNMDPC)**

The mandate of UNMDPC is to regulate and enforce standards of practice and supervise Medical and Dental Education in Uganda

#### **Main Achievements**

- Reserved 200 million for the building of the Council House
- Led the 26 Consultations on the formation of the National Health Authority.

- Recruited 2 key Staff
- Improved Compliance of practitioners to acquire their licences
- Formed 30 new District Supervisory Authorities and supported them
- Published all the licenced Practitioners for the year 2013

### **Major Challenges**

- Council is operating under Weak registration derived from UMDPC Act.
- Though Council recruited the Accountant and the Administrator, Council still lacks more key staff in Accounts, Legal and Registration
- Despite all Council efforts, routine inspection of the health units is still a challenge.

### **Way forward**

- Continue to reserve money for Office building
- Recruitment of more staffing (lawyer and registration officer)
- Procurement of another multipurpose vehicle
- Increased partnerships locally and regionally
- Finalisation of the review of the Acts and the formation of the National Health Authority

### **Uganda Allied Health Professionals Council 2013/2014**

#### **Mandate**

The Council was established by the Allied Health Professionals Act Cap 268 to regulate, supervise and control the training, practice and for other related matters of allied health professionals in Uganda.

#### **Planned activities 2013/2014**

- Save 200M towards procurement of office premises
- Register 2700 eligible applicants
- Issue 12000 registered professionals with Annual Practicing Licenses
- Register and renew 1665 clinics
- Register 1000 medical laboratories
- Investigate and determine 100 cases of professional misconduct/negligence
- Rent of offices for inspection and quality assurance department
- Install an accounting package
- Inspect and supervise 2065 public and private health facilities
- Sensitize allied health professionals, DHOs and CAOs in 100 districts
- Inspect and supervise 25 allied health training institutions
- Monitor and supervise Council activities in 12 regions
- Support 6 staff for short courses
- Organize 4 Council and 24 committee meetings
- Organize 24 Advisory board meetings
- Conduct 1 council and 1 finance committee retreats
- Payment of 34 staff salaries and wages
- Upgrade council website [www.ahpc.ug](http://www.ahpc.ug)
- Procure 2 brand new motor vehicles
- Gazette 15000 professionals, 43 Allied Health training institutions and

- 2665 health units
- Support 112 district Allied health supervisors
- Attend 8 Regional and international conferences
- Support 8 professional Associations to conduct CPD
- Conduct 2 Bi Annual review meetings for Staff
- Organize Annual Allied Health Professionals meeting
- Organize 2 staff orientation workshops

## Achievements

- Registered 1656 professionals
- Issued 6693 registered professionals with Annual Practicing Licenses
- Registered and renewed licenses for 857 clinics
- Registered 270 medical laboratories
- 77 disciplinary cases relating to practicing without APL, clinic license, negligence and professional misconduct cases were handled. Accordingly Council penalized those found guilty and also de-registered a Medical Radiographer (Elema Francis) under section 28(1) of the Act for professional misconduct against a female patient at Lira Regional Referral Hospital
- Inspected and supervised 4478 public and private health facilities out of which 421 clinics and 120 medical laboratories were closed for lack of minimum standards to offer quality health care.
- Sensitized allied health professionals, DHOs and CAOs in 79 districts
- Inspected and supervised 22 allied health training institutions
- Council members carried out monitoring and supervision in 9 regional offices
- Council Supported 1 staff and 1 Council member for 6 short courses in
- Administrative Law
- Conducted 4 council, 16 committee meetings, 10 advisory board meetings and retreat.
- Upgraded council website [www.ahpc.ug](http://www.ahpc.ug)
- Procured 2 motor vehicles
- Gazetted 7835 professionals, published 40 recognized Allied Health training
- Institutions in New Vision and withdrew recognition from one training Institution for lack of minimum standards (Kyobe Medical Laboratory training school)
- Supported 101 district Allied health supervisors
- Attended 7 Regional and international conferences
- Supported 10 professional Associations to conduct CPD namely; Uganda Radiography Association, Uganda Medical Laboratory Technology Association, Ophthalmic Clinical Officers Association, Uganda Society for Advancement of Radiology and Imaging, Uganda Orthopedic Officers Association, Mbarara University Medical Laboratory Students Association and Uganda Dental Officers Association.
- Conducted 2 Bi Annual review meetings for Staff and Organized 2 staff orientation workshops.

## Challenges

- Increased forgeries of academic and professional certificates.
- Inadequate enforcement mechanism for renewal of practicing license in public health facilities.
- Resistance by faith based PNFPs on registration of medical laboratories.
- Frustration by police on reported cases of quacks.
- Inadequate office space to house the secretariat
- Illegal Allied Health training institutions

- Difficulties in implementing CPD for professionals countrywide
- Low compliance by staff in public sector to renew APL
- Most allied health training institutions have inadequate tutors
- There is high enrolment of students compared to available facilities.

## **Recommendations**

- Enforce registration of all medical laboratories.
- Continue sensitization of professionals and employers on registration and licensure requirements for all professionals.
- Strengthen the crack down on all illegal practitioners and quacks.
- Develop general regulations of AHP Act
- Strengthen supervision mechanisms of Regional and District Allied Health Supervisors
- Revoke license of clinics manned by unqualified personnel.
- Delegate and support allied health professional associations to undertake CPD at regional levels.
- Mobilize more funds towards acquisition of council house
- All applicants for registration to undergo pre-registration assessment.
- Gazette the recognized training institutions, clinics and up-dated register of allied health professionals.

## **4.7 Pharmacy Council 2013/14**

### **Mandate:**

Ensure National and International Pharmacy Practice Standards and Codes of Ethics are adhered to, both in the public and private sectors through the registration of eligible newly qualified Pharmacists, coordination of internship for newly qualified pharmacists, and Control of the conduct and discipline of registered pharmacists.

### **Planned Activities FY 2013-2014**

- i. Coordinate internship training countrywide
- ii. Enforce adherence to pharmacy practice standards & ethics in units in 4 regions in collaboration with other Health professional Councils(HPCs)
- iii. Register 100 new Pharmacists
- iv. Hold quarterly Pharmacy Board Meetings and three Board Committee meetings
- v. Gazette the list of pharmacists whose names appear on the register by 31st December 2013
- vi. Investigate four reported cases of professional misconduct
- vii. Contribute to the EAC Health Professionals' Boards/Council activities
- viii. Collaborate with other Stake Holders.

### **Main Achievements**

- Gazetted and Printed the Statutory Instrument "The Pharmacy and Drugs prescription of Forms regulations.
- Streamlined the registration process and made it more user-friendly.
- Quarterly Pharmacy Board members and Committee meetings held.
- Pharmacy Board Vetting committee meetings held.
- Three consultative meetings held to consider the report of the Social Services Committee of parliament on the Pharmacy Profession and Pharmacy Practice Bill, 2006.
- Increased output of pharmacists from the training institutions.

- Contributions made to four meetings of the East African Community Health Professions Councils/Bodies.
- Joint inspection of Health Units in Central and Northern regions with other HPCs.

### **Performance of Lead Program Indicator**

- 67 out of a target of 80 newly qualified pharmacists were registered making a total of 617 registered pharmacists are in active practice excluding 30 registered pharmacists practicing and or studying abroad.
- Pharmacy standards enforcement visits and joint HPCs activities/ inspections carried out in Masaka, Kalangala, Lira, Ssembabule, Luengo and Lyantonde.
- The proposed pharmacy legislation presented to MoH pharmacists and the regulatory working group.
- List of registered Pharmacists being cleaned up for published on the Uganda Gazette(on-going activity)
- Internship training program for Pharmacists coordinated and made contributions to the draft Medical Internship Policy document
- Upgrading the Database for registered Pharmacists is on-going.
- Participated in four regional and one International pharmaceutical activities/meetings
- Participated into the development of a National Health Professions' Authority

### **Major Challenges**

- Weak Pharmacy legislation and contradicting regulatory environment
- Few internship centers with limited capacities (max. six intern pharmacists per center) leading to a backlog of interns having to wait for slots.
- Inadequate Finances and Logistics to support the planned activities
- Inadequate Human Resource due to a rigid structure
- Inadequate office space

### **Key Recommendations**

- Strengthen the regulatory capacity of the Pharmacy Board by expediting the review of the pharmacy law
- Mobilise additional financial and other logistics to establish and maintain an upgraded database and website for the Board
- The Ministry of Health should dialogue and plan with the universities training pharmacists for a lasting solution to the challenges of inadequate internship training centers
- Additional space is required to store the ever increasing files numbers

## **4.2 Health Infrastructure Development and Maintenance (HIDM)**

### **Planned activities FY 2013/14:**

Supervise, monitor and evaluate implementation of Health infrastructure development projects countrywide.

- Develop guidelines on medical equipment disposal and review guidelines for health care waste management and disposal.

There was improved waste management disposal by AIDSTAR-One trained health workers including; national trainers, district supervisors, health service providers and their managers and waste handlers in

all the 16 project districts in HCWM. In addition, the project designed a centralized facility for managing health care waste composed of a large scale incinerator, an autoclave with an accompanying shredder, lagoons, and a land fill. With funding from USAID, a large scale incinerator was procured and installed at the health facility. The project also secured funding from USAID to collect, transport and safely dispose of HCW using environment friendly methods.

Green Label services limited procured land and installed the rest of the equipment. The company provided waste handling services for infectious, highly infectious, plastic, pharmaceutical, glass; metal scrap and expired insecticide treated mosquito nets. All waste generated by Safe male circumcision teams in the regions was handled by the firm. On average each district was generated 1 tonne of HCW per month but most districts having been found with over 5 tons of legacy pharmaceutical waste that had accumulated over years. The program benefited government, Private Not for profit (PNFP) and private health service providers (PHP).

The MoH played a coordinating role, procured and distributed HCWM commodities as well as personal protective equipment. In addition, MoH teams conducted regular technical supportive supervision and participated in documenting costs involved in executing the developed activity plan.

### **4.3 National Medical Stores**

The mandate of NMS is to procure, store and distribute essential medicines and other medical supplies primarily to public health facilities

#### **Core Indicators**

The percentage of health units without monthly stock outs of any indicator medicines (49% of health facilities did not have stock out of any of the six tracer medicines in the FY 2011/12– first line antimalarials, Depoprovera, SP, measles vaccine, ORS, Cotrimoxazole).

#### **Main achievements 2013/14**

- Supplied essential medicines and medical supplies to all Health facilities, including UPDF, Police Force and Prison services.
- Supplied Vaccines, gas and other immunization materials to all 112 districts, including the new PCV to pilot district of Iganga
- Regionalized the Basic kit for HC2 and HC3
- Made improvements in aligning the Orders from Health facilities with their procurement plans
- Responded to all the medical emergencies and epidemics in the country with required additional supplies
- Continued with the embossment of medicines and medical supplies- now at 97%
- Continued with the last mile delivery of medicines to health facilities

### **4.4 Information for Decision Making**

The health sector requires reliable and accurate information to enable evidence-based decision making, sector learning and improvement. Monitoring and evaluation aims at informing policy makers about progress towards achieving targets as set in the annual health sector plans and the HSSP and to help provide managers with a basis in making decisions.

#### **Core HSSIP indicators**

- Timeliness of district HMIS reporting
- Completeness of district HMIS reporting to the RC Division.

### **Lead programme indicators**

- Community based HIS established and linked to HMIS by 2015.
- The proportion of quarterly HMIS reports submitted.
- Proportion of planned validation studies that are carried out.
- The proportion of sub national entities (districts, health facilities) that have reported on the key indicators as planned.

*Annex Two. Table 1: Key HMIS-HSSIP output Indicators 2013/14*

<b>Indicator</b>	<b>2012-13 achievement</b>	<b>2013-2014 target</b>	<b>Actual 2013-14 performance</b>
Timeliness of district HMIS reporting	65.4%	100%	80.0
Completeness of district HMIS reporting	85.2%	100%	95.6%

### **4.5 Quality of Care**

The HSSIP 2010/11 – 2014/15 emphasizes the provision of high quality health services by all. This is ensured through development and dissemination of standards and guidelines; regular supervision, inspection and mentoring; capacity building for quality improvement interventions; and establishment of dynamic interactions between health care providers and consumers of health services.

#### **Core HSSIP indicator**

- % clients expressing satisfaction with health services (waiting time)

### **Lead programme indicators**

- % of districts and facilities with current QA standards and guidelines.
- % of planned support supervision visits that are carried out
- % of functional District QI Teams
- % clients expressing satisfaction with health services (waiting time)

### **Key output Indicators 2013/14**

- Standards and guidelines developed
- Standards and guidelines disseminated
- Support supervision provided to LGs and referral hospitals
- District staff trained in QI methods
- Performance reviews conducted

### **Major Achievements**

- Two biannual sector performance review meetings held in August 2013 and January 2014. Biannual review reports were compiled printed and disseminated.
- Mid-Term review report of the HSSIP 2010/11 – 2014/15 was disseminated both hard and soft copies during the 19th JRM. 2,000 copies were printed and disseminated. Soft copy posted on the MoH website.
- The QAD developed guidelines for development of Client Charters for hospitals and key messages for Lower level health Facilities. Participated in the launch of the Client Charters for the 3 RRHs of Masaka, Mbale and Gulu Hospitals. The rest of the RRHs were supported and developed draft copies of their charters.

- Disseminated 500 copies of the National Infections Prevention and Control Guidelines to 61 district; 3,000 copies of National Quality Improvement Framework and Strategic Plan (QIF &SP) were disseminated with support from QI Implementing Partners, 1,500 copies of the 5S Guidelines and Hand book were also disseminated. 100 copies of the Standards on Diagnostic Imaging and Therapeutic Radiology for Uganda were disseminated to the 13 regional referral hospitals and 20 General Hospitals.
- Governance and Management Guidelines for MoH Structures finalized and 300 copies printed and disseminated.
- Three out of the four planned support supervision visits (Area Team) to LGs were carried out. Onsite support was provided to the district in a number of disciplines. Common challenges identified by the supervision teams include;
  - Delayed salaries for most staff
  - Most districts still lack the critical staff in HC IVs and GHS.
  - Few uniforms delivered to the HF despite the fact that specifications were sent to NMS as required. Lots of miss-matching deliveries
  - Waste management is still a big problem
- 4 technical support supervision visits were carried out in the Rwenzori, STAR SW, STAR EC and STAR E districts focusing on M&E and QI.
- Impromptu inspection visits conducted in 80 districts focusing on absenteeism, uniforms, infection control, availability of EMHS and supervision.
- 5S Conference was held in September 2013 with support from JICA.
- Held an annual QI planning meeting with QI implementing partners in the sector. The meeting enabled harmonization of QI activities to avoid duplication and create synergy.
- Hospital and HC IV census was conducted covering 155 hospitals and 193 HC IVs. By end of FY data analysis was ongoing.
- Conducted QI trainings and 699 health workers were trained in QI principles, tools and implementation with support from Partners (ASSIST, Baylor, Mild May, PREFA, STAR SW, NUHITES, STAR E). 80 districts for example were supported to form District QI Teams and 993 health facilities formed Facility QI Teams. The functionality of the teams however, will be assessed in 2014/15 FY. 29 National 5S Trainers and 25 National QI Trainers were trained with support from JICA and ASSIST respectively.
- The supervision, monitoring and inspection mechanism in the health sector was reviewed and a draft comprehensive SMI strategy was developed. To be finalized in 2014/15 FY.
- Client satisfaction survey was conducted and a draft report submitted in June 2014.
- Finalized the development of the implementation strategy for the National Health Facility Assessment Program.
- 10 out of 12 Supervision, Monitoring, Evaluation and Research TWG meeting were held and resolutions submitted to Senior Management Committee.
- All the 4 quarterly National QI Coordination Committee meetings were held.
- Coordinated 11 out of 12 Senior Management Committee meetings and resolutions submitted to HPAC for consideration.

### **Challenges**

- All result areas for the department were affected significantly by the very low and at times no quarterly releases of funds to implement the various planned activities.
- Support supervision is affected by the aging fleet of vehicles in the MoH. Most areas to supervise and monitor are hard reach with poor road network which require sound means of transport to ease movement of supervising teams.



*Figure 34: Empty medicine vials and ampoules packed in sacks at Budaka HC IV*

### **4.6 Global Fund (GF) Supported Interventions**

The Global Fund supported interventions in this FY contributed towards the attainment of the MDGs 4, 5, and 6 in relation to improving MCH as well as national and international health goals.

The Focal Coordination Office carried out;

- Data quality audits in Apac, Lira, Mbale, Bududa, Kiruhura, Mukono, Kiboga and Mpigi districts
- Integrated Sub-Recipient monitoring in 78 SRs to assess the performance of R7 HIV activities
- A performance audit (by internal and external auditors) to assess the performance of R4 & 7 Malaria grant
- Aggregated SR financial monitoring in all districts to assess the performance and cash balances of R7 HIV activities
- Joint support supervision in 54 sampled districts to follow up on AMFm activities and the areas supported by GF.

### **4.7 Improvement of Health Services Delivery at Mulago Hospital and the City of Kampala (MKCCAP)**

The project interventions fall under 3 broad components as follows:

- Component 1: Capacity Development & Systems Strengthening
- Component 2: Revitalising Referral and Counter-referral Systems
- Component 3: Expanding and Improving Specialised Health Services in the City of Kampala

#### **Performance of Lead program indicators**

- Training activities carried out according to plan
- Hospital Assessment Survey conducted
- Construction of Kawempe and Kirudu Hospitals started
- Tenders for ambulances advertised
- Tenders for Mulago Hospital civil works advertised

## **Planned Activities**

### **Component 1: Capacity Development and System Strengthening**

- i. Conduct in house training of Health workers as per the approved training plan.
- ii. Award scholarships for Master of Medicine.
- iii. Procure a training institution to provide training in Governance, Leadership and Management for MOH, Mulago and KCCA Health workers.
- iv. Conduct Hospital and Health Center IV performance Assessment study in Uganda.

### **Component 2: Revitalization of the Health Referral Services**

- i. Commence the procurement process for 10 ambulances for the Kampala Metropolitan area.
- ii. Recruit a Technical Assistant to advice in setting up a telemedicine system for Mulago National Referral Hospital and the 3 KCCA Hospitals.

### **Component 3: Expanded and improved public health services in Kampala**

- i. Develop a 30 years Master Plan for Mulago National Referral Hospital.
- ii. Procurement of contractor to supervise civil works for Kawempe and Kiruddu General Hospital.
- iii. Procurement of contractors to undertake civil works for Kawempe and Kiruddu General Hospital.
- iv. Commence the construction work of Kawempe and Kiruddu General Hospital.
- v. Commence the procurement of front loaded medical equipment for Mulago National Referral Hospital.
- vi. Procurement of consultant to supervise the civil works for Mulago National Referral Hospital.
- vii. Commence procurement of contractor to undertake civil works for Mulago National referral hospital.

## **Main Achievements**

### **Component 1: Capacity Development and System Strengthening**

- i. Most of the planned training activities were undertaken. These include 300 Nurses trained on Infection Control Measures, 100 Health Workers trained on Trauma and injury management, 20 Administrators trained in Administrative Officers Law. Trained 10 Physicians on Echocardiograph, 10 Technicians and Nurses on Electrocardiogram. 2 physicians from Nuclear Medicine Department attended a 2 weeks placement at Stellenbosch University.
- ii. Ten (10) of the planned 14 Masters of Medicine scholarships for specialist training in: internal medicine, ENT, Obstetrics & Gynecology, ophthalmology, Surgery, Anesthesia and Pediatrics were awarded during the year.
- iii. A detailed assessment of Performance of all Hospitals and Health Centre IV in the country was carried out in collaboration with MOH, WHO and Makerere University School of Public Health.. The assessment covered pharmacy, infrastructure, Diagnostics, Financing, Surgical Services, Personnel and Governance.
- iv. Awarded contract to Makerere University School of Public Health for training of health works in Governance, Leadership and Management.

### **Component 2: Revitalization of the Health Referral Services**

Under this component, the following were achieved:

- i. Tenders for the procurement of 10 ambulances for the Kampala Metropolitan area were advertised and evaluated. There was no responsive bidder and specifications were reviewed for re-tender.
- ii. The procurement of a consultant to design a system for management of referral and ambulances in Kampala was started and advertised. The process was still ongoing by the end of the FY.

### **Component 3: Expanded and improved public health services in Kampala**

- i. A consultant was recruited who reviewed Kirudu and Kawempe Hospitals designs which were tendered and a contractor recruited for each hospital. The consultant is now supervising the works scheduled to last 24 months and 1 year defects period.
- ii. Recruited a consultant to develop a 30 year Master Plan for Mulago Hospital. The consultant submitted a draft 30years Master Plan for the hospital which is under review.
- iii. Contracts for construction of Kawempe (\$11.3M) and Kiruddu (\$10.3M) Hospitals were signed on 4/12/13. The civil works started on 1 January 2014 and are scheduled to be completed by 31 December 2015.
- iv. A consultant for design review and supervision for the rehabilitation and remodelling of Lower Mulago Hospital was recruited. The designs were completed and tendered.
- v. Bids received and evaluated for frontloaded medical equipment for Mulago National Referral Hospital.

### **Challenges**

#### *i. Land issues for Kawempe Hospital*

A family of the late Dr. Sembeguya has been claiming land ownership of Kawempe Hospital site. Ministry of Health and KCCA will verify authenticity of the claimants and agree on requisite compensation if any. In addition, the land at Kawempe Hospital is inadequate there is no space for construction of the staff accommodation block. KCCA will have to buy another plot for the staff accommodation.

#### *ii. Inadequate funds for rehabilitation of Mulago Hospital*

The estimate for the total upgrade of Lower Mulago is USD 38 million. The scope of the current work has been reduced to fit within USD 23 million.

### **Key Recommendations**

Government of Uganda is to identify alternative sources of funding for the remaining scope of work for Mulago Hospital rehabilitation.

## **4.8 Uganda Health Systems Strengthening Project (UHSSP)**

### **Key Achievements**

- Contracts for renovation of 9 Hospitals under Phase I were signed in November 2013 and works started in January 2014. These include Mityana, Nakaseke, Anaka, Moyo, Entebbe, Nebbi, Moroto RRH, Iganga and Kirbyandongo Hospitals and are at various levels of completion.
- The Ministry requested for additional funding of US\$ 90 million from the World Bank for renovation of 13 Hospitals and 26 HCIVs under UHSSP under Phase II namely: Mubende RRH, Apac, Itojo, Bugiri, Buwenge, Kitgum, Anaka, Masindi, Bukwo, Pallisa, Atutur, Kitagata and Abim; and HCIVs: Kasanda, Kiganda, Ngoma, Mwera, Kyantungo Kikamulo, Kabuyanda, Mwizi, Kitwe, Rubare, Aboke, Aduku, Bwijanga, Padibe, Atyak, Obongi, Pakwach, Buvuma, Budondo, Ntenjeru-Kojja, Buyinja, Nankoma, Bugono, Kiyunga, Kibuku and Budaka.
- The Ministry distributed general and specialized equipment and hospital furniture to 46 health facilities. Emergency Obstetric and Neonatal Care equipment has been distributed to 191 out of

230 facilities. The National Committee on Medical Equipment (NACME) inspected the supplied equipment and prepared a report. There were some equipment that had defects and others that were rejected and the suppliers were informed in May 2014 to replace the rejected equipment or where applicable correct the defects as specified in the report.

- Contracts were signed for supply of contraceptives, gloves and long term family planning methods under the National Medical Stores. The first consignment of supplies for the contract to supply medroxyprogesterone signed in May 2013 was delivered in March 2014. The contract for the supply of gloves was signed and the first consignment is expected in August 2014. The contract for supply of safe delivery kits (mama kits) was signed and the letter of credit is being opened and advance payment is being processed.
- A contract was signed with the United Nations Office for Project Services (UNOPS) for supply of 19 ambulances and these are scheduled to be delivered by September 2014.
- 390 health workers were awarded scholarships in FY 13/14 and their allowances and fees have been paid. This was in addition to the 366 health workers offered scholarships from hard to reach areas and the category of health workers pursuing priority disciplines where there is currently few practitioners for example Ear, Nose and Throat, Radiology, Internal Medicine, Orthopedics among others. Over 100 health workers have completed management courses on MSc Hospital Management and advanced Diploma in Health Services Management.
- The Ministry of Public Service approved the creation of full time positions for Managers of Hospitals and Health Centre IVs and the Ministry is making arrangements to recruit the Medical Superintendents and In charges of HCIVs. This is expected to improve leadership and governance of health facilities countrywide.
- During the FY 13/14, the Ministry hired a consultant to develop business plans for professional councils. An inception report was submitted in March 2014 and a preliminary draft was submitted in June 2014 and a review workshop is yet to be held to review the draft report.
- A consultant was hired to conduct a client satisfaction survey under UHSSP. An inception report was prepared and approved and the draft report is awaited.
- The quality assurance department developed a concept note on hospital accreditation which was approved by the World Bank in December 2013. Yellow star implementation manuals which were developed by USAID under UPHOLD were developed and

### **Priorities for 2014/15**

- Completion of renovation of 9 Hospitals renovated under UHSSP as listed in the previous section.
- Embark on renovation of 13 Hospitals and 26 HCIVs under Phase II of civil works
- Procurement and distribution of contraceptives, gloves, safe delivery (mama) kits under National Medical Stores and through a third party distribution agent to the private and Private not for Profit health facilities.
- Roll out of the Human Resource for Health Management Information System
- Recruitment of full time Managers of Health facilities (Medical Superintendents for Hospitals and In Charges for health centres).

- Training of health workers in the provision of long term family planning, post abortion care and Emergency Obstetric Care.
- Continue the revitalization and supervision of Maternal and Peri Natal Death Review Committees in health facilities
- Support students enrolled onto scholarships in training institutions by processing tuition fees and allowances.

## **4.9 Institutional Capacity Building In Planning, Leadership and Management**

**Overall objective:** To improve effective delivery of an integrated Uganda National Minimum Health Care Package.

**Specific objective:** The strengthening of the Planning, Leadership and Management capacities of the health staff at national level and local government levels.

### **Expected outputs**

1. The MoH is strengthened in its organizational and institutional capacity.
2. Organizational and institutional capacity strengthened at regional and district levels in Rwenzori & West Nile regions
3. Training needs in L&M of health sector are strengthened through transformation of HMDC and establishment of two regional satellite training centres
4. A Scientific Support team accompanies the capacity building process in the Ugandan health sector, in order to capitalize on experiences and translation into policy.

### **Achievements FY 2013-2014**

#### **Result Area 1: Health sector / MOH HQ**

- Supported MOH / Sector planning process:
- Budget TWG; budget conference; Regional Planning Meetings; MPS retreat; national infrastructure plan; Joint Review Mission activities; Supervision, Monitoring and Inspection (SMI) Strategic Plan activities
- Supported development of Nursing policy

#### **Result Area 2: Regional support**

- Decentralized project implementation to 15 districts
- Supported the following activities:
  - quarterly regional health forum meetings
  - regional ambulance system - total 13 new ambulances; 9 repaired and equipped, 32 teams trained,
  - introduction of Patient Centered Care (PCC) in RRHs ,
  - the roll-out of Governance,Leadership & Management in training districts teams,
  - the training of HMBs & revision guidelines
  - Training Needs Assessment for district training plans
  - Procured of two ambulances
  - Procured and installed 39 operating theatre tables

### **Result Area 3: HMDC**

- Supported the development of the Strategic Investmenet Plan
- Successfully piloted E-Learning course in Moyo district (graduation May 2014) – expansion to 3 regions (Arua, FP, Lira) – presentation during eLearning Africa conference
- Capacity building staff (IT, eLearning, TNA)
- Courses revised and adapted for eLearning: HIV/AIDS / SRH / IMCI
- Infrastructure rehabilitation including wall fence
- HMDC equipment: office and classroom furniture, IT library and eLearning
- Focus on CPD – regional training coordination

## **4.10 Global and Regional Policy Framework for the Health Sector**

### **East African Community**

Health is among the areas of cooperation under article 118 of the Treaty for the establishment of the East African Community (EAC) Treaty which underscores the need for Partner States to take joint action towards prevention and control of communicable and non-communicable diseases and epidemics of communicable and vector borne diseases such as HIV/AIDS, cholera, Malaria, hepatitis and yellow fever; promote management of health delivery systems and better planning mechanism to enhance efficiency of health care services, develop a common drug policy and quality control capacities; harmonize drug registration procedures so as to achieve good control of pharmaceutical standards without impeding or obstructing the movement of pharmaceutical products within the community; harmonize national health policies and regulations and promote exchange of information on health issues; cooperate in promoting research and cooperate in development of specialized health training among others.

To achieve the treaty obligations, the EAC Secretariat in collaboration with EAC Partner States regularly convenes regional meetings to deliberate on key health issues. The meetings are conducted through:

- Technical working groups (TWGs) on medicines; health systems, policy and research; reproductive and child health; HIV/AIDs, Communicable and Non Communicable diseases.
- Sectoral Committee on health - reviews the reports of the TWGs
- The meetings of National Health Professional Councils usually attended by the Registrars and their Chairpersons.
- Sectoral Council of Ministers of health- makes key policy decision for health in the community. The Sectoral Council of Ministers of Health meeting is conducted through the session of Senior Officials, the session of Permanent Secretaries (Coordination Committee) and then the session of Ministers of Health.

**The Common Market Protocol:** The CMP provides for the free movement of labour which includes the health work force (Article 11). The CMP also commits Partner States to mutually recognize the academic and professional qualifications granted, experience obtained, requirements met, licenses or certificates granted in other Partner States. Article 39 of the CMP commits the Partner States commit to promote occupational safety and health at work places; prevent and manage HIV/AIDS, Malaria and Tuberculosis; prevent and manage outbreak of epidemics and other diseases in order to improve the general hygiene and health of the people, prevent social vices such as alcoholism, drug abuse or substance abuse and perverse behavior.

## **Some of the achievements:**

### **a) Harmonization of the Regulation of training, registration and practice of Health Professions in the EAC.**

EAC integration provides an opportunity for Uganda to harmonize its health professional training, registration and practice with the other EAC Partner States. This will culminate in the mutual recognition of health professional's qualifications in the EAC, cross border registration and practice. Tools and mechanism for joint inspection of health training Institutions have been developed and approved by the EAC Sectoral Council of Ministers' of Health.

The EAC Health Professional Councils have conducted a series of joint inspection of Partner States' university medical and dental schools with a view to harmonizing the standard of training and qualifications that are given to the students to ensure good quality products. The universities found deficient are given clear set of standards, guidelines and deadlines by which to comply, failure of which may lead to closure.

This cooperation will be mutually beneficial to Uganda and her EAC Partners and will ensure marketability of Uganda's health professionals in the region and beyond. There are also discussions to create an overarching EAC Health Professionals Authority to support the work of Partner States Health Professional councils which is consistent with the provisions of the EAC treaty article 118. Harmonization will also encourage innovation and enhance technology transfer in the EAC region spurring economic growth and development.

### **b) Establishment of Regional Centres of Excellence in treatment, training and research for specific NCDs**

The EAC being in the Sub Saharan Africa is faced with the double burden of both infectious and chronic Non-Communicable diseases (NCDs). The World Bank report (2011) estimated the continued rise of NCDs burden in Africa and about 40% of deaths are more likely to be attributed to NCDs in the next decade.

Current disease projections caused by demographic and epidemiologic transitions indicate an increasing prevalence and incidence of obesity, diabetes mellitus, cardiovascular diseases and cancer. There is a mismatch between supply of specialized skills, provision of research and innovation and demand for specialized healthcare services for effective management of the above mentioned diseases in the EAC. Due to lack of state of the art treatment for NCDs such as cancers, the EAC Partner States continue to refer patients to facilities outside the region for specialized care which leads to pilferage of the scarce foreign exchange.

It is imperative that the EAC Partner States should establish centres of excellence in treatment, training and research for most common NCDs in the region.

To achieve this objective the EAC Secretariat in collaboration with Partner States and with support of the African Development Bank (AfDB) is finalizing a project that aims at creating a network of regional centres of excellence in each of the EAC Partner States. Uganda chose the opportunity to strengthen and promote the Uganda Cancer Institute as a regional centre of excellence in cancer treatment, training and research. Kenya will have a centre of excellence in Kidney diseases management, Tanzania for Cardiovascular diseases; Burundi will lead in Nutrition research and Rwanda in Vaccines development and research.

**c) Harmonization of Medicines Registration and common medicines policy in the EAC.**

Better access to medicines is still a challenge in the developing world where there are still multitudes of infectious diseases. Medicines to treat such infectious diseases may be readily available but cannot be readily accessed in the EAC due to lengthy, non-homogenous, and at times non-transparent processes in the registration of new medicines. Like all global commodities the movement of medicines is vulnerable to national tariffs, taxes and regulations. When regulatory requirements become too numerous and disparate like in the EAC Partner States, it becomes too expensive for the drug manufacturers to overcome the multiple regulatory requirements, and this adversely affects the availability and price of essential medicines for the poor who need them most.

To tackle this challenge the EAC Secretariat in collaboration with Partner States and a coalition of development partners have established the East Africa Medicines Regulatory Harmonization (EAC-MRH) Programme. The EAC-MRH provides the community with the opportunity to harmonize the regulation of medicines, registration of new medicines, information management system, quality management system, and implement a framework for mutual recognition of regulatory decisions, in order to improve access to safe and good quality medicines. This initiative conforms to the EAC Treaty article 118 that provides for the harmonization of medicines (drugs) registration and regulation, and the development of common drug policy including establishment of quality control capacities and good procurement practices.

Medicines regulatory harmonization aims at improving access to safe, efficacious and good quality medicines for treatment of conditions of public health importance. This eventually will lead to reduction of costs of medicines. Uganda stands to benefit by supporting the harmonization process in many ways including having stronger medicines regulatory framework, increased access to safe and affordable medicines, reduced counterfeit drugs in the market and eventually bulk procurement of medicines.

**d) Open Health Initiative (OHI) to improve Reproductive, Maternal, Newborn and Child Health.**

The implementation of the “**Open Health Initiative**” to improve the health of women and children in the East African Community countries is ongoing and focuses on three thematic areas:

- (i) Results Based Financing (RBF)
- (ii) Accountability for results and resources
- (iii) Innovation

The Open Health Initiative uses its political leverage and regional influence to effectively translate principles of accountability for results and resources into practice; advocate and support the expansion and strengthening of results-based financing approaches; and accelerate the adoption of successful innovations across the region. It also best practices and knowledge sharing approach where EAC countries learn and leverage the best practices and lessons learned of their neighbors. Lastly an acceleration Fund for Reproductive, Maternal, Newborn, and Child Health is planned is being mobilized.

**e) EAC Regional Health Sector Strategic Plan and Protocol on Cooperation on Health:**

The EAC Regional Health Sector Strategic Plan and the Protocol on Cooperation on health has undergone a couple of in-country and regional consultations and input. It is being finalized for presentation to the Sectoral Council of Ministers for approval.

**f) Aflatoxin control Project:**

Implementation of this project is ongoing in all the partner states through interventions under ministries of Agriculture and Health.

**g) EAC Health and Scientific Conferences**

The 5<sup>th</sup> EAC Annual Health and Scientific conference will be held in Uganda at Speke Resort Munyonyo Hotel next year from 25<sup>th</sup> to 27<sup>th</sup> March 2015. The theme of the conference is “investing in Health through strengthening regional health systems and institutions towards the prevention and control of communicable and non-communicable diseases.” A regional and National Steering Committee has been formed and calls for abstracts sent out. Abstracts can be submitted to: [www.eac.int/eachsc](http://www.eac.int/eachsc).

**h) East, Central and Southern Africa Health Community (ECSA-HC)**

Uganda is an active member of ECSA-HC. The ECSA-HC Secretariat is based in Arusha Tanzania. ECSA-HC is a regional organization set up in 1974 to promote the highest possible standards of health among member countries. It is mandated to foster among member states, cooperation that will lead to the strengthening of health care programmes in the region. The Secretariat implements its activities through specific programmes in Family and Reproductive Health; Food Security and Nutrition; Health Systems and Services Department; HIV/AIDS and Infectious Disease; Human Resources for Health and Capacity Building; Research Information, Advocacy, Monitoring and Evaluation.

The ministry of health has been participating in most of the ECSA-HC activities and meetings, up to Ministerial level.

Some of the benefits that the country has reaped from being a member of ECSA-HC include: The East African Public Health Laboratories Network Project (EAPHLN), training of surgeons by the College of Surgeons in ECSA (COSESCA), training of nurses and midwives by ECSACON (ECSA College of Nurses); and the harmonization of overall health system standards.

**Challenges facing the Health Sector in a regional perspective**

The health sector within the region has made a lot of progress but diseases and scientific innovation are dynamic which comes with several challenges and opportunities. More specifically, the challenges facing the health sector includes: minimal increments to the health budget which is not commensurate with the changing epidemiological pattern and technological advancement; changing market prices and high demands for better infrastructure and quality health services; difficulty in attracting, retaining and motivating skilled human resources for health due to low remuneration, poor work environment and other social considerations; rapidly increasing population coupled with high burden of both communicable and non-communicable diseases; emerging and re-emerging diseases outbreaks such as ebola, hepatitis and marburg; weak health systems in terms of governance, leadership, management and supervision impacting on quality of health services; and inappropriate financing mechanism.

**Report on Bilateral Cooperation**

Bilateral cooperation is ongoing between Uganda and other countries on health issues through Joint Permanent Commissions (JPC) meetings and signed Memorandum of understanding (MoUs).

**Achievements**

MoUs have been drafted and shared with DRC counterparts through the Ministry of Foreign Affairs and was discussed at the Joint Permanent Commission meeting that took place 22 – 27 August 2014 in Kinshasha. Furthermore, the MoU between Uganda and South Africa was drafted and undergoing the process of clearance.

Joint Borders Commission preparatory meeting between Uganda and Kenya were ongoing and are coordinated by Office of the President.

## **Key Challenges**

Inadequate facilitation (field vehicle and inadequate funds for both inland and international travel)

## **Way Forward**

- Continue dialogue with various countries on bilateral cooperation on health issues
- Follow up on draft MOUs till the bilateral signatures are obtained for endorsement
- Follow up on signed MOUs to ensure implementation
- Implement existing bilateral MOUs and monitor implementation progress
- Include bilateral Cooperation in annual work plans

#### 4.11 District League Table for 112 districts - FY 2013/14

Annex Two. Table 2: District League Table – FY 2013/14

District (112 districts)	Total Population (district updates from UBOS 2014)	Coverage and quality of care (75)															Management (25)						HMIS reporting completeness and timeliness			Infrastructure Report (1)			Medicine orders submitted timely																	
		DPT3 Coverage					Delivers in govt and PNP facilities					OPD Per Capita					HIV testing in children born to HIV positive women					Latrine coverage in households					IPT2					ANC4					TB success rate					Approved posts that are filled				
		%	Score	%	Score	%	%	Score	%	Score	%	%	Score	%	%	Score	%	%	Score	%	%	Score	%	%	Score	%	%	Score	%	Total Score	Rank															
Nwoya	57050	228.5	15.0	96.5	14.5	2.6	10.0	100.0	10.0	70.1	7.0	107.7	5.0	59.7	3.0	90.0	4.5	51	5.1	100	100.0	100.0	100.0	0	9.0	100	5	88.1	1																	
Gulu	419060	117.7	15.0	81.1	12.2	2.0	10.0	100.0	10.0	71.3	7.1	73.7	3.7	49.7	2.5	93.8	4.7	85	8.5	71	100.0	100.0	100.0	0	7.7	100	5	86.3	2																	
Masaka	256510	105.6	15.0	94.2	14.1	1.4	10.0	100.0	10.0	77.0	7.7	44.7	2.2	45.2	2.3	70.0	3.5	71	7.1	96.5	100.0	100.0	100.0	0	8.9	100	5	85.8	3																	
Lyantonde	83430	108.7	15.0	74.1	11.1	2.7	10.0	100.0	10.0	86.0	8.6	75.2	3.8	61.5	3.1	100.0	5.0	59	5.9	86.7	100.0	100.0	100.0	0	8.2	100	5	85.7	4																	
Rukungiri	330950	93.8	14.1	58.3	8.7	1.6	10.0	100.0	10.0	98.9	9.9	46.3	2.3	45.9	2.3	90.2	4.5	83	8.3	94.5	100.0	99.5	100.0	0	8.8	100	5	84.0	5																	
Kamwenge	347350	125.4	15.0	62.4	9.4	1.0	9.6	100.0	10.0	79.0	7.9	71.4	3.6	55.9	2.8	96.4	4.8	76	7.6	73.1	100.0	100.7	100.0	0	8.2	100	5	83.8	6																	
Kyegegwa	172000	149.7	15.0	51.8	7.8	1.2	10.0	100.0	10.0	77.5	7.8	88.4	4.4	53.9	2.7	93.5	4.7	81	8.1	64.4	100.0	100.0	100.0	0	7.9	100	5	83.3	7																	
Soroti	228410	103.5	15.0	83.3	12.5	1.8	10.0	100.0	10.0	69.8	7.0	82.5	4.1	50.4	2.5	46.9	2.3	70	7	65.1	91.7	98.0	64.9	0	7.0	100	5	82.5	8																	
Mityana	321560	101.8	15.0	61.9	9.3	1.1	10.0	100.0	10.0	88.2	8.8	55.8	2.8	44.4	2.2	80.0	4.0	56	5.6	95.5	100.0	99.7	100.0	0	8.9	100	5	81.6	9																	
Abim	57880	143.8	15.0	74.6	11.2	2.7	10.0	100.0	10.0	50.3	5.0	74.7	3.7	67.0	3.4	50.0	2.5	73	7.3	74.6	100.0	100.0	100.0	0	8.2	100	5	81.3	10																	
Mbale	467060	112.3	15.0	60.5	9.1	1.1	10.0	100.0	10.0	70.0	7.0	53.7	2.7	33.4	1.7	72.1	3.6	76	7.6	90	100.0	97.3	69.4	0	8.0	100	5	79.7	11																	
Lira	429710	90.0	13.5	48.9	7.3	1.4	10.0	100.0	10.0	82.0	8.2	51.1	2.6	28.7	1.4	85.0	4.2	80	8	88.6	100.0	99.5	82.9	1	9.3	100	5	79.6	12																	
Luwero	463260	111.7	15.0	50.4	7.6	1.2	10.0	93.6	9.4	75.6	7.6	60.1	3.0	42.9	2.1	65.0	3.3	87	8.7	84.9	100.0	97.6	69.9	0	7.9	100	5	79.5	13																	
Mbarara	464390	86.4	13.0	66.0	9.9	1.3	10.0	100.0	10.0	97.0	9.7	40.7	2.0	57.6	2.9	82.4	4.1	47	4.7	79.2	91.7	94.0	94.1	0	8.0	100	5	79.3	14																	
Jinja	527850	88.7	13.3	67.1	10.1	1.5	10.0	100.0	10.0	82.5	8.2	56.9	2.8	36.7	1.8	65.8	3.3	84	8.4	73	75.0	91.1	29.9	0	6.1	100	5	79.1	15																	
Bushenyi	261700	91.5	13.7	60.6	9.1	1.3	10.0	100.0	10.0	89.0	8.9	37.8	1.9	45.9	2.3	69.2	3.5	78	7.8	50.4	83.3	92.1	95.0	0	6.9	100	5	79.1	16																	
Kisoro	261400	98.3	14.7	63.3	9.5	1.6	10.0	100.0	10.0	63.0	6.3	46.8	2.3	31.9	1.6	76.5	3.8	68	6.8	89.7	100.0	100.0	100.0	0	8.7	100	5	78.8	17																	

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	228900	103.5	15.0	56.3	8.4	1.0	10.0	100.0	10.0	78.4	7.8	69.1	3.5	20.5	1.0	92.9	4.6	64	6.4	89.8	100.0	100.0	4.5	0	6.8	100	5	78.6	18
Serere	134600	110.0	15.0	31.2	4.7	1.0	9.8	100.0	10.0	78.9	7.9	44.8	2.2	24.7	1.2	84.8	4.2	90	9	86.8	83.3	93.1	100.0	1	9.1	100	5	78.2	19
Amolatar	506130	89.2	13.4	47.9	7.2	1.7	10.0	100.0	10.0	94.0	9.4	50.5	2.5	38.5	1.9	85.5	4.3	61	6.1	98	100.0	99.0	66.7	0	8.3	100	5	78.0	20
Kabale	221350	117.8	15.0	69.4	10.4	1.3	10.0	75.0	7.5	65.0	6.5	70.4	3.5	54.2	2.7	83.1	4.2	66	6.6	87.8	91.7	98.3	5.1	0	6.5	100	5	77.9	21
Busia	314740	91.6	13.7	58.6	8.8	1.1	10.0	100.0	10.0	84.0	8.4	55.7	2.8	27.3	1.4	83.9	4.2	71	7.1	80.7	100.0	96.0	10.3	0	6.5	100	5	77.9	22
Nebbi	364400	97.5	14.6	64.6	9.7	1.3	10.0	100.0	10.0	77.6	7.8	63.6	3.2	40.1	2.0	61.8	3.1	54	5.4	86.4	100.0	100.0	16.3	0	6.9	100	5	77.7	23
Budaka	188770	104.2	15.0	54.2	8.1	1.0	10.0	51.2	5.1	69.5	7.0	82.6	4.1	37.4	1.9	95.0	4.8	82	8.2	98.4	100.0	99.5	76.5	0	8.5	100	5	77.6	24
Dokolo	196380	91.8	13.8	35.0	5.3	0.9	9.1	100.0	10.0	84.0	8.4	58.3	2.9	34.9	1.7	97.8	4.9	83	8.3	80.7	91.7	97.9	100.0	0	8.2	100	5	77.6	25
Zombo	231160	102.0	15.0	40.9	6.1	0.8	8.3	100.0	10.0	71.0	7.1	58.7	2.9	42.5	2.1	77.1	3.9	82	8.2	97.8	100.0	100.0	0	8.9	100	5	77.5	26	
Rakai	502020	106.8	15.0	47.5	7.1	1.6	10.0	100.0	10.0	86.0	8.6	55.7	2.8	44.0	2.2	76.4	3.8	60	6	93.3	100.0	98.9	9.6	0	7.0	100	5	77.5	27
Iganga	535140	92.8	13.9	49.2	7.4	1.0	9.9	100.0	10.0	74.8	7.5	54.1	2.7	31.5	1.6	86.7	4.3	87	8.7	83.9	100.0	92.9	1.8	0	6.4	100	5	77.5	28
Isingiro	444590	96.1	14.4	47.7	7.2	1.6	10.0	100.0	10.0	86.4	8.6	50.1	2.5	39.3	2.0	90.0	4.5	51	5.1	66.1	100.0	100.0	0	8.0	100	5	77.3	29	
Butambala	102340	87.3	13.1	79.1	11.9	1.6	10.0	73.6	7.4	65.0	6.5	52.1	2.6	31.7	1.6	91.7	4.6	56	5.6	100	100.0	100.0	0	9.0	100	5	77.2	30	
Apac	372680	87.6	13.1	36.5	5.5	1.2	10.0	100.0	10.0	71.6	7.2	45.9	2.3	26.2	1.3	93.2	4.7	120	10	69.5	100.0	97.4	100.0	0	8.0	100	5	77.1	31
Kabarole	428050	119.5	15.0	66.3	9.9	1.5	10.0	100.0	10.0	56.0	5.6	47.1	2.4	45.3	2.3	87.2	4.4	71	7.1	71.4	50.0	87.9	21.9	0	5.3	100	5	77.0	32
Kumi	279080	80.0	12.0	52.2	7.8	1.0	10.0	100.0	10.0	90.0	9.0	44.8	2.2	39.5	2.0	73.3	3.7	61	6.1	98.4	100.0	99.7	100.0	0	8.9	100	5	76.8	33
Kiruhura	322420	109.1	15.0	31.2	4.7	1.1	10.0	100.0	10.0	89.0	8.9	64.3	3.2	55.0	2.8	83.1	4.2	49	4.9	74.8	100.0	102.8	90.5	0	8.1	100	5	76.7	34
Kiboga	179570	98.1	14.7	55.2	8.3	1.0	10.0	100.0	10.0	69.6	7.0	59.1	3.0	36.3	1.8	68.8	3.4	49	4.9	89.7	100.0	92.3	100.0	0	8.5	100	5	76.6	35
Bukwo	79480	117.5	15.0	28.3	4.2	2.0	10.0	100.0	10.0	76.2	7.6	59.5	3.0	36.5	1.8	100.0	5.0	55	5.5	100	100.0	100.0	0	9.0	100	5	76.2	36	
Kyenjojo	412580	110.1	15.0	49.9	7.5	0.8	7.5	100.0	10.0	84.5	8.5	59.3	3.0	51.2	2.6	72.6	3.6	91	9.1	62.4	0.0	80.1	38.8	0	4.3	100	5	76.0	37
Kayunga	373020	101.4	15.0	38.6	5.8	0.8	8.2	95.4	9.5	69.7	7.0	56.2	2.8	36.9	1.8	78.3	3.9	78	7.8	100	100.0	100.0	0	9.0	100	5	75.9	38	
Kanungu	262690	75.5	11.3	43.1	6.5	1.4	10.0	94.2	9.4	92.0	9.2	46.8	2.3	38.8	1.9	89.4	4.5	60	6	94.7	91.7	97.0	100.0	1	9.6	100	5	75.8	39
Mukono	581030	94.2	14.1	43.1	6.5	0.7	7.5	100.0	10.0	83.0	8.3	50.9	2.5	26.8	1.3	70.4	3.5	80	8	99.3	100.0	100.0	0	9.0	100	5	75.8	40	
Buliisa	84870	116.3	15.0	28.3	4.3	1.1	10.0	100.0	10.0	65.0	6.5	74.7	3.7	22.2	1.1	87.5	4.4	73	7.3	83.3	100.0	100.0	0	8.5	100	5	75.8	41	
Nakasongola	163200	77.9	11.7	41.2	6.2	1.7	10.0	100.0	10.0	89.0	8.9	61.7	3.1	48.9	2.4	88.0	4.4	73	7.3	80.4	100.0	96.1	2.9	0	6.4	100	5	75.4	42
Kalungu	180500	70.3	10.6	49.7	7.5	1.0	10.0	100.0	10.0	88.2	8.8	47.6	2.4	40.4	2.0	91.3	4.6	76	7.6	90.4	100.0	100.0	11.5	0	6.9	100	5	75.3	43
Pallisa	388880	89.5	13.4	48.2	7.2	0.9	9.2	100.0	10.0	78.4	7.8	67.3	3.4	25.4	1.3	96.3	4.8	66	6.6	85.9	75.0	93.9	33.3	0	6.6	100	5	75.3	44
Oyam	405530	106.8	15.0	47.2	7.1	0.6	6.0	100.0	10.0	84.1	8.4	60.6	3.0	51.8	2.6	91.0	4.5	76	7.6	62.7	100.0	99.0	8.0	0	6.0	100	5	75.3	45
Ntungamo	502800	79.7	11.9	39.3	5.9	1.0	10.0	100.0	10.0	99.1	9.9	38.0	1.9	28.6	1.4	89.0	4.5	71	7.1	73.9	66.7	91.9	97.8	0	7.3	100	5	75.0	46

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National	36652480	93.0	13.9	44.4	6.7	1.0	10.0	97.5	9.8	71.8	7.2	48.6	2.4	32.4	1.6	80.4	4.0	70.1	7.0	80.9	85.9	95.6	58.3	0.1	7.3	99.0	5.0	74.9	
Mitooma	204560	103.2	15.0	25.7	3.8	1.0	10.0	100.0	10.0	89.6	9.0	30.3	1.5	31.4	1.6	94.7	4.7	67	6.7	78	66.7	89.0	100.0	0	7.5	100	5	74.8	47
Butaleja	236870	83.4	12.5	47.1	7.1	1.4	10.0	100.0	10.0	80.0	8.0	74.7	3.7	27.4	1.4	93.8	4.7	53	5.3	99	100.0	100.0	4.2	0	7.1	100	5	74.7	48
Hoima	602920	81.8	12.3	50.4	7.6	1.2	10.0	100.0	10.0	73.7	7.4	57.3	2.9	37.1	1.9	75.9	3.8	60	6	90.8	100.0	99.1	58.2	0	7.9	100	5	74.6	49
Bundibugyo	289320	96.8	14.5	32.5	4.9	1.1	10.0	100.0	10.0	71.0	7.1	43.0	2.2	18.7	0.9	82.1	4.1	95	9.5	41.1	100.0	99.1	57.1	0	6.4	100	5	74.5	50
Kamuli	534730	145.7	15.0	44.2	6.6	1.0	10.0	100.0	10.0	78.0	7.8	50.7	2.5	35.2	1.8	84.1	4.2	64	6.4	58.5	58.3	89.4	10.0	0	4.9	100	5	74.2	51
Amuru	188630	90.8	13.6	34.9	5.2	1.2	10.0	95.9	9.6	72.4	7.2	69.4	3.5	33.3	1.7	90.2	4.5	75	7.5	73.9	75.0	92.5	26.7	0	6.1	100	5	73.9	52
Ngara	171790	83.1	12.5	49.8	7.5	0.8	8.4	100.0	10.0	81.0	8.1	49.4	2.5	34.0	1.7	80.0	4.0	63	6.3	66.7	100.0	100.0	100.0	0	8.0	100	5	73.9	53
Agago	330500	105.9	15.0	51.4	7.7	1.0	9.8	97.7	9.8	34.5	3.5	51.6	2.6	40.7	2.0	49.1	2.5	75	7.5	87.3	100.0	98.8	100.0	0	8.6	100	5	73.9	54
Kaberamaido	216610	85.0	12.7	43.6	6.5	1.1	10.0	100.0	10.0	69.0	6.9	58.5	2.9	22.6	1.1	88.9	4.4	84	8.4	69.1	75.0	92.4	0.0	0	5.4	100	5	73.5	55
Namutumba	230950	107.9	15.0	37.2	5.6	0.9	9.5	100.0	10.0	74.0	7.4	49.4	2.5	28.8	1.4	90.0	4.5	61	6.1	60.4	75.0	92.4	63.6	0	6.4	100	5	73.4	56
Bukedea	202850	92.0	13.8	47.5	7.1	0.5	5.3	100.0	10.0	77.0	7.7	58.4	2.9	19.7	1.0	100.0	5.0	80	8	94.7	100.0	95.5	0.0	0	6.8	100	5	72.6	57
Buikwe	453050	83.7	12.6	38.8	5.8	1.0	9.8	100.0	10.0	63.4	6.3	50.6	2.5	28.7	1.4	80.6	4.0	71	7.1	98.7	100.0	98.9	43.4	0	7.8	100	5	72.4	58
Lamwo	185310	86.4	13.0	45.4	6.8	1.0	10.0	100.0	10.0	42.0	4.2	50.3	2.5	33.5	1.7	86.7	4.3	59	5.9	99.2	100.0	100.0	100.0	0	9.0	100	5	72.4	59
Kampala	1857140	94.5	14.2	88.5	13.3	1.1	10.0	100.0	10.0	0.0	38.7	1.9	46.7	2.3	81.6	4.1	326	10	15.3	0.0	64.3	3.2	0	1.8	92.6	4.6	72.2	60	
Tororo	513170	98.2	14.7	40.8	6.1	1.6	10.0	100.0	10.0	76.1	7.6	57.1	2.9	27.0	1.4	39.8	2.0	55	5.5	96	100.0	98.9	4.2	0	6.9	100	5	72.1	61
Kitgum	267900	86.5	13.0	55.9	8.4	1.0	10.0	100.0	10.0	55.9	5.6	49.4	2.5	30.2	1.5	74.5	3.7	71	7.1	67	58.3	90.3	12.0	0	5.2	100	5	72.0	62
Kaliro	231770	96.4	14.5	30.0	4.5	0.7	6.6	100.0	10.0	85.0	8.5	48.7	2.4	32.6	1.6	90.5	4.5	89	8.9	66.3	58.3	89.2	20.0	0	5.3	100	5	71.9	63
Bududa	195000	137.0	15.0	25.7	3.9	1.0	10.0	100.0	10.0	71.0	7.1	40.5	2.0	16.8	0.8	70.0	3.5	60	6	86.1	100.0	99.4	100.0	0	8.6	100	5	71.9	64
Maracha	212090	104.4	15.0	51.0	7.6	0.9	8.9	70.4	7.0	70.0	7.0	54.9	2.7	38.5	1.9	69.2	3.5	48	4.8	100	100.0	100.0	64.3	0	8.3	100	5	71.8	65
Nakaseke	204230	71.3	10.7	61.9	9.3	1.2	10.0	67.0	6.7	82.7	8.3	54.0	2.7	32.6	1.6	78.1	3.9	68	6.8	94.3	100.0	98.9	0.0	0	6.8	100	5	71.8	66
Lwengo	272590	144.3	15.0	21.7	3.3	0.8	7.7	100.0	10.0	96.0	9.6	46.1	2.3	30.4	1.5	93.9	4.7	55	5.5	84.6	91.7	96.3	32.4	0	6.9	100	5	71.5	67
Bukomansimbi	156930	108.8	15.0	18.7	2.8	0.7	7.5	100.0	10.0	79.5	8.0	33.9	1.7	22.5	1.1	87.5	4.4	70	7	100	100.0	100.0	100.0	0	9.0	100	5	71.4	68
Arua	827820	102.0	15.0	58.8	8.8	1.1	10.0	100.0	10.0	63.0	6.3	58.1	2.9	39.2	2.0	46.8	2.3	54	5.4	63.7	0.0	74.4	13.6	0	3.7	100	5	71.4	69
Koboko	267670	105.6	15.0	30.9	4.6	0.7	7.4	100.0	10.0	73.0	7.3	38.9	1.9	22.2	1.1	44.8	2.2	77	7.7	99.5	100.0	100.0	100.0	0	9.0	100	5	71.3	70
Kasese	803200	89.0	13.3	37.7	5.6	0.9	9.0	100.0	10.0	85.4	8.5	46.0	2.3	35.8	1.8	95.9	4.8	60	6	49.7	0.0	78.0	85.8	0	4.8	100	5	71.2	71
Alebtong	241200	120.3	15.0	26.7	4.0	0.6	6.0	100.0	10.0	75.9	7.6	53.1	2.7	24.0	1.2	84.0	4.2	75	7.5	72.6	100.0	97.0	85.7	0	7.8	100	5	71.0	72
Kibaale	756030	109.6	15.0	46.4	7.0	0.6	6.3	91.9	9.2	75.6	7.6	56.3	2.8	31.7	1.6	85.7	4.3	51	5.1	90	100.0	101.8	10.7	0	6.9	100	5	70.7	73
Mubende	657370	95.9	14.4	36.5	5.5	0.8	8.4	100.0	10.0	82.1	8.2	59.9	3.0	30.8	1.5	66.7	3.3	49	4.9	88	83.3	93.8	4.3	0	6.3	100	5	70.5	74

## *Annual Health Sector Performance Report for Financial Year 2013/14*

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Luuka	279300	81.2	12.2	21.6	3.2	0.9	8.9	100.0	10.0	63.0	6.3	28.9	1.4	14.9	0.7	80.0	4.0	49	4.9	69.8	91.7	93.5	0.0	0	5.8	100	5	62.5	104
Amuria	479270	53.7	8.1	23.6	3.5	0.6	6.4	100.0	10.0	75.4	7.5	36.0	1.8	11.9	0.6	96.8	4.8	70	7	93.9	100.0	99.8	42.9	0	7.7	100	5	62.4	105
Moroto	152200	57.8	8.7	28.1	4.2	1.0	9.6	100.0	10.0	3.6	0.4	36.7	1.8	24.9	1.2	65.2	3.3	57	5.7	91.1	100.0	93.3	100.0	0	8.6	100	5	58.4	106
Sembabule	326040	64.2	9.6	11.7	1.8	0.5	5.0	100.0	10.0	70.0	7.0	29.6	1.5	19.4	1.0	100.0	5.0	57	5.7	95.8	100.0	97.6	0.0	0	6.8	100	5	58.4	107
Kween	112460	60.4	9.1	10.8	1.6	0.9	9.4	64.3	6.4	80.0	8.0	27.0	1.3	14.8	0.7	100.0	5.0	64	6.4	77.8	50.0	92.1	11.1	0	5.4	100	5	58.4	108
Moyo	479700	21.4	3.2	14.0	2.1	0.8	7.9	100.0	10.0	88.0	8.8	14.1	0.7	9.9	0.5	69.6	3.5	60	6	98.6	100.0	100.0	95.2	1	9.9	100	5	57.6	109
Ntoroko	92970	62.5	9.4	13.6	2.0	0.7	6.7	100.0	10.0	66.3	6.6	20.9	1.0	21.3	1.1	75.0	3.8	66	6.6	54.6	25.0	88.0	0.0	0	3.9	100	5	56.1	110
Kaabong	451600	50.3	7.5	13.6	2.0	0.6	5.7	100.0	10.0	20.9	2.1	19.7	1.0	15.9	0.8	75.0	3.8	43	4.3	87	100.0	100.0	100.0	0	8.6	100	5	50.8	111
Amudat	127760	41.6	6.2	13.3	2.0	0.3	3.4	100.0	10.0	5.4	0.5	21.5	1.1	8.9	0.4	62.5	3.1	46	4.6	62.5	0.0	62.5	62.5	0	4.4	0	0	35.8	112

#### **4.12 Zonal league table and district ranking**

*Annex Two. Table 3: Zonal League table and District Ranking*

<b>Arua - 3,445,590</b>	<b>Rank</b>	<b>Jimja 3,842,440</b>	<b>Rank</b>	<b>Masaka 1,853,640</b>	<b>Rank</b>	<b>Mbarara 4,316,880</b>	<b>Rank</b>
Nebbi	1	Jinja	1	Masaka	1	Rukungiri	1
Zombo	2	Iganga	2	Lyantonde	2	Mbarara	2
Maracha	3	Kamuli	3	Rakai	3	Bushenyi	3
Arua	4	Namutumba	4	Kalungu	4	Kisoro	4
Koboko	5	Kaliro	5	Lwengo	5	Kabale	5
Adjumani	6	Buyende	6	Bukomansimbi	6	Isingiro	6
Yumbe	7	Bugiri	7	Kalangala	7	Kiruhura	7
Moyo	8	Mayuge	8	Sembabule	8	Kanungu	8
<b>Fort Portal- 2,545,470</b>				<b>Mbale- 3,698,450</b>			
				<b>Rank</b>			
Kamwenge	1	Namayingo	9	Mbale	1	Ntungamo	9
			10			Mitooma	10
		<b>Central- 7,103,490</b>		<b>Rank</b>			
	2	Mityana	1	Busia	2	Rubirizi	11
	3	Luwero	2	Budaka	3	Ibanda	12
	4	Mpigi	3	Bukwo	4	Buhweju	13
	5	Butambala	4	Pallisa	5	Sheema	14
Kasese	6	Kayunga	5	Butaleja	6	<b>Moroto- 1,457,690</b>	
	7			Tororo	7	<b>Rank</b>	
		Mukono	6	Bududa	8	Abim	1
		Nakasongola	7	Kibuku	9	Napak	2
		Buikwe	8	Kapchorwa	10	Nakapiripirit	3
		Kampala	9	Bulambuli	11	Kotido	4
		Nakaseke	10	Manafwa	12	Moroto	5
Ntoroko	5	Mubende	11	Sironko	13	Kaabong	6
	6	Wakiso	12	Kween	14	Amudat	7
	7	Gomba	13	<b>Soroti- 1,519,230</b>		<b>Rank</b>	
				Soroti	1		
Gulu-	1	Buvuma	14	Serere	2		
	2	<b>Rank</b>		Kumi	3		
	3	<b>Lira- 2,119,480</b>		Ngora	4		
	4	Lira	1	Kaberamaido	5		
	5	Amolatar	2	Bukedea	6		
	6	Dokolo	3	Katakwi	7		
	7	Apac	4	Amuria	8		
<b>Hoima- 2,567,040</b>		Otuke	7				
		Kole	8				

#### **4.13 Hospital Performance Tables**

*Annex Two. Table 4: Top ten causes of hospital based mortality for all ages FY 2013/14*

<b>Data</b>	<b>Under 5 Mortality</b>	<b>Under 5 Mortality %</b>	<b>5 and over mortality</b>	<b>5 and over %</b>	<b>Total deaths</b>	<b>Total %</b>
Malaria	2,036	19.9%	2,028	9.4%	4,064	12.8%
Tuberculosis (new smear positive cases)	97	1.0%	2,659	12.3%	2,756	8.6%
Pneumonia	1,263	12.4%	1,112	5.1%	2,375	7.5%
Anaemia	1,241	12.2%	1,105	5.1%	2,346	7.4%
Perinatal Conditions (in new borns 0 -7 days)	991	9.7%	0	0.0%	991	3.1%
Other Tuberculosis	44	0.4%	766	3.5%	810	2.5%
Injuries - Road Traffic Accidents	122	1.2%	623	2.9%	745	2.3%
Cardiovascular Diseases (Other)	72	0.7%	621	2.9%	693	2.2%
HIV Related Psychosis	22	0.2%	611	2.8%	633	2.0%
Abortions	0	0.0%	630	2.9%	630	2.0%
All Others	4,322	42.3%	11,503	53.1%	15,825	49.7%
<b>Total</b>	<b>10,210</b>	<b>100%</b>	<b>21,658</b>	<b>100%</b>	<b>31,868</b>	<b>100%</b>

*Annex Two. Table 5: Top ten causes of hospital based morbidity for all ages FY 2013/14*

<b>Causes of morbidity</b>	<b>Under 5</b>	<b>Under 5</b>	<b>5 and over</b>	<b>5 and over</b>	<b>Total</b>	<b>Total cases %</b>
Malaria	236,026	49.3%	101,729	16.1%	337,755	30.4%
Pneumonia	44,244	9.2%	15,476	2.4%	59,720	5.4%
Respiratory Infections (Other)	35,115	7.3%	17,341	2.7%	52,456	4.7%
Anaemia	33,834	7.1%	17,017	2.7%	50,851	4.6%
Hypertension (Old cases)	12	0.0%	40,584	6.4%	40,596	3.7%
Injuries - (Trauma Due To Other Causes)	3,932	0.8%	28,403	4.5%	32,335	2.9%
Diarrhoea – Acute	21,465	4.5%	7,412	1.2%	28,877	2.6%
Abortions	0	0.0%	28,233	4.5%	28,233	2.5%
Gastro-Intestinal Disorders (Non Infective)	7,300	1.5%	15,949	2.5%	23,249	2.1%
Injuries - Road Traffic Accidents	1,644	0.3%	19,560	3.1%	21,204	1.9%
All Others	95,470	19.9%	340,035	53.8%	435,505	39.2%
<b>Total</b>	<b>479,042</b>	<b>100%</b>	<b>631,739</b>	<b>100%</b>	<b>1,110,781</b>	<b>100%</b>

*Annex Two. Table 6: General Hospital Outputs, Efficiency and Outcome indicators 2013/2014*

Hospital	IPD Admissions	IPD Patient Days	Attendance OPD total	Deliveries in unit	ANC Total	Postnatal attendance	Family Planning	Immunizations	IPD Beds Available	BoR	ALOS	IPD Deaths	Maternal deaths	Mat death risk 1:x deliveries	Fresh Still births	FSB risk 1:x deliveries	SUO
Iganga	20,860	60,636	171,001	6,171	13,396	1,213	1,106	40,577	104	159.7 %	2.9	479	23	268	192	32	530,729
Bwera	13,783	51,988	72,110	4,361	11,085	286	2,340	28,297	110	129.5 %	3.8	305	10	436	32	136	313,175
Tororo General	14,810	63,496	59,527	4,114	9,102	2,073	584	15,946	214	81.3%	4.3	522	8	514	81	51	311,316
Mityana	13,759	73,005	57,201	5,497	11,824	1,494	1,117	20,747	122	163.9 %	5.3	343	20	275	109	50	302,438
Kawolo	11,829	29,529	88,042	3,728	10,284	555	1,757	21,197	109	74.2%	2.5	201	2	1,864	27	138	294,654
Angal St. Luke	15,943	89,476	33,653	2,244	5,165	306	3	17,111	260	94.3%	5.6	673	18	125	49	46	290,177
Busolwe	12,209	22,439	79,973	1,598	4,184	867	165	9,528	100	61.5%	1.8	173	5	320	27	59	275,612
Adjumani	11,731	62,579	83,953	1,695	4,099	836	302	9,656	147	116.6 %	5.3	290	5	339	28	61	272,943
Kamuli	11,490	31,229	75,836	2,063	5,521	1,937	1,276	16,477	100	85.6%	2.7	108	4	516	22	94	266,163
Nebbi	12,824	40,197	51,965	2,105	7,249	571	323	20,263	120	91.8%	3.1	210	4	526	21	100	262,974
Pallisa	12,355	42,886	48,918	3,465	7,796	1,414	728	20,873	100	117.5 %	3.5	125	10	347	67	52	260,712
Kalongo Ambrosoli Memorial	13,805	76,758	28,772	3,003	6,722	2,672		12,627	302	69.6%	5.6	219	5	601	22	137	258,084
Kagadi	13,544	46,264	21,966	3,304	8,608	146	108	13,270	160	79.2%	3.4	908	4	826	82	40	248,731
Yumbe	11,361	44,177	56,328	2,242	4,301	846	1,214	20,658	116	104.3 %	3.9	253	5	448	29	77	245,265
Kayunga	10,317	30,757	69,956	2,565	5,057	335	1,006	19,626	104	81.0%	3.0	291	9	285	68	38	244,660
Itojo	11,443	45,245	51,914	2,231	3,777	1,793	166	8,199	165	75.1%	4.0	140	5	446	67	33	239,922
Entebbe	8,845	30,303	62,256	5,046	16,247	1,325	399	37,095	149	55.7%	3.4	185	3	1,682	55	92	236,566
Kitgum	10,238	59,090	62,670	2,294	5,190	858	926	17,193	220	73.6%	5.8	199	1	2,294	11	209	234,636
Ibanda	12,576	38,926	22,903	2,281	4,960	152		11,082	178	59.9%	3.1	124	7	326	95	24	227,720
Masafu General	9,146	24,989	77,199	1,569	4,526	609	160	13,305	92	74.4%	2.7	82	2	785	32	49	227,543
Atutur	9,497	28,394	70,861	1,772	4,444	623	366	13,141	100	77.8%	3.0	75	1	1,772	27	66	227,521
Bugiri	9,621	41,181	52,159	2,556	8,968	659	1,108	15,446	104	108.5 %	4.3	186	5	511	94	27	217,711
Gombe	9,680	35,265	49,724	2,759	5,441	378	354	11,655	100	96.6%	3.6	221	11	251	54	51	214,137
Kisoro	9,147	48,078	53,248	2,955	8,553	200	1,089	15,600	132	99.8%	5.3	138	3	985	25	118	213,269
Lyantonde	7,887	20,970	78,969	1,917	6,177	198	496	12,618	100	57.5%	2.7	95	11	174	172	11	212,818
Ishaka Adventist	11,359	25,121	18,225	3,099	5,909	701	1,168	20,723	104	66.2%	2.2	197	6	517	69	45	212,139

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Kiryandongo	10,243	36,384	35,333	2,010	7,919	149	625	19,595	104	95.8%	3.6	157	7	287	76	26	207,294
Kilembe	10,851	51,175	24,645	2,448	3,615	398		13,351	205	68.4%	4.7	334	7	350	38	64	204,327
Apac	8,419	40,077	54,724	2,020	9,819	596	772	17,137	100	109.8 %	4.8	147	7	289	25	81	200,130
Kiboga	9,071	31,626	39,860	2,532	7,865	1,629	200	8,434	100	86.6%	3.5	158	8	317	89	28	195,119
Bududa	8,361	29,637	53,147	1,237	3,688	686	569	22,105	100	81.2%	3.5	145	3	412	28	44	191,640
Aber Ngo	8,823	33,258	36,707	2,198	8,600	2,077		28,394	172	53.0%	3.8	369	14	157	66	33	191,059
Kisiizi NGO	8,738	55,108	30,175	2,198	8,595		186	21,886	260	58.1%	6.3	182	4	550	28	79	181,003
Katakwi General	8,367	33,632	44,455	1,066	3,040	767	902	10,193	111	83.0%	4.0	84	1	1,066	8	133	179,683
Masindi	7,250	25,141	36,148	3,600	12,743	896	1,483	29,830	143	48.2%	3.5	190	10	360	60	60	176,425
Kumi NGO	7,767	47,277	41,992	1,631	2,946	242	276	7,796	195	66.4%	6.1	127	4	408	34	48	169,943
St. Joseph'S Kitgum	8,468	58,641	27,553	1,764	4,602	623		15,703	270	59.5%	6.9	329	5	353	9	196	169,146
Kaabong	7,858	26,833	42,585	736	2,635	629	214	10,868	100	73.5%	3.4	85	6		15	49	168,048
Nakaseke	5,653	29,264	63,792	2,548	4,319	149	173	12,487	100	80.2%	5.2	2,098	4	637	51	50	166,145
Kapchorwa	6,688	26,774	47,022	1,736	4,887	47	998	9,586	119	61.6%	4.0	174			44	39	160,905
Kagando	8,814	47,094	17,584	1,315	3,913	220	744	10,278	272	47.4%	5.3	312	5	263	35	38	160,863
Kalisizo	6,328	17,413	47,330	2,122	6,456	198	613	14,357	105	45.4%	2.8	102	5	424	45	47	159,365
Ngora Ngo	9,565	7,219	8,586	221	118	8		15,726	103	19.2%	0.8	61			4	55	156,374
Kitagata	4,461	12,221	74,244	1,839	3,638	910	431	7,294	100	33.5%	2.7	45	2	920	38	48	154,302
Mutolere (St. Francis)	7,856	42,925	19,037	1,906	5,462	211	542	11,508	200	58.8%	5.5	251	3	635	121	16	151,816
Murchison Bay	2,415	5,380	107,895	794	3,907	188	712	4,187	165	8.9%	2.2	13			6	132	151,331
Matany	6,918	56,844	33,104	1,064	3,707	663	56	31,427	284	54.8%	8.2	189	23	46	21	51	150,692
Kamuli Mission	6,721	20,579	29,056	1,945	7,187	4,662		11,679	160	35.2%	3.1	186	3	648	62	31	147,856
St. Karolii Lwanga Nyakibale	7,641	24,824	14,109	2,401	4,315	312	3	10,808	169	40.2%	3.2	139	6	400	14	172	145,206
Bombo General Military	5,029	32,441	57,563	1,768	3,649	111	123	7,034	147	60.5%	6.5	193	3	589	33	54	145,186
Kyenjojo	5,888	11,145	39,345	1,643	3,996	131	2,716	17,975	72	42.4%	1.9	96	3	548	36	46	142,897
Bundibugyo	6,113	34,558	37,772	1,495	4,742	34	263	13,236	104	91.0%	5.7	164	6	249	42	36	142,109
St. FrancisNaggalama	6,359	27,401	32,957	1,503	4,976	189		10,920	100	75.1%	4.3	144	5	301	32	47	140,624
Rakai	5,609	17,570	44,773	1,486	2,986	116	128	8,622	69	69.8%	3.1	68	9	165	60	25	139,677
Moyo	4,566	17,871	57,759	986	1,527	482	262	6,025	167	29.3%	3.9	83	1	986	17	58	133,520

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Kiu Teaching	7,248	31,193	18,656	755	1,891	75	363	3,824	291	29.4%	4.3	165		19	40	133,080	
Nkozi	5,585	18,269	29,534	1,760	3,580	1,379		9,517	100	50.1%	3.3	104	5	352	38	46	126,492
St. Joseph Kitovu	6,346	28,630	21,054	1,405	2,058	211		7,359	200	39.2%	4.5	227	7	201	55	26	125,875
Anaka	5,017	18,999	37,328	1,028	4,236	958	425	8,981	100	52.1%	3.8	76	2	514	17	60	122,329
Virika	6,234	18,373	18,202	1,218	2,244	157	11	12,258	207	24.3%	2.9	196	5	244	36	34	121,460
Kisubi	4,371	13,862	37,339	1,562	6,111	441		33,408	101	37.6%	3.2	97		22	71	120,672	
Kuluva	6,276	38,390	15,859	1,003	3,527	168	357	16,271	208	50.6%	6.1	249	11	91	27	37	120,294
Comboni	5,378	15,796	32,643	671	3,003	246		7,548	100	43.3%	2.9	84	5	134	12	56	119,802
Kiwoko	5,064	26,170	26,534	2,192	5,623	479	285	12,924	197	36.4%	5.2	125	7	313	39	56	119,232
Maracha	5,706	46,960	16,677	937	1,983	423		13,967	200	64.3%	8.2	286	7	134	76	12	110,948
Kabarole	5,270	9,366	14,090	847	2,401	226	244	44,171	85	30.2%	1.8	53	6	141	17	50	107,645
Kambuga	4,168	14,413	35,084	1,188	3,426	121	583	5,992	100	39.5%	3.5	65	3	396	35	34	106,807
Buluba	4,637	18,726	29,640	915	1,558	370		6,462	120	42.8%	4.0	145	8	114	16	57	106,026
Bwindi Community	4,569	18,335	26,568	1,249	2,240	181	1,010	4,810	110	45.7%	4.0	64	1	1,249	27	46	104,026
Kanginima	5,959	17,438	8,588	231	1,487	230	560	10,155	45	106.2 %	2.9	42		1	231	102,298	
Rubongi Military	3,446	8,412	47,011	119	1,070	134	474	2,964	69	33.4%	2.4	15		1	119	100,728	
Villa Maria	4,768	19,889	19,968	1,321	1,576	9		5,368	126	43.2%	4.2	158	10	132	43	31	99,959
Nyapea	4,934	14,631	13,692	1,326	3,503	1,013		11,035	139	28.8%	3.0	127	8	166	29	46	98,797
Buikwe St. Charles Lwanga	4,977	15,294	13,641	929	2,725	184		8,245	85	49.3%	3.1	88		21	44	96,045	
Kakira Worker's	2,805	5,066	49,601	367	1,348	115	451	4,574	77	18.0%	1.8	18		5	73	95,383	
Ruharo Mission	3,806	11,757	28,696	703	1,195	131	87	2,806	105	30.7%	3.1	87		7	100	90,569	
Abim	3,622	13,485	29,854	510	982	346	15	3,321	120	30.8%	3.7	61	2	255	8	64	88,070
Rugarama	3,840	22,820	21,944	295	1,822	139	314	4,568	136	46.0%	5.9	110		5	59	83,070	
Nakasero	2,442	9,779	37,068	755	400	85		12,350	68	39.4%	4.0	38		2	378	80,186	
Amudat	4,085	15,460	12,900	426	1,513	777	220	6,957	113	37.5%	3.8	77	1	426	17	25	78,951
St. Francis Nyenga	2,916	12,050	21,832	558	2,997	517	35	6,791	100	33.0%	4.1	74		17	33	71,495	
Dabani	3,977	8,693	4,796	403	980	518		7,938	64	37.2%	2.2	64	2	202	65	6	68,803
Rushere Community	2,998	9,085	11,625	569	3,445	457	195	13,340	92	27.1%	3.0	68	1	569	21	27	64,157
Lugazi Scoul	2,474	10,762	16,685	214	1,294	249	1,004	4,706	44	67.0%	4.4	4		2	107	57,080	
Lwala	2,857	15,787	6,109	666	1,469	667		6,761	100	43.3%	5.5	45	3	222	28	24	54,714

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Hospital	IPD Admissions	IPD Patient Days	Attendance OPD total	Deliveries in unit	ANC Total	Postnatal attendance	Family Planning	Immunizations	IPD Beds Available	BoR	ALOS	IPD Deaths	Maternal deaths	Mat death risk 1:x deliveries	Fresh Still births	FSB risk 1:x deliveries	SUO
Namungoona Orthodox	2,101		14,552	414	2,002	307		6,528	45		17	3	138	7	59	50,597	
St. Anthony'S Tororo	2,533	10,355	8,221	454	1,071	159		5,691	163	17.4%	4.1	75	1	454	3	151	50,239
Nakasongola Military	1,597	13,441	23,243	127	756	12	184	1,561	98	37.6%	8.4	10		1	127	48,621	
Nkokonjeru	1,613	5,022	13,236	540	1,950	249	18	5,173	61	22.6%	3.1	35	5	108	12	45	42,274
GuluMilitary	1,167	10,513	17,527	64	971		130	2,500	114	25.3%	9.0	19	-	-	1	64	36,403
UPDF 2nd Div.	823	4,405	22,175	21	860	85	115	2,123	40	30.2%	5.4	13	-	-	-	-	35,580
Amai Community	1,666	13,065	3,438	358	2,534	234	21	6,967	79	45.3%	7.8	31	2	179	9	40	33,006
Mayanja Memorial	1,243	3,633	9,676	321	648	26	346	4,795	100	10.0%	2.9	23	-	-	2	161	31,395
Oriajini	1,437	4,951	3,172	592	1,573	192	194	6,900	48	28.3%	3.4	15	-	-	9	66	30,047
5ThMilitary Division	666	3,511	18,377	118	699	90	191	1,516	50	19.2%	5.3	3	-	-	2	59	29,750
Bukwo General	1,524	11,150		287	1,738	562	279	5,702	30	101.8 %	7.3	11	1	287	10	29	26,725
Kida	1,304	2,542	2,639	358	1,143	38	78	3,045	30	23.2%	1.9	101	-	-	8	45	25,228
Galilee Community General	1,035	146	5,536	279	368	128	386	9,566	21	1.9%	0.1	5	-	-	3	93	24,810
Senta MedicareCLINIC	627	2,205	10,683	199	565	245	6	3,570	15	40.3%	3.5	1	-	-	3	66	22,205
Gulu Independent	836	3,604	5,595	56	248	7	73	12,678	81	12.2%	4.3	34	-	-	1	56	21,115
Buwenge NGO	722	2,115	3,946	631	2,393	612	871	5,179	41	14.1%	2.9	5	-	-	3	210	20,905
Saidina Abubakar Islamic	438	9,421	8,067	183	818	53	23	5,154	20	129.1 %	21.5	62	-	-	-	-	17,030
Uganda Martyrs	493	1,084	5,963	255	822	42	1	2,588	20	14.8%	2.2	6	-	-	1	255	15,583
Mbarara Community	614	1,556	4,877	45	133	12	61	967	53	8.0%	2.5	4	-	-	-	-	14,608
Kabasa Memorial	753	2,658	1,662	17	659	307	154	4,668	45	16.2%	3.5	3	-	-	2	9	14,536
Bamu	703	2,113	2,382	184	271	5	24	108	66	8.8%	3.0	2	1	184	5	37	14,019
Old Kampala	173	477	6,071	45	68	14	1	9,323	20	6.5%	2.8	-	-	-	-	-	10,797
ParagonKampala	294	625	3,199	268	1,351	130	211	2,517	22	7.8%	2.1	1	-	-	3	89	10,298
Divine Mercy	185	70	1,551	1	4			0	15	1.3%	0.4	3	-	-	-	-	4,333
Bethany Women and Family	102	274		26	61	14	77	430	20	3.8%	2.7	-	-	-	-	-	1,822
Novik	-	-	12,505	21	1,450	11	54	389	-	-	-	-	-	-	-	-	-
St. Catherine	-	-	23,498	14	33	17		851	-	-	-	-	-	-	-	-	-
Kibuli	-	-	17,926	594	456	4		1,070	-	-	-	1	594	5	119		

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Hospital	IPD Admissions	IPD Patient Days	Attendance OPD total	Deliveries in unit	ANC Total	Postnatal attendance	Family Planning	Immunizations	IPD Beds Available	BoR	ALOS	IPD Deaths	Maternal deaths	Mat death risk 1:x deliveries	Fresh Still births	FSB risk 1:x deliveries	SUO
Kitintale	-	-	322	11	14	7	4	330	-	-	-	-	-	-	-	-	
Middle East Bugolobi	-	-	1,747					88	0	-	-	-	-	-	-	-	
Ntinda	-	-	462	9	7	5	127	268	-	-	-	-	-	1	9	-	
Mildmay Uganda	334	3,413	63,175	-	-	181	186	961	33	28.3%	10.2	27	-	-	-	-	
Cure Children's	1,094	6,951	4,859	-	-	-	-	165	40	47.6%	6.4	17	-	-	-	-	
Benedictine EYE	1,602	6,288	7,260	-	-	-	-	0	68	25.3%	3.9	238	-	-	-	-	
Buliisa	-	-	2,234		88		16	0	-	-	-	-	-	-	-	-	
Hunter Foundation	-	-	43		8	-	-	519	-	-	-	-	-	-	-	-	
Holy Innocents Children's	3,671	8,171	17,653	-	-	-	-	2,361	55	40.7%	2.2	77	-	-	-	-	
Average	6,035	24,114	32,077	1,387	3,665	488	450	10,462	114	1	4	154	5.8	241	33	42	138,459
minimum	102	70	43	1	4	4	1	-	15	0	0	1	1	46	1	6	1,822
maximum	20,860	89,476	171,001	6,171	16,247	4,662	2,716	44,171	302	2	22	2,098	23	2,294	192	378	530,729
sum	688,024	2,724,938	3,849,271	159,460	432,427	55,124	41,804	1,286,885	13,071	61	467	17,217	449	36,589	3,493	7,402	15,230,510
count	114	113	120	115	118	113	93	118	115	113	113	112	78	77	106	106	110

*Annex Two. Table 7: Outputs and Ranking of HC IVs 2013/2014*

Facility	IPD Admissions	IPD Patient Days	IPD Beds Available	Total OPD	Deliveries in unit - OPD	Total ANC	Postnatal Attendances	Family Planning contacts	Immunization	Caesarian Sections-IPD	Major operations	Blood Transfusions (Units) - IPD	IPD Deaths	Fresh Still births in unit - OPD	Maternal deaths - OPD	SUO	Rank
Mukono T.C.	6492	7194	21	43710	5225	10150	5057	1719	25683	594	704	22	11	31	180,815	1	
River Oli	8192	16379	56	26419	3709	3387	526	40	12645	4	12	6	45	172,350	2		
Kabuyanda	7208	26769	49	17696	1914	2548	106	940	3131	387	432	306	44	44	2	137,809	3
Serere	6256	22024	81	29173	1700	2223	750	300	4413	231	709	448.9	60	43	5	134,032	4
PAG Mission	6365	38745	163	32988	587	1533	659	121	3636	66	215	961	148	6	1	133,282	5
Nyahuka	5671	17739	69	33387	1514	3094	52	113	2841	284	496	530	55	42	4	128,220	6

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Facility	IPD Admissions	IPD Patient Days	IPD Beds Available	Total OPD	Deliveries in unit - OPD	Total ANC	Postnatal Attendances	Family Planning contacts	Immunization	Caesarian Sections-IPD	Major operations	Blood Transfusions (Units) - IPD	IPD Deaths	Fresh Still births in unit - OPD	Maternal deaths - OPD	SUO	Rank
Koboko	5858	18958	95	25422	1860	3371	313	311	15928	161	234	103	85	31	2	127,775	7
Pakwach	6309	15507	65	24749	923	2114	419	322	4955	9	11	233	161	10	3	126,418	8
Luwero	4556	8220	50	44030	1952	4693	1497	133	5497	76	171	122	51	15		126,391	9
Rubaare	4374	28768	54	47207	1948	2802	670	861	7327	264	363	2	35	14	3	126,189	10
Bugobero	5421	18877	47	31721	922	3259	499	561	14039	90	190	313	20	10		122,613	11
Azur	6689	12625	73	9848	1910	1505	205	386	4996	113	169	6	90	11	1	121,780	12
Kyangwali	5487	19013	32	28994	954	2308	102	525	6101		15	1042	128	14	1	118,757	13
Mpigi	5327	9197	43	23789	2271	4709	567	36	4904	251	359	110	15	26	4	118,686	14
Budaka	5379	9663	35	25559	1496	2566	651	67	3234		23		9	15		116,013	15
Kitwe	5153	11396	48	26980	1355	3957	196	205	8226	16	17	43	27	19	1	114,874	16
Omugo	4425	9600	28	34855	1042	2650	455	626	6683		0		25	11		109,642	17
Busia	3631	4701	34	41414	1660	5815		298	9904	31	38		23	29		109,216	18
Buyinja	4775	13057	27	27868	734	1769	237	298	3370		28		27	6		104,989	19
Midigo	4995	9641	72	21687	902	1909	739	1020	4816	38	74	177	29	14		103,919	20
Budadiri	4459	11810	47	25059	1628	2910	295	340	9129	54	141	87.5	34	26	2	103,682	21
Kaberamaido	3521	12253	74	41124	723	1386	127	140	2600	42	183	11	34	9	2	98,901	22
Buwenge	4613	12239	32	21667	879	1862	723	153	3814	11	21		6	2		97,389	23
Kakuuto	4423	17202	55	25489	505	1735	118	157	6418	55	76	443	62	15	2	96,648	24
Kumi	3220	5547	22	39864	461	2013	417	1183	6668		0		1	1		93,609	25
Dokolo	4116	22233	65	25398	771	1565	266	698	4269	104	253	66	73	96	4	93,111	26
Kibuku	3599	5487	33	29637	1198	2063	509	146	3953		30	73.2	9	6	2	91,762	27
Bishop Asili Ceaser	4260	14800	80	21169	1078	640	262		2711	488	841	741	308	52	6	91,452	28
Mukuju	3624	10222	26	29297	664	2209	1126	459	4916		1		7	2		89,857	29
Ogur	2190	6902	36	48970	1007	1595	197	448	6305		6		19	8	1	89,236	30

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Facility	IPD Admissions	IPD Patient Days	IPD Beds Available	Total OPD	Deliveries in unit - OPD	Total ANC	Postnatal Attendances	Family Planning contacts	Immunization	Caesarian Sections-IPD	Major operations	Blood Transfusions (Units) - IPD	IPD Deaths	Fresh Still births in unit - OPD	Maternal deaths - OPD	SUO	Rank
Ntwetwe	3803	8764	39	22454	1332	2748	140	612	6024	72	116	7	24	21		89,114	31
Kibaale (Kibaale)	4581	4556	34	13405	998	1911	180	427	3045	75	94	34	12	22	2	88,978	32
Kasangati	2662	4140	31	29987	2364	6536	484	256	14817	32	32		1	7		88,338	33
Rwashamaire	3383	13690	37	29767	1150	2294	129	520	2863		0		12	123	1	88,306	34
Wakiso	2512	3769	26	35183	1646	4296	660	641	21207	28	63		1	3		88,133	35
Mulanda	3557	10410	32	25956	965	3283	1585	1174	3735		0		22	96	1	87,904	36
Rukunyu	4150	13840	64	17739	1079	828	1077	347	4834	345	425	330	92	27	3	87,477	37
Mukono CoU	3674	9882	47	21248	1300	2333	1078	10	5397	353	584	261	74	20	3	85,648	38
Kigoroby	3228	6074	34	29637	910	2387	58	647	3314		10	8	16	3		84,816	39
Bwizibwera	3082	6051	32	26715	1603	2815	2630	193	3394		10	2	2	12		84,458	40
Muyembe	3669	6860	30	22217	906	2783	197	154	4201		0		23	5		84,189	41
Anyeke	3276	8372.4	58	26699	1028	2370	319	222	4804	85	143	85	35	14		83,395	42
Amuria	3380	11793	70	24058	1184	1919	719	335	4592	117	295	10	11	15	1	83,083	43
Namwendwa	3186	7658	31	25629	1156	2357	665	1085	5626	25	53	156	31	1		82,378	44
Busiu	3687	6412	42	19523	822	1468	140	201	2576	7	74	95	11	8	1	80,358	45
Kinoni	3558	5695	25	21008	582	1718	1384	262	2156	17	21			34		79,401	46
Tokora	4002	8996	34	15266	359	1115	1317	89	3183	50	54	230	53	14	3	78,988	47
Bukedea	3290	13320	42	19495	1309	2401	386	319	6500		73		13	9		78,243	48
Bumanya	3455	9395	32	20963	726	1860	240	283	3142	61	252		7	8		78,238	49
Bukomero	3005	5031	42	23249	1251	2787	113	311	6902		0		17	81		77,565	50
Rugazi	3166	6779	39	22141	1067	2101	90	163	3470		486	7	8	8		76,837	51
Nankandulo	2763	5122	37	29688	687	1620	390	1042	3253		0	105	8			76,745	52
Magale	3805	11314	91	12426	941	1652	893		6022	71	135	319.3	76	32		76,683	53
Atirir	3106	6229	34	25363	483	1220	348	136	3040		13		5	3		75,828	54

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Facility	IPD Admissions	IPD Patient Days	IPD Beds Available	Total OPD	Deliveries in unit - OPD	Total ANC	Postnatal Attendances	Family Planning contacts	Immunization	Caesarian Sections-IPD	Major operations	Blood Transfusions (Units) - IPD	IPD Deaths	Fresh Still births in unit - OPD	Maternal deaths - OPD	SUO	Rank		
Lalogi	2353	7981	38	35919	476	1399	242	437	3912	0	65	44	58	1	75,415	55			
Kabwohe	2373	4503	33	28164	1736	2426	321	172	4053	99	103	90	26	15	1	74,709	56		
Aduku	2948	10791	31	20547	1358	2609	337	404	4381	126	242	20	470	35	2	74,108	57		
Nagongera	2550	4792	43	27180	984	2366	52	431	5945	0	4	12	72,964	58					
Karenga	3073	10492	64	22836	265	909	326	34	3618	0	22	1	71,614	59					
Kyabugimbi	2461	7277	30	28735	763	1975	137	559	3011	55	58	2	13	71,403	60				
Pajule	3067	9942	37	18333	832	2240	600	540	3052	0	28	4	70,798	61					
Princes Diana	3139	19561	40	18642	692	1350	458	241	2338	0	6	5	70,679	62					
Kihiihi	2885	10722	64	21308	719	1795	128	772	2748	16	47	44	2	4	70,075	63			
St. Paul	3565	13563	90	10123	954	1340	325	586	2830	407	655	403	85	22	4	70,060	64		
Kyegegwa	2653	8992	36	22466	1063	1808	487	222	4533	120	229	102	30	18	1	69,741	65		
Ruhoko	2349	6655	45	27247	1060	2149	55	232	2132	54	78	143	36	174	3	69,426	66		
Butebo	2890	6697	34	16870	1035	3032	393	296	4590	10	39	114	10	15	1	68,174	67		
Nakasongola	2240	4992	54	29400	682	1613	144	159	3339	62	37	28	2	68,036	68				
Kiganda	2335	5128	20	22434	1415	3472	236	520	3883	132	183	10	46	1	67,425	69			
Amach	2435	7676	52	25943	642	1245	61	354	3939	892	8	9	67,296	70					
Kotido	2904	11523	59	19763	534	579	371	109	1307	54	55	19	20	2	66,784	71			
Kidera	2615	7878	30	19985	796	1899	823	237	7897	21	122	12	10	1	66,249	72			
Alebtong	1803	9529	59	31883	807	2219	79	441	7784	5	8	37	11	2	65,889	73			
Bufumbo	2735	7796	30	18975	595	1639	569	304	3898	0	229	59	65,011	74					
Kangulumira	2009	3262	23	25606	1135	3191	187	596	6168	0	16	6	64,637	75					
Obongi	2482	8132	47	24033	401	738	207	686	1445	9	79	123	138	3	64,373	76			
Kawempe	1909	1909		23571	1485	3843	776	370	6210	15	17		2		63,368	77			
Nankoma	2101	4995	25	24668	660	2517	1031	629	7172	0	7	5	63,006	78					

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St. Ambrose Charity	3201	7487	65	5391	1487	1462	114	174	4516	545	660	447	86	54	8	62,619	79
Nsinze	2253	5106	30	22028	908	1486	361	675	2288	0	0	11	4	4	62,082	80	
Aboke	2410	5458	18	18537	935	1994	115	341	5338	40	69	1	8	8	61,655	81	
Busesa	2018	4060	24	23102	878	2593	2934	590	3107	10	11	61	6	6	61,442	82	
Kanungu	2392	7136	20	21303	546	1051	56	202	1391	0	0	5	4	4	60,846	83	
Patongo	1692	4232	23	29656	563	2852	177	417	5509	0	0	6	2	2	60,676	84	
Apapai	2226	4103	23	22850	617	1262	213	97	2806	0	0	1	9	9	60,672	85	
Mungula	2488	9153	36	20037	379	754	135	180	1542	0	0	18	3	3	60,095	86	
Kakumiro	2098	10120	55	19255	1266	2853	111	136	4873	111	120	79	20	13	59,580	87	
Mitooma	1236	3348	41	36226	489	1750	64	277	4318	12	12	9	1	1	59,120	88	
Semuto	1582	2416	24	30458	574	2019	228	30	2954	0	0	4	73	73	58,787	89	
Benedict Medical centre	1358	2955	49	33941	367	584	237		1723	88	183	35	10	6	56,901	90	
Buliisa	2272	5126	36	18118	557	1692	102	37	4501	0	0	25	66	66	56,799	91	
Nyamuyanja	1859	3226	24	25185	444	1193	35	583	2669	45	57	5	53	53	56,729	92	
Bbaale	1669	4739	17	27204	370	1607	200	727	2234	0	113	10			55,803	93	
Rugaaga	1737	4190	18	25842	395	1424	105	206	4206	2		1	3	3	55,581	94	
Kiruhura	1936	5222	27	22384	416	1390	134	151	4832	11		4	6	6	55,308	95	
Kakindo	2007	4642	37	18358	752	2420	300	255	5614	116	116	34	11	11	54,833	96	
Kyarusozi	1795	4157	30	22189	818	1617	86	562	1924	60	74	94	27	6	54,721	97	
Bubulo	1716	2561	24	20545	780	2081	2361	525	3701	3		3	10	10	53,409	98	
Amolatar	2047	5851	44	17116	617	1929	171	88	2514	0	0	30	3	3	52,503	99	
Padibe	1763	5046	34	20581	659	968	390	646	2466	21	27	26	45	7	51,816	100	
Kitebi				29881	2776	9855	766	886	11194	0			7	1	51,753	101	
Kassanda	1671	3335	8	18145	1137	3236	152	187	4202	0	0	1	16	16	51,523	102	

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Ishongororo	1696	4988.9	35	20732	664	2337	52	180	3479	16	33		6	11		51,472	103
Naam Okora	1985	5389	36	18039	481	876	186	303	2156		0		15	1		51,333	104
Nabilatuk	2325	5144	30	13473	368	789	289	36	2900	14	48	47	50	7		51,325	105
Kigandalo	1219	1916	16	26259	784	1956	154	643	4044		0		2	3	1	50,649	106
Awach	1852	5349	31	19555	447	705	182	132	2806		46		9	1	1	50,641	107
Namayumba	1133	1873	20	27693	733	2320	80	53	3175	19	59	30	19	16	1	50,215	108
Kazo	1032	2273	35	29290	537	2237	162	250	3747		0		6	2		49,529	109
Bwijanga	1662	4727	26	19812	577	2178	131	298	2968		6		20	7		49,524	110
Rhino Camp	2203	4166	30	12098	533	1263	243	173	3755		0		17	7	1	49,399	111
Kapelebyong	1592	5246	47	21714	462	1163	308	182	2980		0		1	4		49,327	112
Kiyunga	1573	2416	30	17980	933	2468	1200	577	2799	5	12		4	7		48,922	113
Kityerera	1146	1618	9	25887	645	2635	247	563	4413		0			5		48,907	114
Ntara	1982	5694	31	13677	682	1282	465	549	2871	152	155	112	15	12		48,539	115
Kaproron	2150	2477	34	13109	366	1180	423	17	1748		55		10	7		48,349	116
Kebisoni	1558	2477	32	20323	569	1383	200	279	1967		3		1	1		47,862	117
Bugembe	433	259	27	30026	1461	3638	419	691	7256		0			6		47,651	118
Ndejje	1053	2165	16	23108	930	3170	533	292	8846	1	8		6	2		47,320	119
Toroma	1651	4991	36	18254	486	818	460	617	2431		0		6	1		46,883	120
Bukulula	949	1751	17	30029	173	1045	591	213	2922		2	70	4	1		46,638	121
Atiak	1673	4900	26	18985	188	860	124	985	2657		4		10			46,536	122
Bukuku	1051	1506	6	19189	954	2232	981	8611	3255	50	78		10	5		46,287	123
Lwengo	1270	3038	14	23645	337	1664	167	160	4133		0	11	4			46,202	124
Budondo	1327	2384	23	21316	615	1635	339	594	3078		0			2		46,196	125
Rwekubo	1325	3097	18	22182	557	954	45	276	1072	203	275	4	8	10	1	45,694	126

*Annual Health Sector Performance Report for Financial Year 2013/14*

Facility	IPD Admissions	IPD Patient Days	IPD Beds Available	Total OPD	Deliveries in unit - OPD	Total ANC	Postnatal Attendances	Family Planning contacts	Immunization	Caesarian Sections-IPD	Major operations	Blood Transfusions (Units) - IPD	IPD Deaths	Fresh Still births in unit - OPD	Maternal deaths - OPD	SUO	Rank
Nyimbwa	1474	2413	18	19456	452	1415	137	281	1939	6	18		4	4	-	45,130	127
Adumi	1468	5234	38	18489	462	1333	98	205	4872	3	8		7	15	-	44,611	128
Bugangari	879	2063	22	27501	465	1201	204	379	2670		0		1	5	-	44,437	129
Kibiito	766	1081	6	26544	705	2427	138	331	2552	19	22		7	-	43,517	130	
Kalangala	603	895	41	31768	211	887	45	1216	1095	15	123	2	14	1	-	43,161	131
Kikyo	1806	2761	18	14155	238	700	71	59	1424	-	0		2	4	1	43,135	132
Bugono	1398	1506	20	17615	605	1150	314	659	2131	-	62		54	2	-	43,098	133
Wagagai	1149	1957	19	23058	328	695	772	87	1854	68	122	24	125	2	-	43,081	134
Muko	1230	2102	20	20572	411	1328	211	520	1922	3	5		6		-	42,491	135
Walukuba	-	-	-	37752	554	2054	445	367	2071	-	0			3	-	42,369	136
Orum	1314	3948	35	19349	374	867	15	216	2256	-	6		10	4	-	41,929	137
Chahafi	1239	2808	19	19909	407	1376	196	203	1659	-	0		1		-	41,748	138
Kalagala	1409	1296	30	16467	387	1208	234	1580	2285	8	34		11	5	-	41,505	139
Karugutu	1106	2138	30	22115	267	1097	42	116	3754	-	5		9	2	-	41,418	140
Hamurwa	1025	1847	26	21735	460	1450	85	467	1802	-	0		1	3	-	40,771	141
ASTU	-	-	-	39972	-	-	101	0	-	0					-	40,023	142
Shuuku	954	2704	28	21385	539	1288	105	233	2660	11	13			3		39,735	143
Rubuguri	1198	3825	32	18652	413	809	72	239	1934		2		4	6		39,634	144
Kyazanga	967	2354	19	19577	421	1975	246	282	4667		7		3	1		38,372	145
Kiwangala	753	1702	13	22006	398	1412	353	294	9627	11	53	6	65	3		38,246	146
Buwambo	338	671	14	30335	298	943	77	193	3679		0			2		38,237	147
Madi-Opei	997	2027	33	20481	310	816	355	469	1928		1	3	7	1		38,192	148
Maddu	1124	1968	32	17204	440	1208	407	71	2525		0		14	5		37,612	149
Mpumudde	516	409	25	23293	618	2848	803	670	2623		0			1		36,808	150

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Facility	IPD Admissions	IPD Patient Days	IPD Beds Available	Total OPD	Deliveries in unit - OPD	Total ANC	Postnatal Attendances	Family Planning contacts	Immunization	Caesarian Sections-IPD	Major operations	Blood Transfusions (Units) - IPD	IPD Deaths	Fresh Still births in unit - OPD	Maternal deaths - OPD	SUO	Rank
Butenga	885	1999	21	18753	331	1503	342	134	3749	12	27	108	8	28		35,422	151
Rwesande	1663	4998	36	6905	314	1223	240	135	2796	86	138		22	6		34,778	152
Buwasa	408	476	12	25113	393	1108	197	677	2447		0			4		34,678	153
Busaru	1940	5866	54	1335	322	1477	157		5048	30	34	82	22	2		33,872	154
Rubaya	864	2430	33	17891	351	1166	127	222	1525		0		7	3		33,669	155
Mukwaya General Hospital	461	846	28	24517	282	461	37	47	2079	53	91	4	2			33,530	156
Ssembabule	619	1006.3	24	19683	379	2478	116	555	5138		0			1		33,465	157
Nsiika	488	820	16	24000	244	754	9	328	1502	5	5			28		33,386	158
Masindi Military Army Barracks	738	2077	40	21427	33	197	9	37	522		0		3			32,888	159
Ssekanyonyi	878	1901	24	15874	455	1264	241	719	2170		0		2	5		32,865	160
Kikuube	-	-	-	25495	1019	2836	92	328	2668	-	0	-	-	20	-	32,752	161
Mparo	980	2013	23	14664	310	663	223	600	859	-	0	-	7	-		31,829	162
Bishop Masereka Christian Foundation	1626	3246	18	4817	297	633	36	166	1783	139	229	-	26	1	-	31,466	163
St. Joseph of the Good Shepherd Kyamulibwa Ngo	1458	4599	73	7724	270	200	150	11	795	50	114	213	11	5	-	31,284	164
Bulkwa	1412	4193	60	7748	202	645	501	68	2669	26	136	8	9	8	-	31,079	165
Kyannamukaaka	622	1088	35	20090	143	846	101	161	1826	-	0	-	-	1	-	31,054	166
Bugamba	763	1929	29	16094	318	1489	300	362	1775	-	0	-	-	-	-	30,560	167
Buhunga	687	2103	18	17149	363	607	90	433	1653	-	0	-	-	-	-	30,165	168
Maziba Gvt	920	2535	34	13378	228	1018	103	820	844	-	0	-	10	1	-	29,457	169
Franciscan	1591	1291	20	5125	71	120	16		40	-	2	-	3	2	-	29,421	170
Kamwezi	430	999	30	19479	426	860	273	299	2063	-	11	-	5	-	-	29,188	171
Ntungamo	-	-	-	23084	770	2337	54	405	3638	-	0	-		7	-	29,060	172
Buvuma	716	1457	20	15567	329	1035	116	140	2082	-	14	-	1	40	-	29,014	173
Bushenyi	447	855	28	19223	292	1058	367	324	2900	-	0	-	1	3	-	28,843	174

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Facility	IPD Admissions	IPD Patient Days	IPD Beds Available	Total OPD	Deliveries in unit - OPD	Total ANC	Postnatal Attendances	Family Planning contacts	Immunization	Caesarian Sections-IPD	Major operations	Blood Transfusions (Units) - IPD	IPD Deaths	Fresh Still births in unit - OPD	Maternal deaths - OPD	SUO	Rank
Koija	318	491	23	17759	579	2138	322	1089	5474	-	50	-	4	3	-	28,293	175
Mwera	690	1797	18	14269	324	815	147	130	2088	5	9	-	-	-	-	27,203	176
Kamukira	-	-	-	25577	43	773	146	626	963	-	0	-	-	-	-	26,757	177
Ngora Gvt	316	416	20	19374	201	1249	134	186	1948	-	0	-	32	1	-	26,293	178
Kiyumba	530	890	16	15346	310	808	43	223	1300	27	30	16	1	-	-	25,643	179
Namatala	-	-	-	23542		2027	539	292	2728	-	0	-	-	-	-	25,517	180
Busanza	631	1558	16	13682	326	604	45	189	740	-	0	-	1	1	-	25,344	181
Ngoma	282	703	20	18491	158	958	82	110	2449	-	0	-	1	3	-	24,576	182
Luwunga Barracks	187	54	30	19914	64	324	49	201	514	-	0	-	-	-	-	23,429	183
Kyantungo	591	1136	22	12425	221	522	256	116	2041	1	1	-	8	-	-	23,250	184
Butiru	-	-	-	20854	126	998	178	424	3791	-	0	-	-	-	-	23,042	185
Mbarara Municipal Council	-	-	-	14954	166	3068	4288	649	4512	-	0	-	-	2	-	20,689	186
Kataraka	1	2		16003	23	653	170	189	1234	-	0	-	-	-	-	16,886	187
North Kigezi	847	2100	22	2267	221	246	463	104	586	6	12	4	-	1	-	16,601	188
Bukasa	320	619	11	10708	65	253	75	78	1102	-	0	-	2	-	1	16,256	189
Kampala Hospital	-	-	-	11409	479	210	265		3034	-	0	-	-	3	2	14,648	190
Ntuusi	98	226.6	1	11212	116	1194	50	213	1436	-	0	-	-	-	-	14,278	191
SAS Clinic, Bombo Road	-	-	-	6911	29	58	28	36	66	-	0	-	-	-	-	7,130	192
Nyamirami	-	-	-	6456	2	491	15	49	1430	-	0	-	-	-	-	7,030	193
Hiima Iaa (Uci)	-	-	-	5149	8	44	5	1	33	-	0	-	-	-	-	5,221	194
Women's Hospital and Fertility Centre-Bukoto	-	-	-	2913	108	266	32		0	-	0	-	-	-	-	3,602	195
Mbarara Municipal	-	-	-	1547	9	274		116	197	0	-	-	-	-	-	1,826	196
<b>Count</b>	<b>181</b>	<b>181</b>	<b>179</b>	<b>196</b>	<b>194</b>	<b>196</b>	<b>193</b>	<b>189</b>	<b>196</b>	<b>88</b>	<b>196</b>	<b>70</b>	<b>161</b>	<b>167</b>	<b>49</b>	<b>196</b>	
<b>Mean general</b>	<b>2,347</b>	<b>6,219</b>	<b>35</b>	<b>21,988</b>	<b>748</b>	<b>1,810</b>	<b>391</b>	<b>409</b>	<b>3,864</b>	<b>90</b>	<b>77</b>	<b>146</b>	<b>29</b>	<b>15</b>	<b>2</b>	<b>60,270</b>	

*Annual Health Sector Performance Report for Financial Year 2013/14*

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Minimum	1	2	1	1,335	2	-	5	1	-	1	-	2	1	1	1	1,826	
Maximum	8,192	38,745	163	48,970	5,225	10,150	5,057	8,611	25,683	594	892	1,042	470	174	8	180,815	
Sum	424,828	1,125,651	6,324	4,309,611	145,124	354,793	75,489	77,242	757,440	7,906	15,096	10,208	4,621	2,500	104	11,812,901	
Count non blanks	181	181	179	196	194	195	193	189	194	88	121	70	161	167	49	196	

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