THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

ANNUAL HEALTH SECTOR PERFROMANCE REPORT

FINANCIAL YEAR

2016/17

Hon. Dr. Jane Ruth Aceng
Minister of Health

Hon. Sarah Opendi
Minister of State for Health /
General Duties

Hon. Dr. Joyce Moriku
Minister of State for Health /
Primary Health Care

Dr. Diana Atwine Kanzira
Permanent Secretary

Prof. Anthony Mbonye
Ag. Director General Health Services

Dr. Henry G. Mwebesa
Director Health Services
Planning& Development

Dr. Charles Olaro
Director Health Services
Clinical Services

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ACT	Artemisinin Combination Therapies
AHSPR	Annual Health Sector Performance Report
AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Ante Natal Care
ART	Anti-retroviral Therapy
ARVs	Antiretroviral Drugs
CAO	Chief Administrative Officer
CCM	Country Coordinating Mechanism
CDC	Centres for Disease Control
CDR	Case Detection Rate
CEmNOC	Comprehensive Emergency Neonatal and Obstetric Care
CLTS	Community Led Total Sanitation
CPHL	Central Public Health Laboratories
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
CYP	Couple Years of Protection
DFID	Department for International Development
DHO	District Health Officer
DHT	District Health Team
DHMT	District Health Management Team
DLT	District League Table
DOTS	Directly Observed Treatment, short course (for TB)
DPT	Diphtheria, Pertussis (whooping cough) and Tetanus vaccine
EDC	Effective Development Cooperation
EID	Early Infant Diagnosis
EMHS	Essential Medicines and Health Supplies
CEmOC	Comprehensive Emergency Obstetric Care
CHEW	Community Health Extension Worker
CLTS	Community Led Total Sanitation
DHSCG	District Hygiene and Sanitation Conditional Grant
DWSDCG	District Water and Sanitation Development Conditional Grant
eMTCT	Elimination of mother-to-child transmission of HIV
FP	Family Planning
FY	Financial Year
GAVI	Global Alliance for vaccines and Immunization
GBV	Gender Based Violence
GFTAM	Global Fund to fight TB, Aids and Malaria
GH	General Hospital

GoU	Government of Uganda
HAART	Highly Active Anti-Retroviral Therapy
HC	Health Centre
HDP	Health Development Partners
HIC	Home Improvement Campaign
HRIS	Human Resource Information System
HMIS	Health Management Information System
HPAC	Health Policy Advisory Committee
HRH	Human Resources for Health
HSD	Health Sub-Districts
HSDP	Health Sector Development Plan
HTI	Health Training Institution
IDSR	Integrated Disease Surveillance and Response
iCCM	Integrated Community Case Management
IEC	Information Education and Communication
IMAM	Integrated Management of Acute Malnutrition
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IPT	Intermittent Presumptive Treatment for malaria
IRS	Indoor Residual Spraying
ITNs	Insecticide Treated Nets
JICA	Japan International Cooperation Agency
JMS	Joint Medical Stores
JRM	Joint Review Mission
KOICA	Korea International Agency for Cooperation
LG	Local Government
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
MoPS	Ministry of Public Service
MOU	Memorandum of Understanding
MPDR	Maternal Perinatal Death Review
MTEF	Medium Term Expenditure Framework
NCD	Non Communicable Diseases
NDA	National Drug Authority
NDC	National Disease Control

NGOs	Non-Governmental Organizations
NHP	National Health Policy
NMCP	National Malaria Control Program
NMR	Neonatal Mortality Rate
NMS	National Medical Stores
NPHC	National Population and Housing Census
NSDS	National Service Delivery Survey
NTDs	Neglected Tropical Diseases
NTLP	National Tuberculosis and Leprosy Control Program
ODF	Open Defecation Free
OPD	Out Patients Department
ORS	Oral Rehydration Salt
PHC	Primary Health Care
PLWHA	People with HIV/AIDS
PMI	Presidential Malaria Initiative
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
RMNCAH	Maternal and Child Health
RRH	Regional Referral Hospital
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender Based Violence
SHRH	Strengthening Human Resources for Health
SLD	Second Line Drugs
SMC	Senior Management Committee
SMER	Supervision, Monitoring, Evaluation and Research
SP	Sulfadoxine/Pyrimethamine
STI	Sexually Transmitted Infection
SUO	Standard unit of Output
SWAP	Sector-Wide Approach
TB	Tuberculosis
TFR	Total Fertility Rate
TMC	Top Management Committee
TSR	Treatment Success Rate
TWG	Technical Working Group
UACP	Uganda Aids Control Program
UBOS	Uganda Bureau of Statistics

UBTS	Uganda Blood Transfusion Services
UCI	Uganda Cancer Institute
UDHS	Uganda Demographic and Health Survey
UHC	Universal Health Coverage
UHI	Uganda Heart Institute
UNEPI	Uganda Expanded Program on Immunization
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
UNMHCP	Uganda National Minimum Health Care Package
UPHIA	Uganda Population based HIV Impact Assessment
USAID	United States Agency for International Development
USF	Uganda Sanitation Fund
UVRI	Uganda Virus Research Institute
VHT	Village Health Team
WHO	World Health Organization

FOREWORD

The health of the population is central to socio economic transformation of the country. In line with statutory requirements, Government reviews the annual performance of the health sector in order to assess progress on agreed outputs, performance of the health sector and come up with strategies and recommendations on how to improve health care service delivery.

The annual Health Sector Performance Report for financial year 2016/17 provides progress of the annual health sector work plan as well as the overall health sector performance against the set targets agreed upon with key stakeholders in financial year 2016/17. In addition, the report provides current trends in progress against the key health impact indicators based on the Uganda Demographic Health Survey Results for 2016. The report is the second annual review under the Health Sector Development Plan 2015/16 - 2019/2020 This report shall be presented to stakeholders in the 23rd Joint Review Mission in which the sector shall specifically review what has been achieved, what has not been achieved and the reasons why the set targets have not been achieved. The review shall guide future planning and programming and help to refocus priorities towards achieving the second National Development Plan targets and the Sustainable Development Goals.

The sector will continue to prioritize interventions defined in the five-year Health Sector Development Plan with emphasis on efficiency and effectiveness in health service delivery. The Government of Uganda recognizes the contributions of the Health Development Partners, the Civil Society Organizations, the Private Sector and the Community in the achievement of progress in financial year 2016/17.

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

I wish to thank members of Ministry of Health Senior Management Committee and all partners for their contributions in the preparation of the Annual Health Sector Performance report and co-financing the Joint Review Mission. Special gratitude to the MoH Planning Directorate that ensured that this annual report and the accompanying documents were compiled.

For God and My Country

Hon. Dr. Jane Ruth Aceng
Minister of Health

EXECUTIVE SUMMARY

The Annual Health Sector Performance Report (AHSPR) highlights progress, challenges, lessons learnt and proposes mechanisms for improvement. The report focuses on the progress in implementation of commitments in the Ministerial Policy Statement, overall sector performance against the targets set for the Financial Year (FY) 2016/17, and trends in performance for selected indicators over the previous FYs. The compilation process of the AHSPR 2016/17 was participatory with involvement of all the 14 Technical Working Groups and Senior Management Committee. The overall coordination and technical support was by the MoH Planning Department.

Data

The report focuses on the key indicators for monitoring performance of the HSDP 2015/16 - 2019/20 which are linked with the monitoring of the second National Development Plan (NDP II) and international initiatives such as the Sustainable Development Goals (SDGs). The report is based on the health facility and district reports gathered as part of the routine Health Management Information System (HMIS), administrative sources, program data and surveys. Generation of output indicators for this report largely utilized data from the DHIS2, with timeliness of monthly HMIS 105 reporting at 88% in 2016/17 from 79.4% in 2015/16 and completeness at 94.3% compared to 96.5%% in 2015/16. Coverage estimates for the routine HMIS indicators uses the UBOS 2016 mid-year population projections to estimate the target populations.

Health impact indicators

The UDHS report 2016 shows positive trends, with a progressive reduction of most of the mortality indicators over the previous ten to fifteen years. In particular, Under-five mortality rate showed a significant decline from 90 (2011) to 64 per 1, 000 live births in 2016. The IMR stands at 43 per 1,000 (UDHS 2016) which is a significant improvement from IMR of 54 per 1,000 live births (UDHS 2011). Neonatal Mortality Rate stagnated at 27 per 1,000 live births falling short of the HSDP target of 16 per 1,000 live births. According to the MoH HMIS reports, malaria remains the leading cause of death among infants and the under-fives and was responsible for 26.8% of hospital-based under-five deaths, followed by anaemia (13.6%), pneumonia (13.1%) and neonatal sepsis (7.3%). Maternal Mortality Ratio reduced from 438 per 100,000 (UDHS 2011) to 336 per 100,000 (UDHS 2016) live births which is still far below the HSDP target of 121 per 100,000 live births by 2020.

The 2016 Uganda HIV Impact Assessment (UPHIA) established an HIV prevalence that was estimated at 6.0% down from 7.3 % in 2011. From UPHIA, the number of people in the country estimated living with HIV was estimated at 1,300,00. The trend of new HIV infections (incidence) has continued to decline. New infections fell to an all-time low of approximately 60,000 in 2016, indicating that the target of a 40% reduction of new HIV

infections by 2015 relative to 2010 has been met. The number of children born with HIV infection in Uganda declined by 86% between 2011 and 2015. The Country is at the verge of epidemic control and on the right path to the Fast Track UNAIDS target of ending AIDS by 2030.

Service coverage

The sector recorded improvement in ART coverage from 64.4% in 2015/16 to 73% (964,232 adults and 64,677 children) in 2016/17; HIV positive pregnant women not on HAART receiving ARVs for elimination of mother-to-child transmission of HIV during pregnancy, labour, delivery and postpartum improved to 90% from 68.3%; $DPT_3HibHeb_3$ coverage was at 99.2% above the HSDP target of 95%. The sector also achieved an increase in contraceptive prevalence rate among married women 15 – 49 years for any method from 30% in 2011 to 39% in 2016 (UDHS), for modern methods increase was from 24% to 35% and the unmet need for family planning was 28%.

Health facility deliveries were 58.1% in 2016/17 above the HSDP target of 56%. According to UDHS 2016 results deliveries by skilled health workers were 74% and deliveries in health facilities were 73%. The UDHS results include deliveries in private health facilities that may not be reporting through the national HMIS. The sector also achieved an increase in the proportion of HC IVs offering Comprehensive Emergency Obstetric Care (i.e. Caesarean section and blood transfusion) from 36% in 2015/16 to 44.6% (83/186) in 2016/17, HC IVs conducting Caesarean Sections increased from 62% to 70.4% (131/186) and HC IVs that offer blood transfusion increased from 40.4% to 47.3% (88/186). There is need to increase blood transfusion services at HC IV level. The following HC IVs performed the highest number of C/S; Mukono Town Council HC IV (1,414), Rwekubo HC IV (795), Rukunyu HC IV (715), St. Paul HC IV (553) and Mukono Church of Uganda HC IV (502) and Mpigi HC IV (489).

The sector recorded no progress or decline in a number of indicators as follow; TB case detection rate stagnated at 50% below the target of 75%; IPT_2 coverage declined from 55% in 2015/16 to 55% in 2016/17, which is below the target of 71%; inpatient malaria deaths decreased from 22 per 100,000 to 20 per 100,000 but far below the HSDP target of 5 per 100,000 as envisioned in the Malaria Reduction Plan. Similarly, the number of malaria cases per 1,000 persons increased to 433 per 1,000 from 408 per 1,000 in 2015/16. Apart from the malaria epidemic and the high incidence of malaria in a number of districts, non-adherence to test results still remains a major challenge. Only 69% (10,922,161/15,857,997) of patients treated for malaria had a laboratory confirmatory test.

Besides routine channels, LLINs are distributed to the general population through mass campaign. A total of 24,019,282 were secured for distribution in 2017. One round of IRS was conducted in the ten (10) epidemic districts in the northern part of the country. In addition to the six districts that sprayed earlier on, Gulu, Omoro, Apac, Pader & Kitgum sprayed in quarter four of the FY 2016/17. IRS has continued in the ten (10) Districts (Tororo, Bugiri, Mayuge, Serere, Pallisa, Budaka, Butaleja, Kaberamaido and Kibuku) of

eastern Uganda and five in the north (Amolatar, Dokolo, Lira, Otuke and Alebtong) in FY 2016/17.

The under-five Vitamin A coverage also declined from 28% to 25.3% in 2016/17 and is far below the HSDP target of 60%. This is despite the availability of Vitamin A capsules at health facilities. Measles coverage under 1 year was 86.7% in 2016/17 a decline from 96% in 2015/16 and below the target of 92%. UDHS 2016 results showed measles coverage of 80%.

Hospital quality is assessed by Bed Occupancy Rate (BOR) and Average Length of Stay (ALoS). BOR for the national referral hospitals was 70%; Regional Referral Hospitals was 106%; General Hospitals was 60% and HC IVs 54.2%. BOR for Butabika National Mental Referral Hospital, General Hospitals and HC IVs is below the target of 85%. Among the hospitals and HC IVs the BOR varies and this needs to be analyzed further for efficiency and optimal resource allocation. The ALoS was 7.7 days for National Referral Hospitals, 6.9 days for the RRHs, 5.1 days for general hospitals and 3.2 days for HC IVs. Target is 3 days.

Couple Years of Protection is a measure of family planning use and there was a decline from 2,232,225 in 2015/16 to 2,156,240 CYPs in 2016/17 far below the target of 4.4 million CYPs. Although there was an increase in the number of Implants, IUDs, there was a decrease in the users for all other methods and most significantly for male condoms from 80,816 CYPs in 2015/16 to only 3,554 CYPs in 2016/17.

Antenatal Care four visits declined from 38% to 37% and is still below the HSDP target of 40%. According to UDHS 2016, 60% of women who had delivered in the previous 5 years had attended ANC four and above times.

Quality of Care

In respect to quality of care, the facility based fresh still births (per 1,000 deliveries) reduced to 10.1 per 1,000 deliveries from 13 per 1,000 in 2015/16. On the contrary, the number of maternal deaths among 100,000 health facility deliveries increased to 148.3 per 100,000 health facility deliveries from 119 per 100,000 in 2015/16. In 2016/17 FY a total of 1,118 maternal deaths were reported through the MoH HMIS compared to 1,136 in 2015/16. Of these only 267 (24%) reviewed/audited compared to 246 (22%) maternal deaths notified and 419 (37%) reviewed/audited in 2015/16.

ART retention increased to 82% in 2016/17 from 79% in 2016/17 short of the HSDP target of 84%.

TB treatment success rate improved slightly to 80% in 2016/17 from 79% in comparison with the previous FY, and below the HSDP target of 84%.

Health Risks and Social Determinants

The health sector continues to promote environmental health and sanitation interventions at community level. Latrine coverage improved to 77% in 2016/17 from 75% in 2015/16 and attained the HSDP target of 76%. The districts with the lowest latrine coverage were;

in the Karamoja region and islands of Buvuma. The National Housing and Population Census (2014) estimates that 10% of the rural population lack access to a toilet facility, while 58% use unimproved toilets. The variation between the access figures is attributed to a difference in definition which should be harmonized especially now that the sector needs to set a baseline for the SDG agenda.

The access to hand washing in rural areas is estimated to be 37%, indicating a 1% increase from FY 2015/16. According to the National Service Delivery Survey, 2015; only 7% had hand washing facilities with both soap and water.

Ug. Shs. 1.43 billion of the District Water and Sanitation Development Conditional Grant was used to construct public sanitation facilities at markets and rural growth centres. Ug. Shs. 2 billion was disbursed to 91 districts under the District Health Sanitation Conditional Grant, with each district receiving approximately Ug. Shs. 23 million.

The USF program supports hygiene and sanitation promotion in 30 districts using the Community Led Total Sanitation (CLTS) Approach. During the FY 2016/17, 317 villages were targeted for triggering. However, an additional 295 villages were triggered making the total of triggered villages 612. For this reporting period, 910 villages achieved ODF status. In the USF program area 15,218 new latrines were constructed and an additional 539,400 people are now living in ODF environment. Further still 42,132 new hand washing facilities were constructed and latrine coverage in the program area is averaged at 96%.

There was no significant investment in building the capacity of Village Health Teams (VHTs). With support from partners there was intensification of community child health activities through the VHT and other structures, including Integrated Community Case Management which has been expanded to 75 districts and recently a newer focus on community TB and HIV activities.

Much effort was towards finalizing the Community Health Extension Workers policy, strategy and training curriculum.

Health Financing

Investments in health are measured by financing, human resource, access, availability of medicines and health supplies, financing and human resources for health. The health sector received a total of Ug. Shs 1.87 trillion representing 8.9% of the total national budget, and 96% of the budget was released. Of the funds released, absorption was 94% and all sector votes utilized more than 90% of their resources except the Regional Referral Hospitals (88%). The poor budget performance largely arose to low absorption of the development budget due to delays in the procurement process.

PHC Non-Wage allocation by Service Delivery Strata are far below what is required to carry out the core functions of management and ensure quality service delivery. For example, average annual PHC Non-Wage allocation for HC IVs is Ug. Shs. 16,501,363/= and HC IIIs Ug. Shs. 6,424,413/= against a requirement of Ug. Shs. 42,232,000/= and Ug.

Shs. 15,592,000/= respectively. The Sanitation Grant increased slightly by Ug. Shs 780 million in FY 2016/17 which enabled the Ministry to expand the program to more districts.

The health sector staffing improved slightly in 2016/17 to 73% (45,029/61,796) from 71% (42,530/60,384) in 2015/16 above the HSDP target of 70%. The number of health workers per 1,000 population in Uganda is still far below the WHO threshold of 2.3 doctors, nurses and midwives per 1,000 population. In 2016/17 FY the ratio of doctors, nurses and midwives to the population was 1: 28,202; 1: 2,121 and 1: 6,838 respectively. In 2016/17, 116 districts and 18 Central institutions were supported to develop costed recruitment plans. Following this mechanism 2,222 positions were advertised and 2,129 health workers were recruited, and of these 642 were absorbed from the USG contracted health workers. Staffing levels are lowest for Dispensers (41%), Anaesthetic officers (28.9%) and Health Assistants (26.7%).

A mechanism for attendance tracking and absenteeism management using the Automated Attendance Analysis was rolled out to all districts, and most districts are now tracking attendance monthly and the analysis is being used in some district by managers for administrative decision including salary payment based on number of days worked. Absenteeism without approval decreased from 50% in 2015 to 10% by April 2017.

In terms of access by the general population, OPD utilization rate was 1.1 (Males 0.9 & females 1.3) in 2016/17 compared to 1.2 in 2015/16. Hospital admissions were 7.8 per 100 population which was an increase from 7.2 in 2015/16.

Population living within 5 km of a health facility (public or private) was 100%. The NSDS 2015 found that nationally, the median distance to the public health facility is 3 km compared to only 1.2 km for other health facilities. During 2016/17, 79% (44,141,928) of the total Out Patient attendances were in public health facilities, 14% (6,222,339) in Private-not-for profit health facilities and 7% (2,885,407) from private health providers.

Health Infrastructure

Investments in health infrastructure has continued and this included construction of new and rehabilitation of old infrastructure at various levels, provision of medical equipment and hospital furniture; provision of solar lighting, improvement of operations and maintenance of health infrastructure; strengthening the referral system by providing ambulances, general transport and Information Communication and Technology (ICT) equipment and services in selected health facilities; and renovation/construction of selected health facilities.

Examples of major infrastructure development projects during 2016/17 were; Rehabilitation work was done at Mulago National Referral Hospital, construction of a 450 bed specialised Maternal and Neonatal hospital at Mulago, all Regional Referral Hospitals including installation of oxygen plants, construction of 19 medicines stores, upgrading of Maracha and Rukunyu HC IVs to general hospitals, renovation of 23 General hospitals, construction of 34 staff houses in Karamoja region and 26 staff houses under GAVI. In addition 83 motorcycles were procured for the laboratory hubs.

Medicines & Health Supplies

The availability of health commodities in the last quarter of FY 2016/17 as measured by a basket of 41 commodities dropped to 83% in 2016/17 from 87% in 2015/16, and an average of 55% of health facilities that reported had over 95% availability of the basket of commodities in comparison with 52% in 2015/16. The RMNCH basket had the highest availability at 88% of facilities reporting availability.

Monitoring Implementation of the Country Compact and IHP+

Functionality of the HPAC is very crucial in monitoring implementation of the Compact and provision of advice on the implementation of the HSDP and policies. Attendance of HPAC meetings by the various stakeholders was varied, with the HDP representatives attending more consistently than other members. The MoH Top Management, HPAC, Senior Management Committee and Technical Working Groups discussed and approved a number of reports, project proposals, policy documents, strategies, standards and guidelines for improving service delivery.

During FY 2016/17, the IHP+ 6th monitoring round was conducted and most of the targets for Aid Effectiveness (Paris Declaration and IHP+ indicators) assessed showed significant progress on the country performance.

District League Table Performance

There is an improvement in the DLT national average performance from 63.9% in 2015/16 to 66.2% in 2016/17. The improvement in performance was observed for most of the indicators. Among all the 116 LGs the top five are Adjumani (80.9%), Gulu (78.5%), Mbale (76.6%), Kamwenge (76.6%) and Kiboga (76.5%). The bottom five LGs in performance are Moroto (56%), Bulambuli (55.7%), Kaabong (54.6%), Buvuma (53%) and Amudat (46.8%).

Hospital Performance

The 14 RRHs and 4 large PNFP hospitals assessed registered an increase in SUO in 2016/17 compared to 2015/16 from 9,837,521 to 9,956,067. Mbale hospital continues to lead in volume of outputs pushed by the very high number of admissions (58,387) compared to other RRHs.

The average BOR is 105%, the lowest is 59% at Kabale and highest is 383% at Lira RRH. There is need to investigate the very high BOR at Lira RRH (there is a possibility of this being a data quality issue i.e. over reporting). The ALoS is similarly higher in Lira RRH at 29.7% which further points to data quality issues and lowest at Mbale and Mubende RRH at 2.4 days. The average Caesarean Section (C/S) rate in the RRH was 28% in 2016/17 FY. Soroti RRH and Nsambya hospital had a C/S rate of 48%, Lubaga 38% and Mengo 37%. The lowest C/S rate was in Masaka RRH at 7% far below the expected 15%.

The total SUO for GHs has declined from 17,692,056 in 2015/16 to 17,418,297. The average outputs were lower for the listed outputs except for ANC visits, postnatal and family planning visits. Iganga Hospital had the highest SUO 580,406 followed by Kitgum Hospital with 390,879. The lowest ranked hospitals are predominantly private hospitals

with no or irregular reporting through the national system. 13 general hospitals reported bed occupancy rates above 100%, with Apac Hospital reporting the highest bed occupancy rate of 178%. Some general hospital had high ALoS notably Kagando Hospital, St. Joseph's Kitgum, Kuluva and Murchison Bay with ALoS of 7 days which far above the target of 3 days.

The average C/S rate in the general hospitals was 25% in 2016/17 FY. Gulu Independent Hospital had the highest C/S rate of 76% which needs to be verified, followed by Mbarara Community hospital at 62%, Nakasero Hospital at 59%, Mayanja Memorial at 57% and Bethany Women & Family Hospital at 55%.

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 finalized the PPPH strategy and disseminated the PPPH Guidelines for PNFPs.

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 UMMB, UCMB and UPMB. The inability to generate comprehensive reports from the private sector is still a major challenge, though some significant contribution is from PHPs and CSOs. The introduction of DHIS2 has considerably improved the reporting rate for PNFP facilities and some large PHPs. At the same time, most PHP facilities are still lacking the required human resources, equipment and infrastructure to effectively report.

The Self-Regulatory Quality Improvement System (SQIS) was rolled in the private sector in August 2015 and since then 300 private facilities have conducted self-assessments under the support of UHF. This is aimed at institutionalization of Continuous Quality Improvement in the private health facilities.

1 INTRODUCTION

1.1 Background

The Annual Health Sector Performance Report (AHSPR) is an institutional requirement compiled to highlight progress, challenges, lessons learnt and propose ways of moving the health sector forward in relation to the National Development Plan (NDP), National Health Policy, and the National Health Strategy. The AHSPR Financial Year (FY) 2016/17 is the seventeenth annual report produced by the Ministry of Health (MoH). This report is the second annual report for the Health Sector Development Plan (HSDP) 2015/16 - 2019/20. The report mainly focuses on the progress in implementation of the annual work plan as well as overall health sector performance against the targets set for the FY 2016/17. The report takes into consideration the annual performance in terms of the effectiveness, responsiveness and equity in the health care delivery system, how well the integrated support systems have been strengthened as well as the status of program implementation and overall development mechanisms. The report also presents the trends in the key health impact indicators and outcome indicators based on the Uganda Demographic Health Survey (UDHS) report 2016. The sector performance will be deliberated upon during the 23rd Joint Review Mission (JRM) slated for September 26th to 27th 2017. The outcomes of the sector performance review are expected to guide planning and programming for the next FY.

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

1.2.1 Vision

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

1.2.2 Mission

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

1.2.3 Goal

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

1.2.4 Strategic Objectives

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

i. To contribute to production of a healthy human capital for wealth creation through provision of equitable, safe and sustainable health services.
ii. To address the key determinants of health through strengthening inter sectoral collaboration and partnerships.

iii. To increase financial risk protection of households against impoverishment due to health expenditures.
iv. To enhance the health sector competitiveness in the region and globally.

1.3 The Projected Demographics for FY 2016/17

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

TABLE 1: POPULATION PROJECTIONS FOR FY 2016/17

Demographic Variable	Proportion	Population
Total population	100%	36,605,900
Males	48.6%	17,790,467
Females	51.4%	18,815,433
Children under 1 year	4.3%	1,574,054
Children under 5 years	17.7%	6,479,244
Children below 18 years	55.1%	20,169,851
Adolescents and youth (young people) (10 – 24 years)	34.8%	12,738,853
Expected pregnancies	5%	1,830,295
Women of reproductive age (15 - 49 years	20.2%	7,394,392

UBOS Mid-year population projections 2016

1.4 The process of compiling the report

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

Information used for compiling the report was both quantitative and qualitative and consisted principally of data generated from the MoH Health Management Information System - District Health Information Software (DHIS)-2 for the FY 2016/17 supplemented by;

i. Ministerial Policy Statement (MPS) 2016/17
ii. Annual Health Sector Performance Report 2015/16
iii. Monitoring and Evaluation (M&E) Plan for the Health Sector Development Plan (HSDP) 2015/16 to 2019/20
iv. Quarterly progress reports for the FY 2016/17
v. Quarterly financial reports (OBT) FY 2016/17
vi. Program and project reports
vii. National Population and Housing Census Report, 2014
viii. National Service Delivery Report, 2015
ix. Uganda Demographic Health Survey Report, 2016

2 Overall Sector Performance and Progress

This chapter highlights an overview of the sector performance of FY 2016/17. It focuses on the performance indicators enshrined in the HSDP 2015/16 – 2019/20, Ministerial Policy Statement of FY 2016/17 and annual work plans from different departments and institutions in the sector.

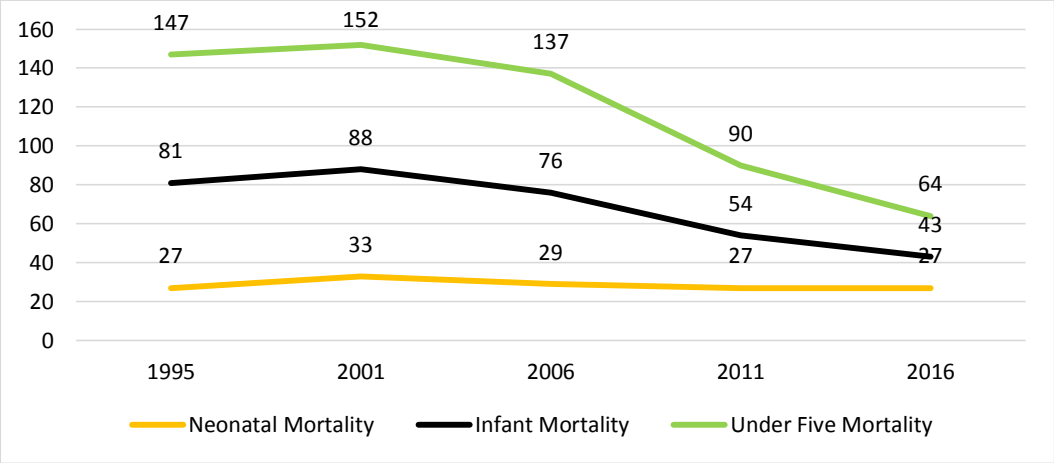
2.1 Health Impact Indicators

The health impact indicators are used to assess the effect of service delivery on the population and these include but not limited to;

1. Neonatal Mortality Rate (NMR)
2. Infant Mortality Rate (IMR)
3. Under five mortality Rate
4. Maternal Mortality Ratio (MMR)

Figure 1 presents the trends in newborn, infant and child mortality in Uganda.

FIGURE 1: TRENDS IN NEWBORN, INFANT AND CHILD MORTALITY IN UGANDA



SOURCE: UDHS 1995, 2001, 2006, 2011, 2016

2.1.1 Neonatal Mortality Rate

Neonatal mortality rate (NMR) captures newborn deaths occurring in the first 28 days of life and is expressed at the population level as a rate per 1,000 live births. There has been stagnation in NMR at 27 per 1,000 live births (UDHS 2016). With three years to go this performance falls short of the HSDP target of 16 per 1,000 live births. Intensification of perinatal deaths surveillance and audits, strengthening community awareness, perinatal health and quality of newborn care services should further accelerate the reduction of preventable newborn deaths.

2.1.2 Infant Mortality Rate and Under Five Mortality Rate

The IMR stands at 43 per 1,000 (UDHS 2016) which is a significant improvement from IMR of 54 per 1,000 live births (UDHS 2011). Regarding the Under Five Mortality Rate there has been a significant reduction from 90 per 1,000 live births (UDHS 2011) to 64 per 1,000 live births (UDHS 2016).

Key interventions that have been scaled up to accelerate the reduction in child mortality include immunization, increased use of Long Lasting Insecticide Treated Nets (LLINs), elimination of mother to-child transmission of HIV (eMTCT), and improved water and sanitation. Training programs for skilled birth attendants and other health workers launched by the MoH have also helped to raise newborn care standards and the diagnosis and management of common childhood illnesses including the iCCM. Also the strengthening and scaling up immunization including introduction of the pneumococcal vaccine since 2013, have also contributed to this. More concerted efforts are needed to sustain this and work towards the target at all levels.

According to MoH HMIS reports, malaria remains the leading cause of death among infants and the under-fives. In 2016/17, the disease was responsible for 26.8% of hospital-based under-five deaths. According to hospital records in 2016/17, the other leading causes of child mortality are anemia (13.6%), pneumonia (13.1%) and neonatal sepsis (7.3%).

TABLE 2: LEADING CAUSES OF UNDER 5 IN-PATIENT MORTALITY 2014/15 – 2016/17

2014/15 FY			2015/16 FY			2016/17 FY		
Diagnosis	**No.**	**Diagnosis**	**No.**	**Diagnosis**	**No.**	**Diagnosis**	**No.**	**%**
Malaria	3,059	Malaria	3,059	Malaria	3,059	Malaria	2,333	26.8
Pneumonia	1,659	Pneumonia	1,659	Pneumonia	1,659	Anaemia	1,181	13.6
Perinatal Conditions (in new borne 0 -7 days)	1,476	Perinatal Conditions (in new borne 0 -7 days)	1,476	Perinatal Conditions (in new borne 0 -7 days)	1,476	Pneumonia	1,142	13.1
Anaemia	1,314	Anaemia	1,314	Anaemia	1,314	Neonatal Sepsis 0-7days	638	7.3
Neonatal Septicaemia	712	Neonatal Septicaemia	712	Neonatal Septicaemia	712	Septicemia	351	4.0
Septicemia	457	Septicemia	457	Septicemia	457	Diarrhoea - Acute	204	2.3
Diarrhoea – Acute	404	Diarrhoea – Acute	404	Diarrhoea – Acute	404	Respiratory Infections	124	1.4
Injuries - (Trauma due to other causes)	382	Injuries - (Trauma due to other causes)	382	Injuries - (Trauma due to other causes)	382	Other Types Of Meningitis	111	1.3
Injuries - Road Traffic Accidents	375	Injuries - Road Traffic Accidents	375	Injuries - Road Traffic Accidents	375	Injuries: Road Traffic Accidents	100	1.1
Severe Malnutrition (Kwashiorkor)	317	Severe Malnutrition (Kwashiorkor)	317	Severe Malnutrition (Kwashiorkor)	317	Respiratory distress	98	1.1
Others	3,399	Others	3,399	Others	3,399	Others	2,464	28.3
Total	**13,552**	**Total**	**13,552**	**Total**	**13,552**	**Total**	**8,708**	**100.0**

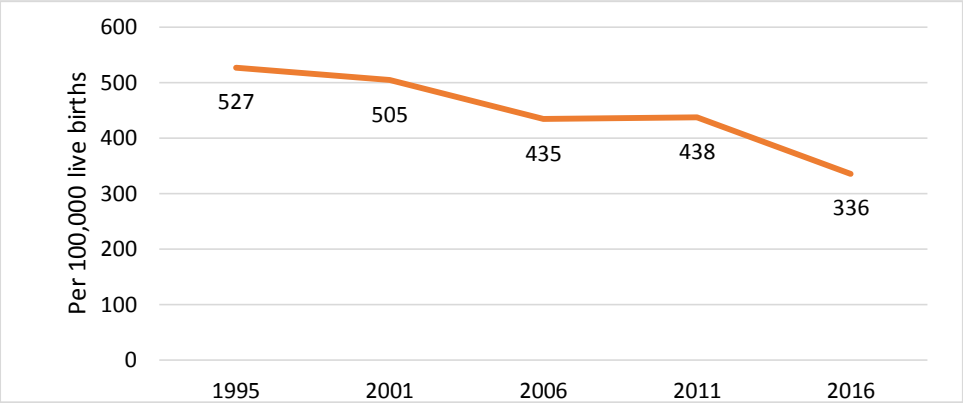
Source: MoH HMIS

2.1.3 Maternal Mortality Ratio (MMR)

The MMR has reduced to 336 per 100,000 live births (UDHS 2016) from 438 per 100,000 (UDHS 2011). The reduction is attributed to Governments efforts in recruiting critical skilled staff especially Medical Officers and midwives to functionalize HC IVs and IIIs, renovation and equipping of hospitals and HC IVs plus improvements in the roads network, all which have improved access to maternal health services.

It is worth noting that the MMR in Uganda has fallen by approximately 33% over the past 20 years, which is still lower than the global reduction of 45% over the same period. Therefore, urgent effort is needed to first tackle the immediate causes of death for the majority of women, while putting in longer-term efforts to strengthen the health system and working on the social determinants that majorly lie outside the health sector.

TABLE 3: TRENDS IN MATERNAL MORTALITY RATIO 1995 TO 2016



SOURCE: UDHS 1995, 2001, 2006, 2011, 2016

2.2 Performance against the key Health and Related Services Outcome Targets

The health and related services outcome indicators focus on communicable disease prevention and control, and essential clinical and rehabilitative care. The sector performance is highlighted in table 4 focusing on comparison of performance with the previous FY and the HSDP targets for 2016/17 FY.

TABLE 4: PERFORMANCE AGAINST THE HEALTH SERVICE OUTCOME TARGETS

Indicator	2014/15	Achieved 2015/16		Achieved 2016/17		HSDP Target
ART Coverage	56%	64.4%	Adult = 915,833 Children = 65,121	73%	Adults = 964,232 Children = 64,677	65%
HIV+ pregnant women not on HAART receiving ARVs for eMTCT during pregnancy, labour, delivery and postpartum	72% (2013/14)	68.3%		90%		87%
TB case detection Rate (all forms)	80% (2014/15)	50.7%		50%		75%
IPT[2] doses coverage for pregnant women	53.4% (2014/15)	55%		54.4%		71%
IPT3 doses coverage for pregnant women	NA	NA		NA		71%
In Patient malaria deaths per 100,000 persons per year	30 (2013/14)	22	M = 20 F = 23	20.2	M = 21.6 F = 18.8	5
Malaria cases per 1,000 persons per year	460 (2013/14)	408	M = 365 F = 480	433	M = 516 F = 354	329
Under five vitamin A second dose coverage	26.6% (2013/14)	28%	M = 27% F = 28%	25.3%	M = 24.7% F = 25.8%	60%
DPT[3]HibHeb[3] Coverage	102.4% (2014/15)	103%	M = 105% F = 99%)	99.2%	M = 103.0% F = 95.5%	95%
Measles coverage under 1 year	90% (2014/15)	96%	M = 96% F = 93%	86.7%	M = 88.8% F = 84.7%	92%
Bed occupancy rate (Hospitals & HC IVs)	NA	82%	NRH = 82%	60.1%	NRH = 70.1%	85%
	NA	83%	RRH = 83%		RRH = 106%	85%
	50% (2013/14)	62%	GH = 62%		GH = 60.0%	70%
	59% (2013/14)	52.2%	HC IV	54%	HC IV = 54.2%	60%
Average length of stay (Hospitals & HC IVs)	NA	4	NRH	5.1	NRH = 7.7	3
	NA	4	RRH		RRH = 6.9	
	4 (2013/14)	4	GH		GH = 5.1	
	3 (2013/14)	3	HC IV	3.2	HC IV = 3.2	3
Contraceptive prevalence Rate among married women for all methods	30%	30% (UDHS 2011)		39% (UDHS 2016)		39%
Couple year of protection	2,196,713 (2014/15)	2,232,225		2,156,240		4.4 million
ANC 4 Coverage	37%	38%		37%		40%
Health Facility deliveries	53%	55%		58.1%		56%
HC IVs offering CEmOC services	33%	36%		44.6% (83/186)		55%
HC IVs conducting C/S	51%	62%		70.4% (131/186)		55%
HC IVs conducting blood transfusion	38.5% (75/198)	40.4%		47.3% (88/186)		55%

- ART coverage among HIV infected adults and children improved to 73% (1,028,909/1,402,628) in 2016/17 from 61.4% (898,197/1,461,744) in 2015/16 though

above the HSDP target of 65%. WHO ART Treatment Guidelines, all HIV-positive individuals are eligible ART. This implies that the country is on track to achieve the second of the triple 90-90-90 by 2020 targets in the Fast Track Strategy for ending AIDS by 2030, i.e. 81% of all HIV infected people enrolled on ART. Consistent with previous trends, approximately 93% (964,232) of clients are adults aged 15+ years, and 64,677 are children. Adults increased from 915,833 and children reduced from 65,121 respectively, at the end of the previous quarter. Similarly, consistent with reports at the end of June 2017, the proportions of clients on first, second and third-line ART regimens were 96.2% (989,672), 3.8% (38,883) and <1% (354) respectively.

Among the clients on first-line ART regimen, approximately 6.3 % were children, while among those on second and third line, 13.9% and 8.5% were children respectively.

- HIV+ pregnant women not on HAART receiving ARVs for eMTCT during pregnancy, labour, delivery and postpartum was 90% (38,243/42,467) in 2016/17 which was above the 68.3% (34,357/50,323) in 2015/16 and above the HSDP target of 87%. The number of districts with >80% HIV+ pregnant women initiated on ARVs for eMTCT increased from 32 in 2015/16 to 855 in 2016/17. Only 6 districts including Amuru (57%), Otuke (56%), Bududa (50%), Bukwo (49%), Dokolo (48%) and Kaabong (39%), had <60% of women initiated compared to 43 districts in 2015/16.

FIGURE 2: HIV+ PREGNANT WOMEN INITIATED ON ART BY DISTRICT FY 2016/17

- TB Case Detection Rate was 50% in 2016/17 compared to 50.7% in 2015/17 and this is far below the HSDP target of 75%. This is in contrary to the high TB Case Notification Rate of 117% in 2016/17.

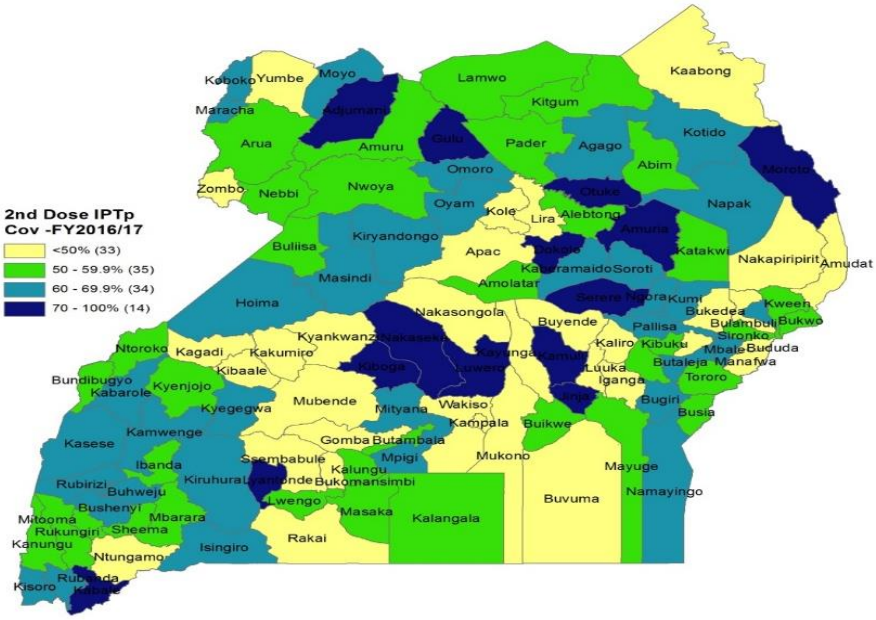
TABLE 5: BREAKDOWN OF TB CASE NOTIFICATION & CASE DETECTION BY REGION.

Region	Estimated Population 2017	Case Notification Rate	Case Detection Rate
Arua	2,907,382	104%	45%
Fort Portal	2,812,581	101%	43%
Gulu	1,810,534	156%	66%
Hoima	2,678,807	109%	46%
Jinja	3,907,806	90%	39%
Kampala	8,023,646	78%	34%
KCCA	1,646,827	446%	191%
Lira	2,252,869	134%	57%
Masaka	1,992,647	126%	54%
Mbale	3,970,441	68%	29%
Mbarara	4,641,778	95%	41%
Moroto	1,054,492	175%	75%
Soroti	1,988,444	67%	26%
TOTAL	**38,041,427**	**117%**	**50%**

Source: NTLP Quarterly case notification reports

- IPT_3 coverage was not assessed this FY because the HMIS tools have not yet been revised to capture this indicator. IPT_2 coverage was used as a proxy measure and was at 54.4% (995.390 / 1,830,295) which is a decline from 55% (982,276/1,787,840) in 2015/16 and far below the HSDP target of 71%. Districts which achieved the 71% target were; Moroto (110.3%), Kabale (89.4%), Serere (88.3%), Adjumani (84.5%), Dokolo (82.5%), Gulu (79.7%), Kiboga (77.5%), Otuke (77.2%), Amuria (77.1%), Kamuli (74%) and Lyantonde (73.4%). IPT_2 coverage was lowest in the following districts; Iganga (33.9%), Manafwa (30.9%), Bududa (28.7%), Kole (26.5%), Buvuma (24.9%) and Wakiso (22.3%).

FIGURE 3: IPT[2] COVERAGE BY DISTRICT 2016/17 FY

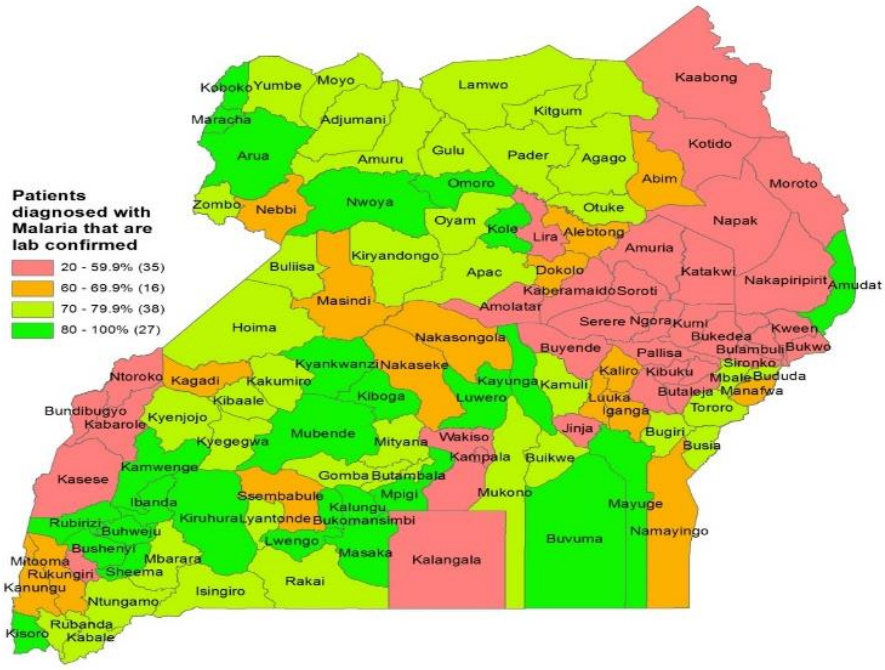


- In Patient malaria deaths recorded in 2016/17 were 20/100,000 which is a slight decline from 22/100,000 persons in 2015/16. This is still far below the HSDP target of 5/100,000 for FY 2016/17. More deaths occurred among males at 21.6/100,000 compared to 18.8/100,000 among males.

- The number of malaria cases per 1,000 persons increased from 408 in 2015/16 to 433 in 2016/17 way above the HSDP target of 329 per 1,000 in 2016/17. More males were affected at 516 cases per 1,000 compared to 354 per 1,000 among females. Malaria is still the top most cause of morbidity among all ages.

  Apart from the malaria epidemic and the high incidence of malaria in a number of districts, non-adherence to test results still remains a major challenge. Only 69% (10,922,161/15,857,997) of patients treated for malaria had a laboratory confirmatory test. The following districts had >90% of patients diagnosed with malaria that were laboratory confirmed; Luwero (110.9%), Kiboga (107.5%), Buhweju (98.9%), Rubirizi (97.2%), Bukomansimbi (92.1%), Mpigi (91.8%), Amudat (91.6%) and Koboko (91.2%). The following districts had <40% of patients diagnosed with malaria that were laboratory confirmed; Kapchorwa (39.9%), Kotido (38.9%), Budaka (37.1%), Kalangala (36.7%), Butaleja (34.2%), Kaberamaido (34%), Bukwo (30%), Sere (26.4%) and Kween (24.5%).

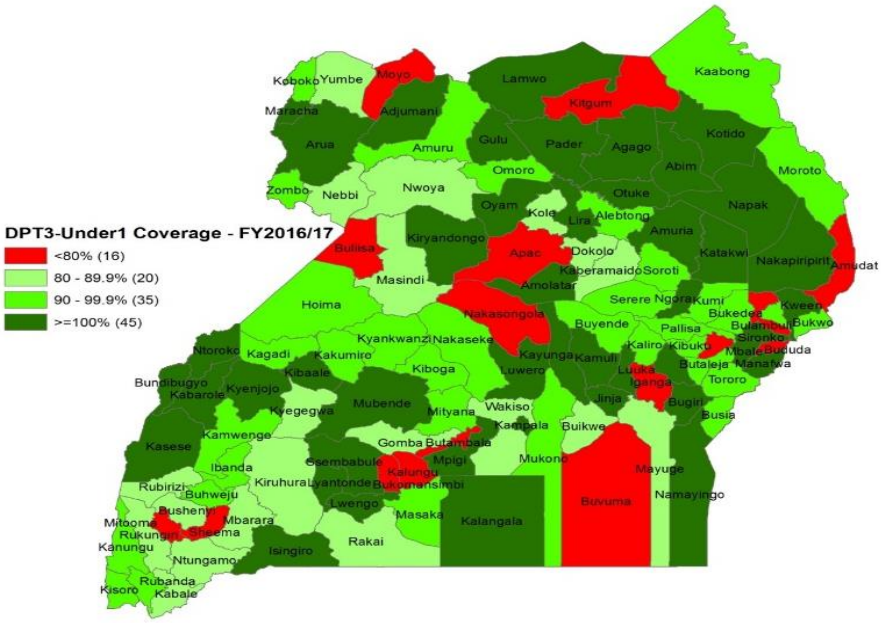
FIGURE 4: MALARIA CASES LABORATORY CONFIRMED BY DISTRICT 2016/17



- The under-five Vitamin A second doses coverage declined to 25.3% in 2016/17 from 28% (1,889,053/6,794,599) in 2015/16, with 24.7% coverage for males and 25.8% for females. Coverage was far below the HSDP target (60%) for 2016/17. Despite the availability of Vitamin A capsules at health facilities, there has been a decline in Vitamin A coverage over the last 4 years because the districts no longer conduct Child Days or Family Health Days. There is need to integrate Vitamin A administration with EPI activities.

- DPT_3 coverage was 99.2% (1,561,539/1,574,054) compared to 103% in 2015/16. Of these 793,324 were males with coverage of 103% (793,324/764,990) among males, and 768,215 were females with coverage of 95.5% (768,215/809,064). DPT^3 coverage was lowest in the following districts; Iganga (79.2%, Bududa (79%), Buliisa (79%), Kitgum (78.2%), Apac (77.8%), Butambala (77.7%), Mitooma (76.7%), Nakasongola (76.7%) and Amudat 76.6%).

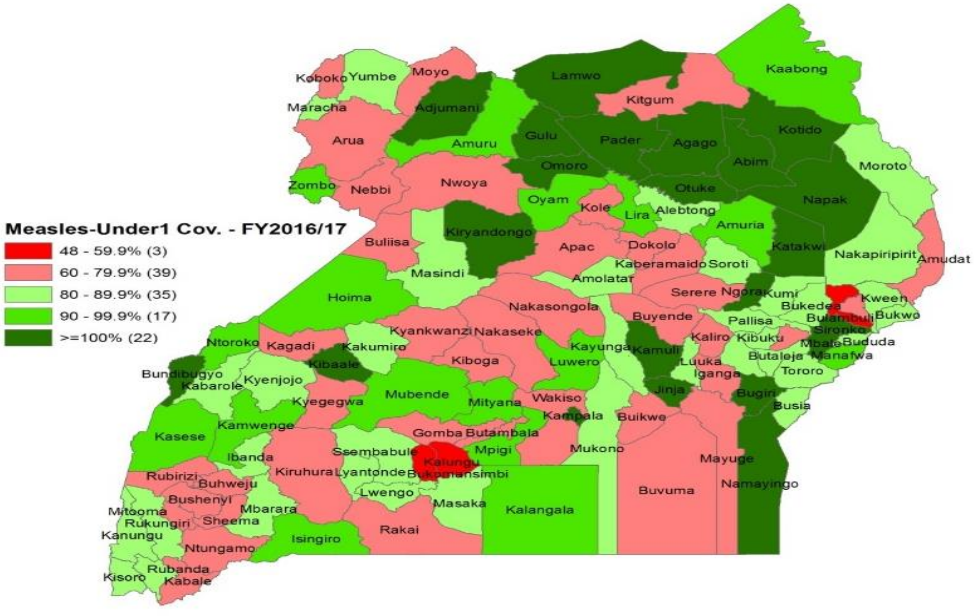
FIGURE 5: DPT3 COVERAGE BY DISTRICT 2016/17



- Measles coverage declined from 96% in 2015/16 to 86.7% (1,365,082/1,574,054) in 2015/16 FY. Of these 683,680 were males with coverage of 88.8% (683,680/764,990) among males, and 681,402 were females with coverage of 84.7% (681,402/809,064). This was below the HSDP target of 92% for 2016/17.

  Measles coverage was highest in the following districts; Pader (171.1%), Abim (133.4%), Lamwo (132.6%), Napak (130.7%) and Mbale (127.1%). The lowest measles coverage was in the districts of Budaka (60.2%), Kalungu (58.6%), Sheema (55.3%), Bulambuli (50.8%) and Bukomansimbi (48.9%).

FIGURE 6: MEASLES COVERAGE BY DISTRICT 2016/17



- The bed occupancy rate (BOR) was 60.1% for hospitals of which the National Referral Hospitals had a BOR of 70.1%, RRHs had BOR of 106%, general hospitals at 60.1%. BOR and HC IVs at 54% in 2016/17 compared to 52.2% in for HC IVs and still below the HSDP target of 60%. The performance level of the various levels shows that there is need to improve the functionality of the HC IVs and general hospitals to decongest the RRHs so that they concentrate on delivering secondary level care. The 71.9% BOR at the national referral hospitals is attributed to the low BOR at Mulago Hospital which is 52% compared to 120% at Butabika. Mulago is undergoing renovation and therefore Inpatient services scaled down.

- The average length of stay (ALoS) for hospitals was 5.1 days and 3.2 days for HC IVs. All these were within the HSDP target.

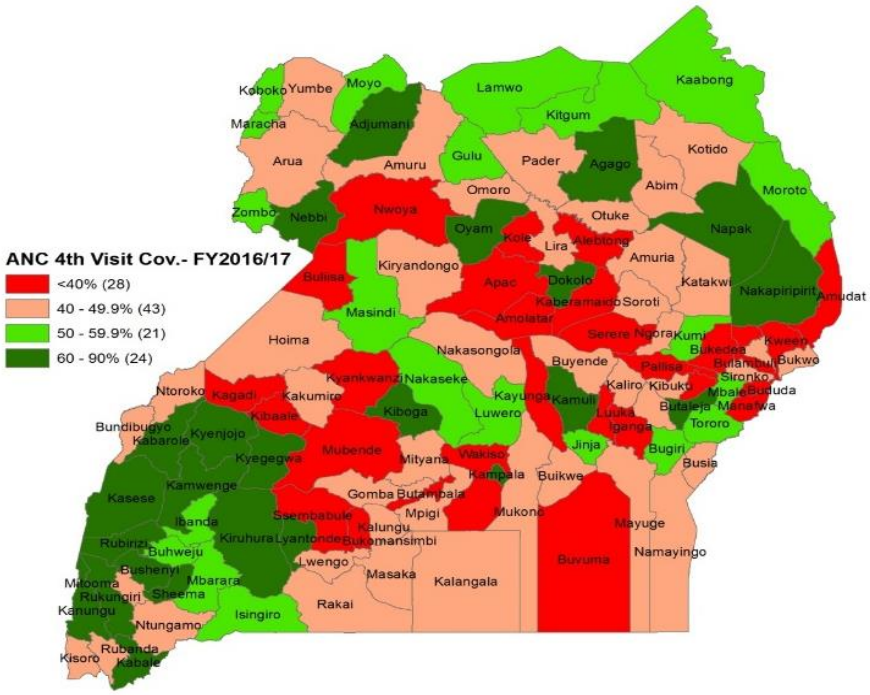
- Contraceptive Prevalence Rate (CPR) among married women improved to 39% for all methods in 2016 (UDHS 2016) from 30%. CPR for modern methods improved from 26% to 35%. There was a decrease in the Couple Years of Protection (CYP) to 2,156,240 in 2016/17 from 2,242,225 in 2014/15. Although there was an increase in the number of Implants, IUDs, there was a decrease in the users for all other methods and most significantly for male condoms from 80,816 CYPs in 2015/16 to only 3,554 CYPs in 2016/17. See Table 6.

TABLE 6: TRENDS IN CYP BY METHOD

Data	Total CYP 2014/15	Total CYP 2015/16	User by method Jul 2016 to Jun 2017	CYP Factor	Total CYP 2016/17
Emergency contraceptives	1,078	414	57,818	0.0143	827
Female condoms	1,196	989	116,587	0.002	233
IUD	761,005	727,910	152,652	5	763,260
Injectable	555,543	572,342	1,334,886	0.25	333,722
Male condoms	50,113	80,816	1,776,869	0.002	3,554
Oral microgynon	5,220	4,562	142,637	0.0143	2,040
Oral other	435	389	34,902	0.0143	499
Oral ovrette or another POP	467	395	15,993	0.0143	229
Oral: Lofeminal	560	506	12,166	0.0143	174
Tubal Ligation	150,025	85,150	7,282	12.5	91,025
Implant Users	647,010	735,952	269,783	3.5	944,241
Vasectomy	24,063	32,800	1,315	12.5	16,437.5
Total	**2,196,713**	**2,242,225**			**2,156,240**

- Antenatal care (ANC) coverage for the fourth visit was 37% (677,338/1,830,295) in FY 2016/17 which was a decline from 38% in 2015/16 and below the HSDP target of 40% for FY 2016/17. ANC4+ visits were highest in the districts of Adjumani (65.8%), Butaleja (63.8%), Kabarole (63.1%), Bushenyi (59.6%) and Kamuli (57.5%). The lowest ANC4+ visits were in the districts of Amudat (19.5%), Manafwa (18.4%), Wakiso (17%), Bududa (16.8%) and Buvuma (10%).

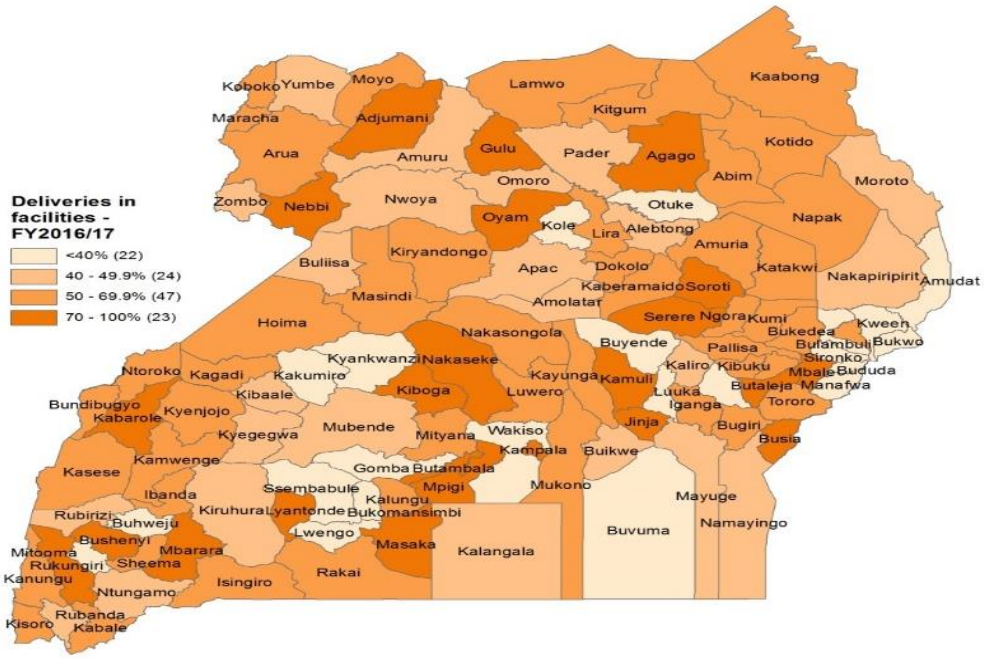
FIGURE 7: ANC4 VISITS BY DISTRICT 2016/17



- Health facility deliveries improved to 58.1% (1,032,020/1,775,386) in 2016/17 from 55% in 2015/16 and this was above the HSDP target (56%) for FY 2016/17. Districts with over 80% health facility deliveries were; Kampala (117.3%), Gulu (98%), Butambala (96.2%), Kamuli (95.4%), Masaka (91.5%), Kiboga (91%), Bushenyi (83.3%), Adjumani (83%), Kabarole (82.9%), Nakaseke (82.8%), Soroti (82%) and Jinja (81.2%). District with less than 30% of health facility deliveries were; Wakiso (29.4%), Bulambuli (29.4%), Luuka (26.2%), Kyankwanzi (25.5%), Kween (25.3%), Sembabule (22.8%) and Buvuma (17.1%).

- The proportion of HC IVs offering CEmOC services (Caesarean Section (C/S) and blood transfusion) improved to 44.6% (83/186) compared to 36% in 2015/16. The number of HC IVs conducting C/S without blood transfusion services also increased significantly to 70.4% (131/186) from 62% (122/198) in the previous FY. Similarly, there was an increase in the percentage of HC IVs offering blood transfusion to 47.3% (88/186) to 40.4% (80/198) in 2015/16. The following HC IVs performed the highest number of C/S; Mukono Town Council HC IV (1,414), Rwekubo HC IV (795), Rukunyu HC IV (715), St. Paul HC IV (553) and Mukono Church of Uganda HC IV (502) and Mpigi HC IV (489).

FIGURE 8: % OF HEALTH FACILITY DELIVERIES BY DISTRICT FY 2016/17



2.3 Performance against the key Health Investment and Quality Output Targets

The key health result areas under health investments and quality are health infrastructure, medicines and health supplies, improving quality of care and responsiveness, health information, financing and human resources. The sector performance is highlighted below focusing on comparison of performance with the previous FY and the HSDP targets for 2016/17 FY. Summary of the performance is in Table 7.

TABLE 7: PERFORMANCE AGAINST THE HEALTH INVESTMENT TARGETS

Indicator	Achieved 2014/15	Achieved FY 2015/16		Achieved FY 2016/17		HSDP Target 2016/17
New OPD Utilization rate	1.2	1.2	M = 1.0 F = 1.5	1.1	M = 0.9 F = 1.3	1.2
Hospital (Inpatient) admissions per 100 population	6 per 100 (2013/14)	7.2 per 100		7.8 per 100		7.1 per 100
Population living within 5km of a health facility	75%	100%		100%		80%
Availability of a basket of commodities in the previous quarter (% of facilities that had over 95%)	64% for the 6 tracer medicines	87%		83%		100%
Facility based fresh still births (per 1,000 deliveries)	16 (2013/14|)	13		10.1		14
Maternal deaths among 100,000 health facility deliveries	118	119		148.3		110
Maternal death reviews	32%	37%		23.9%		45%
Under Five deaths among 1,000 under 5 admissions	17 (2013/14)	19	M = 15.1 F = 22.3	20.2	M = 17.1 F = 23.6	17.3
ART Retention rate	79% (2014/15)	79%		82%		84%
TB treatment success rate	79%	79%		80%		84%
Client satisfaction index	69% (UHSSP, survey 2014)	46% (NSDS 2015)		na		73%
Timeliness of reporting (HMIS 105)	88%	79.4%		88.1%		90%
Latrine coverage	77% (2014/15)	75%		77%		76%
Villages/ wards with a functional VHT	75% (2014/15)	75% (2014/15)		na		80%

2.3.1 Utilization of health services

- The new OPD utilization rate for FY 2016/17 was 1.1 of which per capita utilization for males was 0.9 and females 1.3 indicating that females utilize the OPD services more than males.
- Hospital (Inpatient) admissions were 7.8 per 100 population, compared to the HSDP target of 7.1. The HSDP target was 7.1 for 2016/17.
- Population living within 5 km of a health facility (public or private) was 100%. The National Service Delivery Survey (NSDS) 2015, found that nationally, the median distance to the Government health facility is 3 km compared to only 1.2 km for other health facilities.

According to NSDS 2015, the majority of persons who fell sick first sought treatment from a Government health facility, which has persistently increased from 33% to 51%; followed by private health facilities which, has also increased from 29% to 36% between 2004 and 2015.

Table 8 shows comparison of source of services in FY 2016/17 which also shows that over 79% of the patient contacts were from the public sector.

TABLE 8: COMPARISON OF SOURCE OF SERVICES BASED ON THE HMIS DATA FOR 2016/17 FY

Service	PNFP	%	PHP	%	Public	%	Total
OPD New Attendance	5,113,584	13%	2,087,262	5%	33,155,053	82%	40,355,899
OPD Re-Attendance	1,108,755	29%	798,145	21%	1,879,129	50%	3,786,029
Total OPD	6,222,339	14%	2,885,407	7%	35,034,182	79%	44,141,928
Admissions	760,513	27%	81,951	3%	1,969,676	70%	2,812,140
Deliveries	193,405	19%	52,835	5%	781,476	76%	1,027,716
DPT-HepB+Hib$_3$	301,843	19%	49,851	3%	1,199,483	77%	1,551,177
Measles	270,423	19%	50,209	4%	1,074,038	77%	1,394,670

2.3.2 Essential Medicines and Health Supplies (EMHS)

The availability of health commodities as measured by a basket of 41 commodities dropped to 83% in 2016/17 from 87% in 2015/16, and an average of 55% of health facilities that reported had over 95% availability of the basket of commodities in comparison with 52% in 2015/16. The RMNCAH basket had the highest availability at 88%, however more than a quarter of health facilities still experienced a stock out of EMHS.

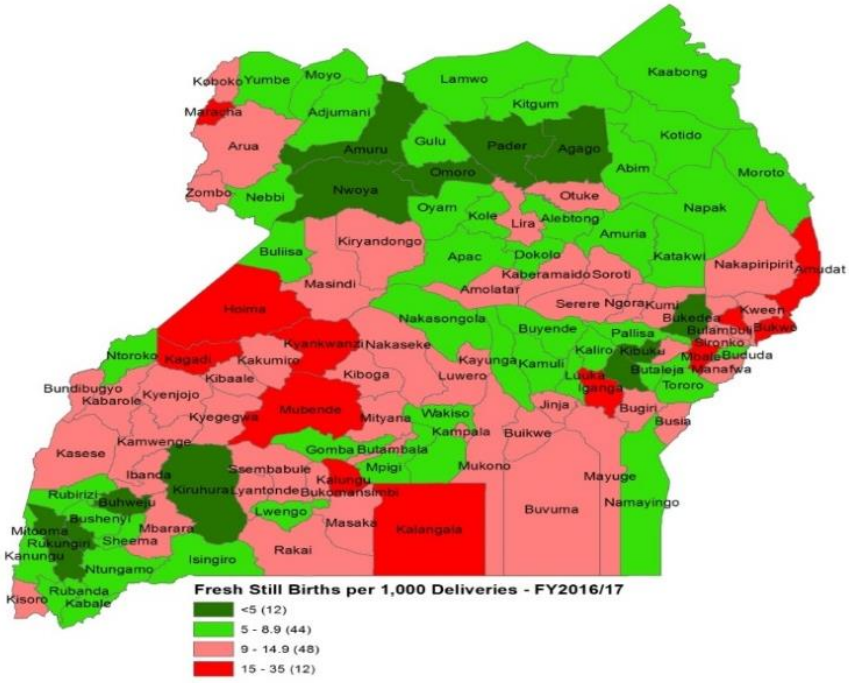
TABLE 9: AVAILABILITY FOR THE 41 COMMODITIES 2016/17

Avg %ge Availability of the basket of 41 comodities									
	Jul- Sept 2016		Oct-Dec 2016		Jan-Mar 2017		Apr-Jun 2017		Overall average
Basket	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
EMHS	84	3863	87	3988	82	3530	83	3590	84
ARV	83	1924	89	3059	79	1902	80	1951	82
LAB	85	1574	88	3916	84	3423	84	3486	85
RMNCAH	87	3627	90	3978	87	3527	87	3578	88
TB	75	3749	86	2857	71	1557	71	1623	76
Overall Average	83		88		81		81		83
%ge of facilities with over 95% availability									
	Jul- Sept 2016		Oct-Dec 2016		Jan-Mar 2017		Apr-Jun 2017		Overall average
Basket	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
EMHS	51	3863	62	3988	49	3530	50	3590	53
ARV	55	1924	68	3059	49	1902	50	1951	55
LAB	52	1574	59	3916	51	3423	50	3486	53
RMNCAH	51	3627	57	3978	49	3527	47	3578	51
TB	60	3749	75	2857	55	1557	53	1623	61
Overall Average	54		64		50		50		55

2.3.3 Improving Quality of Care

- Facility based fresh still births (per 1,000 deliveries) reduced to 10.1 per 1,000 deliveries from 13 per 1,000 in 2015/16. This performance is above the HSDP target of 14/1,000 for 2016/17. Among the RRHs the highest number of fresh still births was in Hoima (256) and Mbale (249). Among the general hospitals, the highest number of fresh still births were reported in; Iganga (171), Kamuli Mission (105), Mityana (96), Kagadi (82), Tororo (74) and Buluba (69).

FIGURE 9: FRESH STILLBIRTHS PER 1,000 DELIVERIES BY DISTRICT 2016/17



- The number of maternal deaths among 100,000 health facility deliveries increased to 148.3 per 100,000 health facility deliveries from 119 per 100,000 in 2015/16. This is in contrast to the reduction in the facility based still births which are decreasing. Among the RRHs the highest number of maternal deaths was in Hoima RRH (51) and Fort Portal RRH (50). Among the general hospitals, the highest number of maternal deaths were reported in the following; St. Mary's Lacor (30), Lubaga (18), Angal St. Luke (17) and Aber (17)

- In 2016/17 FY a total of 1,118 maternal deaths were reported through the MoH HMIS compared to 1,136 in 2015/16. Of these only 267 (24%) reviewed/audited compared to 246 (22%) maternal deaths notified and 419 (37%) reviewed/audited in 2015/16.

TABLE 10: MATERNAL DEATH NOTIFICATION AND REPORTING

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

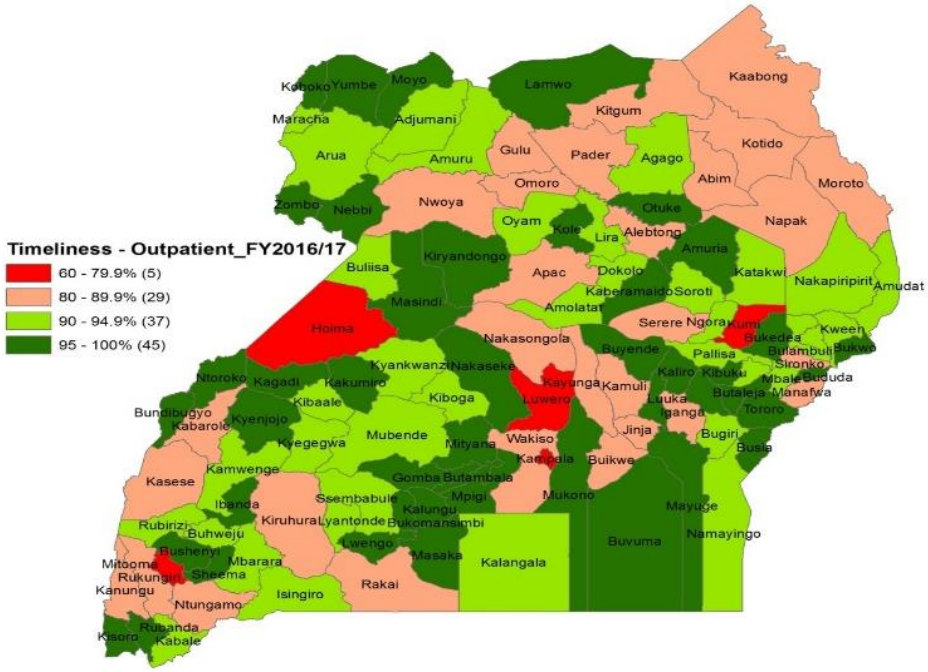
- The rate of under five deaths among 1,000 under 5 admissions was high at 20.2 per 1,000 which was an increase from 19 per 1,000 in 2015/16 FY. The HSDP target was 17.3 per 1,000.

- ART retention increased to 82% in 2016/17 from 79% in 2016/17 short of the HSDP target of 84%.

- TB treatment success rate improved slightly to 80% in 2016/17 from 79% in comparison with the previous FY, and below the HSDP target of 84%.

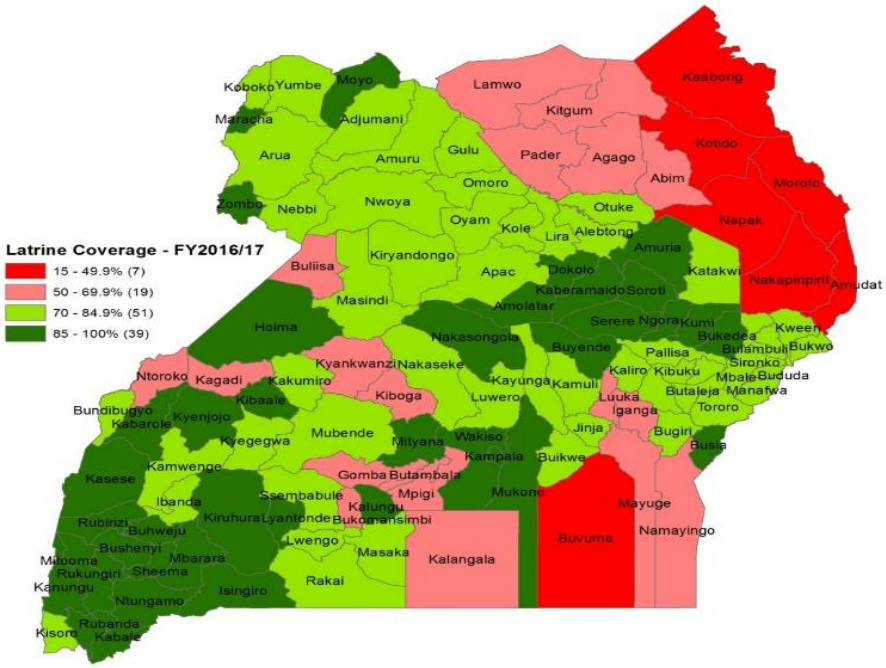
- Timeliness of monthly HMIS reporting improved to 92% in 2016/17 from 79.4% in 2015/16. Figure 10 shows the performance by district.

FIGURE 10: TIMELINES OF MONTHLY REPORTING (HMIS FORM 105)



- Latrine coverage improved to 77% in 2016/17 from 75% in 2015/16 and attained the HSDP target of 76%. The districts with the lowest latrine coverage were; in the Karamoja region and islands of Buvuma.

FIGURE 11: LATRINE COVERAGE BY DISTRICT 2016/17



- There was no significant investment in building the capacity of Village Health Teams (VHTs). Much effort was towards finalizing the Community Health Extension Workers (CHEWs) policy and strategy.

2.3.4 Health Financing

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

The health sector received a total of Ug Shs 1.87 trillion representing 8.9% of the total national budget. Of the Ug Shs. 993.34 billion contributions from GoU approximately 40% (Ug Shs 375.77 billion) was released to the Local Governments (LG). In FY 2016/17, 96% of the GoU budget for both, Recurrent and Development budget categories was released amounting to Ug Shs 952.52 billion. An additional Ug Shs 31.82 billion was released to cater for pension and gratuity arrears and medicine supply shortages experienced by some votes under the sector namely Uganda Blood Transfusion Services (0.247 billion), Uganda Heart Institute (0.22 billion), Butabika Hospital (0.288 billion), Mulago Hospital Complex (0.242 billion), Regional Referral Hospitals (3.8 billion) and National Medical Stores (27 billion).

Of the funds released, all sector votes utilized more than 90% of their resources except the Regional Referral Hospitals (88%). This can be attributable to poor performance of the development budget largely due to delays in the procurement process. MoH recorded the least absorption rate of the budget at 72% on account of less than planned external financing from some projects.

TABLE 11: GOU BUDGET PERFORMANCE FOR FY 2016/17 IN UG. SH.BN

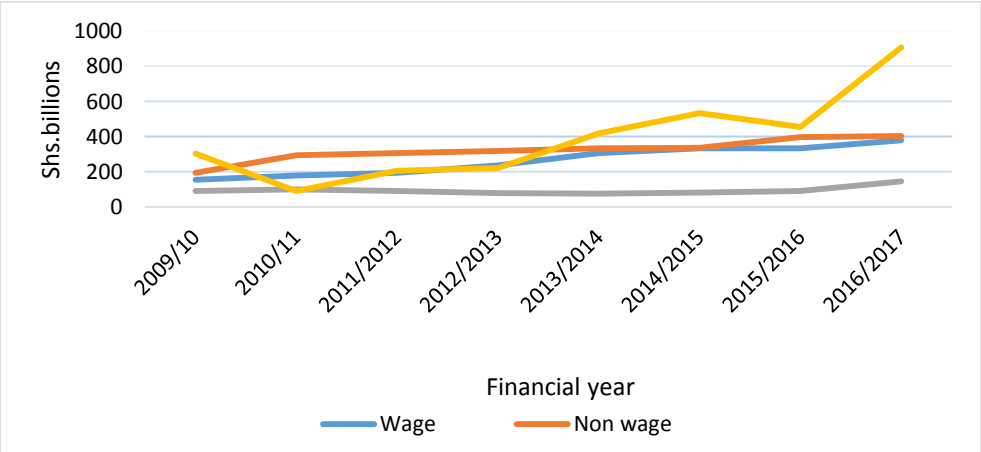
Institution	Revised Budget	Release	Expenditure	% of Budget Released	% Release Spent	Budget Absorption
Ministry of Health	135.02	98.92	96.78	73%	98%	72%
Uganda AIDS Commission	7.69	7.69	7.03	100%	91%	91%
Uganda Cancer Institute	14.86	14.58	14.42	98%	99%	97%
Uganda Heart Institute	12	11.9	11.39	99%	96%	95%
National Medical Stores	264.96	264.96	264.96	100%	100%	100%
Health Service Commission	5.26	5.26	5.14	100%	98%	98%
UBTS	8.88	9.12	8.54	103%	94%	96%
Mulago Hospital Complex	63.3	60.73	57.26	96%	94%	90%
Butabika Hospital	11.33	11.33	10.82	100%	95%	95%
Regional Referral Hospital	94.27	92.26	80.97	98%	88%	86%
Local Government Grants						
Recurrent	367.17	367.17	367.17	100%	100%	100%
Development	8.6	8.6	8.6	100%	100%	100%
Total Health	**993.34**	**952.52**	**933.08**	**96%**	98%	**94%**
Central Government	617.57	576.75	557.31	97%	97%	90%
Local Government	375.77	375.77	375.77	100%	100%	100%
Total Health	**993.34**	**952.52**	**933.08**	**96%**	98%	**94%**

Source: Approved estimates and quarterly progress report for FY 2016/17 - (Excludes External Financing)

Analyzing the performance of budget categories of wage, non-wage and development for the health sector since 2009/10, it is clear that the development budget allocation to the sector has stagnated over the years since 2009/10 while the wage budget has increased steadily over the years. The non-wage allocation has also stagnated over the period except a slight increase in FY 2015/16.

External financing registered a big drop in FY 2015/16 attributed to reduced external in flows from donors due to uncertainty of the political environment caused by the election years. However, an upward trend was registered in FY 2016/17 due to increase donor confidence.

TABLE 12: PERFORMANCE OF BUDGET CATEGORIES



2.3.4.1 PHC Allocations (PHC NWR FY 2016/17)

There was an increase of Ug Shs. 32 billion in the PHC wage from the previous year to cater for annual salary increments and recruitment of health workers in the LGs in FY2016/17.

The changes in the PHC non-wage recurrent and Development grants were as a result of a restructuring of the grants as follows;

i) In FY 2016/17, the continued implementation of inter-government fiscal transfer reforms by Government, led to the consolidation of the discretionary grants. Therefore, PHC Development PRDP of Ug Shs. 14.9 Billion under the health sector in FY 2015/16 was consolidated with other discretionary grants to form the District Development Equalization Grant under the management of the Office of the Prime Minister in FY 2016/17.
ii) The PHC Non-Wage Grant, the PHC Non-Wage –District Hospital Grant and the PHC Non-Wage NGO Grant of FY 2015/16 were all consolidated into one grant i.e. PHC Non-Wage Recurrent Grant in FY 2016/17.
iii) With the purpose of advancing the sector priorities, Ug Shs. 2.2 Billion of the PHC Development –Normal of Ug Shs. 3.2 Billion (FY 2015/16) was shifted to PHC Non-

Wage to enhance funding to health facilities and scale up HSD/ Constituency Health Taskforce activities in FY 2016/17 while the balance of Ug Shs. 1 Billion was added to PHC General Hospital Rehabilitation Grant of FY 2015/16 to form the PHC Transitional Development Ad Hoc of FY 2016/17.

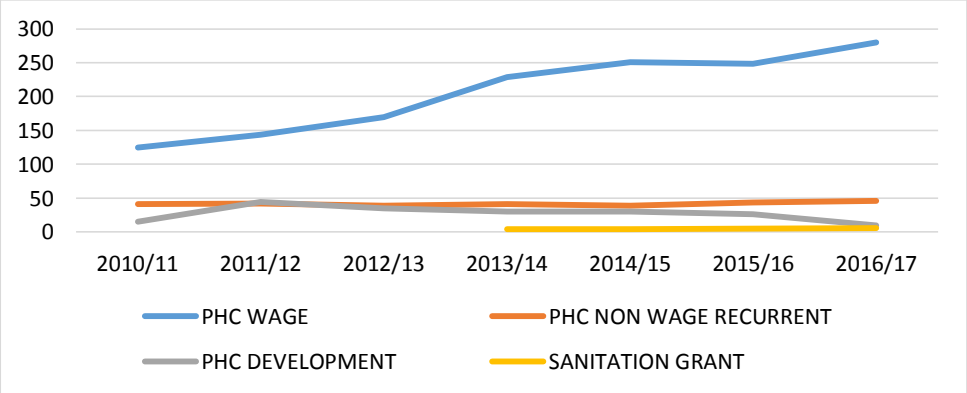
iv) Only Ug Shs. 300 million was additional funding for PHC Transitional Development Ad Hoc in FY 2016/17.

Except for the PHC wage component that has been rising, the other grants have remained static over the last 8 years as shown in Table 13 and Figure 12. The Sanitation Grant increased slightly by Ug Shs 780 million in FY 2016/17 which enabled the Ministry to expand the program to more districts.

TABLE 13: HEALTH SECTOR GRANTS TRENDS FY 2010/11 – 2016/17

FY	PHC Wage	PHC Non-Wage Recurrent	PHC Development	Sanitation Grant	Total
2010/11	124.5	41.00	15.3		**180.80**
2011/12	143.43	41.63	44.43		**229.49**
2012/13	169.38	38.97	34.81		**243.16**
2013/14	228.69	41.18	30.08	4.16	**304.11**
2014/15	250.61	38.97	30.08	4.16	**323.82**
2015/16	248.06	43.67	26.28	4.68	**322.69**
2016/17	279.61	45.85	9.50*	5.46	**340.42**

FIGURE 12: TRENDS IN THE HEALTH SECTOR GRANTS



Analysis of the PHC Non-Wage allocation by Service Delivery Strata reveals that average allocations per level of service are far below what is required to carry out the core functions of management and ensure quality service delivery. At the individual facility level, the challenge of inadequate PHC non-wage recurrent funding is escalated by the huge disparities across the districts as shown by the ranges in table 14.

TABLE 14: PHC NON-WAGE ALLOCATION BY SERVICE DELIVERY STRATA WITHIN THE PHC SYSTEM FOR FY 2016/17

Level of Health Service Delivery	Number of Units	Annual NWR Allocation Per Level	Annual Average Allocation Per Level	Annual Allocation Range Per Level		Annual requirement
				Maximum	Minimum	
District Health Office	115	4,696,841,333	40,842,099	91,862,402	10,647,282	99,360,000
Municipal Health Office	41	496,386,017	12,106,976	40,936,268	2,598,440	-
Health Sub Districts	220	5,823,358,729	26,469,812	75,951,723	3,636,423	-
Hospitals	102	16,990,584,261	166,574,356	586,400,743	42,010,002	366,650,000
HC IVs	190	3,135,258,973	16,501,363	44,469,764	7,003,466	42,232,000
HC IIIs	1,170	7,516,563,332	6,424,413	23,091,103	1,199,107	15,592,000
HC IIs	1,954	7,192,076,216	3,680,694	12,690,163	990,458	12,592,000

Table 15 shows average credit line allocations for EMHS per health facility level in FY 2016/17 at the NMS.

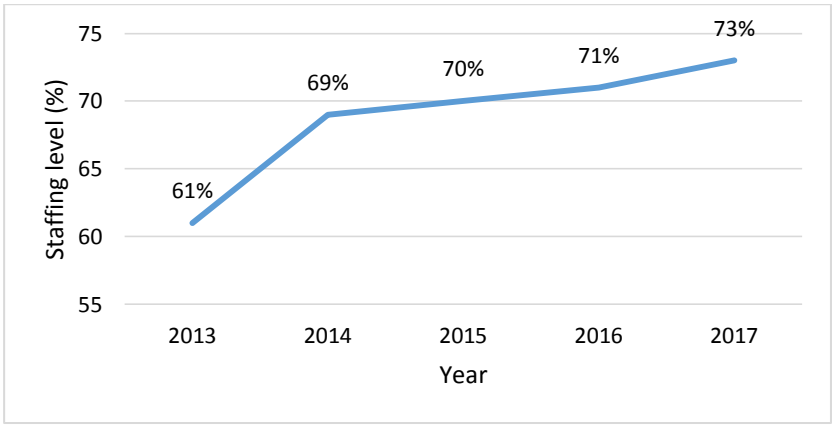
TABLE 15: MEDICINE BUDGET ALLOCATIONS (AVERAGES) TO HEALTH FACILITIES FY 2016/17

Level	Average Allocation Ug. Shs
HC II	7,427,474
HC III	22,364,882
HC IV	52,561,792
General Hospitals	321,989,798

2.3.5 Human Resources for Health

The health sector staffing improved slightly in 2016/17 to 73% (45,029/61,796) from 71% (42,530/60,384) in 2015/16 above the HSDP target of 70%. The objective of the HSDP is to fill the current staffing norms in the public sector to at least 80% of the current staffing norms by 2019/20, by which time the structure of the whole health workforce should have been reviewed.

FIGURE 13: APPROVED STAFFING LEVEL TRENDS



Source: MoH Bi-Annual HRH report 2017

The number of health workers per 1,000 population in Uganda is still far below the WHO threshold of 2.3 doctors, nurses and midwives per 1,000 population. In 2016/17 FY the ratio of doctors, nurses and midwives to the population was 1: 28,202; 1: 2,121 and 1: 6,838 respectively.

Overall, staffing has improved though still skewed in favour of specialized health institutions and larger health facilities (NRH 92; RRH 80%; GH 68%; HC IV 85%; HC III 80%; HC II 53%). The overall staffing level at central-level institutions (national referral hospitals, specialized health institutions and RRHs) increased to 83% (2017) from 69% in 2015. The staffing at health facilities and management offices at the District LG and Municipal Council levels increased to 71% (2017) from 67% in 2015. The staffing for Municipalities increased to 100% (2017) from 63% (2015). Generally, more females (54%) than males (46%) existed in the sector.

2.3.5.1 Staff Recruitment

The GoU together with HDPs have been supporting the health sector and district to conduct wage analysis and develop costed three-year and annual recruitment plans for wage allocation. In 2016/17, 116 districts and 18 Central institutions were supported to develop costed recruitment plans. Following this mechanism 2,222 positions were advertised and by the end of the FY, 2,129 health workers were recruited.

TABLE 16: SUMMARY OF POSITIONS ADVERTISED AND RECRUITED

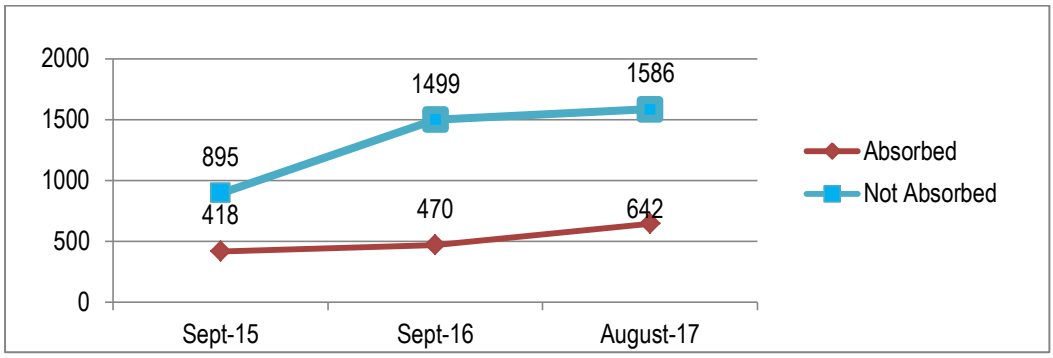
Institution	No. of positions advertised	Number Recruited
Districts (43)	1,143	1,056
HSC (MoH, NRH,RRH)	1,003	1,014
PEPFAR (RRHs)	76	59
Total	**2,222**	**2,129**

Source: Bi-annual HRH Report 2017

2.3.5.2 USG funded contract staff absorption

Although the GoU recruits health workers every year, it is constrained by inadequate funds for wage and recruitment costs including advertisement and allowances for District Service Commission members**.** Given the urgency to achieve the global UNAIDS targets of 90-90-90 towards HIV epidemic control, it became necessary for PEPFAR to complement GoU efforts to accelerate availability of health workers for HIV/AIDS services on the understanding these would gradually be prioritized for absorption as wage becomes available. A total of over 3,000 health workers have been so far recruited with PEPFAR support since 2012. Although GoU has progressively absorbed these contracted health worker, the progress has been slow.

FIGURE 14: PROGRESS OF ABSORPTION OF USG-CONTRACTED HEALTH WORKER



Source: Bi-annual HRH report 2017

A total of 1,965 have not been absorbed yet even though GoU recruitment has been happening every year.

TABLE 17: SHOWING UNABSORBED USG-CONTRACTED STAFF IN THE HEALTH SECTOR

1	MoH	164	66	230
2	NRH-Mulago	8	1	9
3	RRH	274	19	293
4	Districts	1,259	25	1,284
5	Recruited at MoH but based in districts & RRHs (CPHL & MSH-UHSC)	70	79	149
	Grand total	1,775	190	1,965

Source: Bi-annual HRH report 2017

TABLE 18: NATIONAL SUMMARY OF STAFFING LEVEL AS OF JUNE 2017

No	Level	No. of Units	Total Norms	Filled	% Filled
1	Ministry of Health Headquarter	1	821	771	94%
2	Mulago NRH	1	2,335	2,072	89%
3	Butabika NRH	1	429	407	95%
4	Regional Referral Hospital	14	5,430	4,353	80%
	MOH's National Institutions:				
5	Uganda Virus Research Institute	1	227	82	36%
6	Uganda Cancer Institute	1	272	147	54%
7	Uganda Heart Institute	1	190	118	62%
8	Uganda Blood Transfusion. Services	1	246	322	131%
	Sub-total: Centre Level	**21**	**9950**	**8272**	**83%**
11	General Hospitals	45	8,550	5,816	**68%**
12	DHOs Offices	116	931	1,012	**109%**
13	HC IV	171	8,208	6,896	**84%**
14	HC III	953	18,107	14,501	**80%**
15	HC II	1,690	15,210	8,116	**53%**
16	Municipal Councils	36	216	216	**100%**
17	Town Councils (Big)	2	14	8	**57%**
18	Town Councils (Small)	122	610	192	**31%**
	Sub-total District	**3,135**	**51,846**	**36,757**	**71%**
	Total National Level	**3,156**	**61,796**	**45,029**	**73%**

Source: MOH HRH Audit Report 2017

2.3.5.3 Staffing level by type of cadre

Staffing analysis by cadre for all levels shows that Entomological Staff (102%), Clinical Officers (100.6%) and Laboratory Staff (93.4%) are generally high in the public sector. However, staffing levels are lowest for Dispensers (41%), Anaesthetic officers (28.9%) and environmental health officers (26.7%).

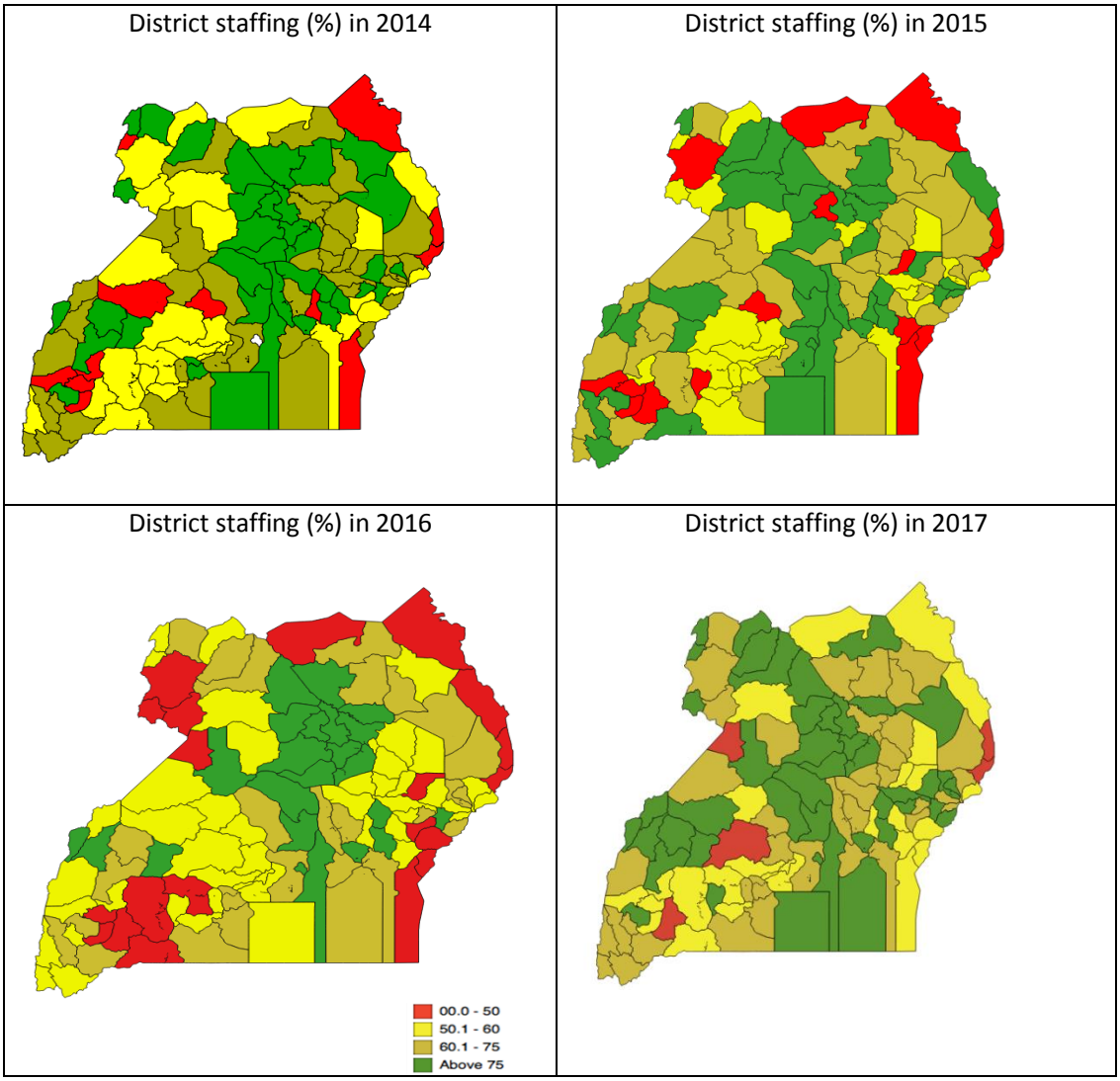
TABLE 19: TOTAL FILLED POSITIONS BY CADRE OF STAFF IN PUBLIC HEALTH INSTITUTIONS, JUNE 2017

No	Establishment Details	Units No.	Total Norms	Total Filled	% Filled
1	Entomological Staff	1,322	232	237	102.2%
2	Clinical Officers	2,993	2,740	2,756	100.6%
3	Laboratory Staff,	2,996	2,958	2,762	93.4%
4	Nursing Staff	3,032	19,843	17,258	87%
5	Midwifery Staff	2,994	6,729	5,353	80%
6	Biostasticians	116	43,413	34,227	78.8%
7	Theatre Staff	233	512	368	71.9%
8	Psych. Clinic Off & Psych Soc. W	232	160	110	68.8%
9	Orthopaedic Clinical Officers	232	376	235	62.5%
10	Public Health Dental Officers	1,301	533	316	59.3%
11	Health Inspectors	3,150	3,778	2,185	57.8%

No	Establishment Details	Units No.	Total Norms	Total Filled	% Filled
12	Doctors	1,342	2,256	1,298	57.5%
13	Pharmacy Staff	351	116	64	55.2%
14	Radiographers & Imaging Staff	63	241	129	53.5%
15	Physio. & Occup. Therapists	235	237	122	51.5%
16	Health Educators	2,061	420	200	47.6%
17	Cold Chain Technicians	1,285	287	126	43.9%
18	Ophthalmic Clinical Officers	349	280	115	41.0%
19	Dispensers	350	512	210	41.0%
20	Anaesthetic Officers	232	855	247	28.9%
21	Environment Officers	161	232	62	26.7%
	Grand Total	**25,030**	**86,710**	**68,380**	**78.9%**

Source: MOH HRH Audit report 2017

FIGURE 15: COMPARISON OF DISTRICT STAFFING FROM 2014 TO 2017

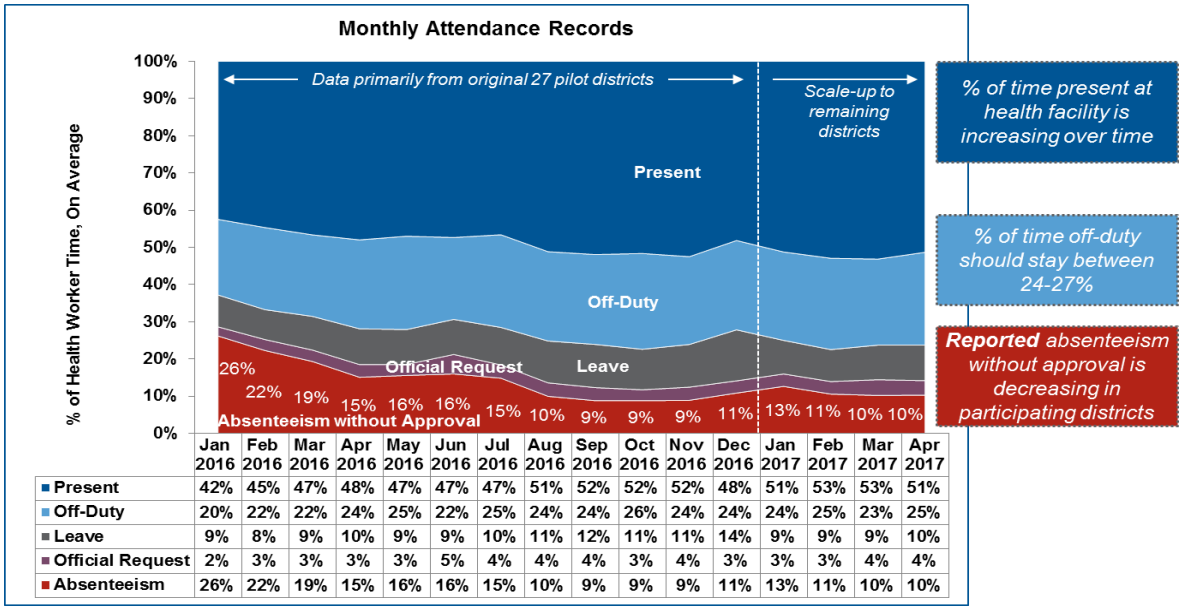


Source: HRIS 2017

2.3.5.4 Managing absenteeism in the Health sector

As part of managing performance of health workers, MoH with support from Strengthening Human Resources for Health (SHRH) Project rolled out the mechanism for attendance tracking and absenteeism management using the Automated Attendance Analysis in 2016 starting with a few districts as a pilot. By June 2017, the rollout had covered all the 116 districts in the country. Most districts are now tracking attendance monthly and the analysis is being used in some district by managers for administrative decision including salary payment based on number of days worked.

FIGURE 16: MONTHLY ATTENDANCE ANALYSIS FROM HEALTH FACILITIES



	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017
Present	42%	45%	47%	48%	47%	47%	47%	51%	52%	52%	52%	48%	51%	53%	53%	51%
Off-Duty	20%	22%	22%	24%	25%	22%	25%	24%	24%	26%	24%	24%	24%	25%	23%	25%
Leave	9%	8%	9%	10%	9%	9%	10%	11%	12%	11%	11%	14%	9%	9%	9%	10%
Official Request	2%	3%	3%	3%	3%	5%	4%	4%	4%	3%	4%	3%	3%	3%	4%	4%
Absenteeism	26%	22%	19%	15%	16%	16%	15%	10%	9%	9%	9%	11%	13%	11%	10%	10%

Source: Bi-annual HRH Report 2017

Although absenteeism (with or without approval) is still generally high, absenteeism without approval decreased from 50% in 2015 to 10% by April 2017.

TABLE 20: TREND IN ABSENTEEISM BY CAUSE, 2015 AND 2016

Absenteeism	Rate (2015)	Rate (2016)
Absence with or without approval	68.8%	14%
Absence without approval	50%	10%

Source: HRH annual surveys- 2015 & 2016

The government through the Office of the Prime Minister's Monitoring and Delivery Unit is working with MoH and HDPs to implement attendance tracking in 20 districts in Eastern Uganda using biometric machine and smartphones. These measures are expected to bring absenteeism down in due course.

The staffing norms for the health facility staff should be revised to take into consideration the 24 – 27% absence due to off duty.

2.4 Health Partnerships

2.4.1 Progress in implementation of the HSDP Compact

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

2.4.1.1 Performance of HPAC

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

In terms of meetings, HPAC was able to hold 12 meetings during FY 2016/17. Membership attendance of the meetings varies among the different categories representatives (See Table 21). There is need to improve HPAC attendance by most of the representatives through delegation and ensuring that meetings are held as scheduled and on time.

TABLE 21: HPAC INSTITUTIONAL REPRESENTATIVES' ATTENDANCE

Representatives	Average Annual Attendance Rate		
	2014/15	2015/16	2016/17
MoH (11)	65%	38%	45%
HDP (4)	108%	42%	100%
CSO (3)	50%	64%	67%
Private Sector (2)	33%	25%	50%
NMS (2)	67%	67%	50%
Medical Bureaus (2)	46%	54%	50%
NRH (2)	17%	13%	50%
RRHs (1)	-	-	0%
DHOs (1)	-	-	-
Line Ministries (5)	7%	5%	20%

Source: HPAC Minutes

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

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

Performance against the implementation of the Compact is shown in Table 22.

TABLE 22: PROGRESS IN IMPLEMENTATION OF THE COUNTRY COMPACT DURING FY 2016/17

/#	Compact Indicator	Targets/Means of Verification	Achievement	Comments
1.0.	**Planning and Budgeting**			
1.1.	MoH Annual Work plan reflecting stakeholder contribution (all resources on-plan)	Partners' support is captured in the plan	Not all resources in one MoH Annual Work plan	Some donors still prefer off-budget support
1.2.	All new sector investments are appraised by SBWG	Submission of new projects to SBWG	Increase in submission of new projects to SBWG	SBWG met regularly to review new projects.
1.3.	All planned procurements reflected in the Comprehensive procurement plan	Adherence to procurement plan	Annual integrated comprehensive procurement plan was made but not fully implemented	Delays in initiating procurements
1.4.	Response to Auditor General's report	Timely response to AG's report	Response to all audit reports was made.	Advise of the AG's advice is being used in improving accountability systems
1.5.	Implementation of harmonized Technical Assistance (TA) Plan	HPAC approval of ToRs & procurement of short & long term TA	Harmonized TA plan not developed	To develop a harmonized TA plan
2.0.	**Monitoring Program Implementation and Performance**			
2.1.	Area Team Visits - Quarterly Reports	Presentation of reports to HPAC within 30 days after completion of Area Team visits	One brief report from Area Teams was submitted to HPAC.	Reports submitted though not discussed because of tight HPAC agenda
2.2.	MoH Quarterly Performance Assessment	Dissemination of reports to HPAC within 30 days after completion of MoH quarterly review.	Two quarterly performance review meetings held	Reports circulated on the MoH website
2.3.	Technical Review Meeting	Present of report from TRM to HPAC by 30 April	TRM not done	Funding was inadequate
2.4.	Technical Working Group meeting	Target 80% of TWG meetings held	40% of TWGS held regular meetings and briefs informing policy presented to senior management and HPAC.	Some TWG need to be revived and to sit regularly.
2.5.	Annual Health Sector Performance Report	Submission of Final Report by 30 Sept	Report written, discussed at the 22nd JRM and disseminated	Achieved fully
2.6.	Submission of Annual Report to OPM	Submission to OPM by 30 August	Health component of the GAPR submitted to OPM on time.	
2.7.	Joint Review Mission - review of sector performance	Aide Memoire presented to HPAC by 30 Nov	The JRM was held on schedule and AIDE Memoire was presented to HPAC signed in January 2016	
2.9.	End of HSDP Evaluation	Completion of end of HSDP review by June	Not due	

/#	Compact Indicator	Targets/Means of Verification	Achievement	Comments
		2018		
3.0.	**Policy Guidance and monitoring**			
3.1.	Senior Management Committee	12 SMC meetings	10/12 SMC meetings were held	Technical issues from TWGs discussed.
3.2.	Health Policy Advisory Committee	12 meetings	All 12 meetings were held	Discussed issues with policy implications.
3.3.	Country Coordination Mechanism	4 meetings	CCM met quarterly and organized other meetings to support the Global Fund Grant Application	Grant application finalized and approved

2.4.1.2 Performance of MoH Senior Management Committee

10 out of the 12 (83%) SMC meetings were conducted in 2016/17 FY. The following items were discussed and forwarded to HPAC and Top Management for further information and approval:

- ✓ Health Sector Quality Improvement Framework and Strategic Plan (2015/16 to 2019/20).
- ✓ Health Service Standards and Service Delivery Standards.
- ✓ Eye Care guidelines
- ✓ Revised MoH (Central Level) Structure
- ✓ Area Team Support Supervision reports (2 reports were shared).
- ✓ Study proposal for development of Diagnosis Related Groups and Ambulatory Care categories for Uganda.
- ✓ Pilot Regional Joint Review Mission report and Guidelines
- ✓ MoH Knowledge Management Portal concept.
- ✓ Concept Leadership and Management for QI Managers in districts in Uganda.
- ✓ Highlights of the Report of the 13th EAC Council of Ministers.
- ✓ National Communication Strategy for Palliative care.
- ✓ Integrated Vector Management strategy and guidelines.
- ✓ School Based Net Distribution guidelines and training manual.
- ✓ Proposed priorities for Malaria funding application to the Global Fund.
- ✓ Rewards and Sanctions Guidelines for the Health sector.
- ✓ Scope of Practice for Nurses and Midwives.
- ✓ Infertility Management Guidelines.
- ✓ Report on review of medicines and medical supplies management in public health facilities in West Nile and Rwenzori region.
- ✓ Parasite Based Diagnostic guidelines.
- ✓ Revised Public Health Act.
- ✓ Investment Plan for Sanitation and Hygiene.
- ✓ IHP+ 2016 report.

- ✓ Assessment of injection safety & health care waste management practices in health facilities in Uganda.
- ✓ Private Health Sector support Project to the PPPH Unit.
- ✓ Proposal on floor that may eradicate jiggers in Uganda.
- ✓ Report on budget execution bottlenecks report.
- ✓ Brief from the TWG meetings.

2.4.1.3 Performance of the MoH TWGs

There are 14 TWGs which are fully constituted and with updated membership. 6 out of the 14 (40%) TWGs were able to hold regular monthly meeting and these are: Health Sector Budget; Supervision Monitoring Evaluation and Research; Maternal and Child Health; Medicines Procurement and Management, and e-Health. 5 TWGs (35%), PPPH, Non-Communicable Disease Control, Health Infrastructure, Hospitals and Lower Level Health Facilities, and Nutrition TWGs met at least once in each quarter. The rest of the TWGs (25%) held fewer meetings recorded. The policy issues raised from each TWG were forwarded to SMC to be considered for approval.

2.4.2 International Health Partnerships (IHP+)

During FY 2016/17, the IHP+ 6th monitoring round was conducted with inputs from the MoH, MoFPED, HDPs and CSO representatives. It measures 8 Effective Development Cooperation (EDC) practices. 11 of the 18 HDPs active in the health sector, 20 CSOs and 8 private sector organizations participated.

Data was collected for 2014 /2015 FY, 61% of DPs participated (including: Belgium, DFID, JICA, GAVI, GFATM, Sweden, UNFPA, UNICEF, USA, WHO and World Bank), representing 93% of total external support (source: OECD, CRS database);

Most of the targets for Aid Effectiveness (Paris Declaration and IHP+ indicators) assessed showed significant progress on the country performance. The final report was presented to the MoH SMC and HPAC and is available on the MoH website. The most critical issues to be focused on by the different actors are highlighted in Table 23.

TABLE 23: ISSUES TO BE FOCUSED ON IN ENSURING GOOD EDC PRACTICES

EDC Practice	Issues to be focused on
EDC 1 (Partners support a single national health strategy)	• Stick to the Compact. Operationalize the HSDP compact. Improve HMIS Data. • All DP should support what is in the Strategic plan (Single National Health Strategy). MoH should take leadership and demand for adherence to this.
EDC 2 (Practice 2a/b: Health development cooperation is more	• To improve predictability, strengthen the AID Liaison Office at MoFPED with staff and equipment to capture and maintain funding data but details of disbursement be communicated to line Ministry/MoH as well. • Have a focal person at MoH in the Planning department. Current staffs have other

EDC Practice	Issues to be focused on
predictable) (Practice 2c: Health aid is on budget)	commitments. USG and CDC funding most problematic.
EDC 3 (Public Financial Management (PFM) systems are used and strengthened)	• GoU and MoH address transparency and accountability concerns expressed by donors. • Support and implement gaps identified through the PFM assessment. • Special attention to gaps in PPDA and Public Finance Management Act • Fast track proposed Health Insurance Bill and Results Based Financing. • All capacity building be coordinated by AID Liaison Office MoFPED
EDC 4 (Procurement systems are used and strengthened)	• Most DPs don't use national procurement system. Sight weaknesses in GoU systems and need for economies of scale. • Action; Short term MoH focus on effective coordination to avoid duplication. But need a unified Procurement plan for Uganda – GoU to take leadership. Rather than weaken the system by not using it – DPs need to use and strengthen national system.
EDC 5 (Mutual accountability is strengthened)	• Stick to the WHO principle of 3 ones; 1 plan, 1 implementation, 1 M&E. All should be guided by the NDP, sector strategic plan. • DPs need to be accountable for commitments made.
EDC 6 (Technical support is coordinated and South to South Cooperation supports learning)	• No TA plan for Uganda. Need national plan and learn best practices from other Countries. MoH should take leadership. • DPs need to be transparent in selection of TA.
EDC 7 (Engagement of CSOs)	• CSO need more capacity building to generate own data and for self-coordination. • Locally founded CSOs need affirmative action in DPs and MoH consultative processes which tend to be dominated by international NGOs with local chapters. • Need of pooled resources for CSOs, Address operating legal environment: Public management Act 2013, NGO Act 2016.
EDC 8 (Engagement of Private sector)	• Most Private sector not aware of PPPH policy, Feel left out. • Need more MoH leadership, implement PPPH policy fairly, increase PPPH awareness

2.5 Key Sector Challenges and Recommendations

Despite the achievements, the sector still faces several challenges in ensuring a healthy and productive population among which are;

TABLE 24: KEY SECTOR CHALLENGES AND RECOMMENDATIONS

	Challenges	Recommendations
1.	Huge disease burden owing to mainly malaria, pneumonia, diarrhea and newborne diseases in children	Investment in health promotion and disease prevention interventions for example the CHEWs, since 75% of the diseases are preventable.
2.	Newborne and Maternal mortality is still high to eet the SDG target	Intensification of perinatal deaths surveillance and audits, strengthening community awareness, perinatal health and quality of newborn care services should further accelerate the reduction of preventable newborn deaths. Urgent effort is needed to first tackle the immediate causes of death for the majority of women. This includes increasing blood transfusion services at HC IV level.
3.	Weak implementation of the laws and policies on Public Health and Sanitation.	Engagement of the LGs and other relevant MDAs in enforcement of the laws on Public Health and sanitation at household and institutional level.
4.	Inadequate staffing at all levels a significant number of posts are not filled and current staffing norms not commensurate with the services provided and workload.	The staffing norms for the health facility staff should be revised to take into consideration the 24 – 27% absence due to off duty.
5.	Low salaries and incentives which do not attract graduates in remote services areas.	Increase the health workers salaries
6.	Stocks outs of key commodities at facility level owing to incorrect forecasting.	Improve on forecasting for medicines as well as increased budget for EMHS to address the inadequate supply of medicines and laboratory reagents.
7.	Funding gaps for ARVs, Antimalarials and chemistry and haematology laboratory reagents in the public sector.	Operartilinalise the Aids Trust Fund and increase funding for EMHS
8.	Inadequacy in the maintenance of medical equipment nationwide.	Increased funding for maintainance of medical equipment including training and recruitment of Biomedical Engineers.
9.	Management of various disease outbreaks and public health emergencies is not equitably funded for example current influx of refugees into the country and internally displaced persons puts pressure on existing resources and is a risk of	Finalise and mobilize resources for the emergency health and nutrition action plan.

	importation of vaccine preventable diseases.	
10.	There is inadequate funding for sector activities especially PHC Services at lower level leading to influx of patients at the referral facilities.	Increase investment in health towards meeting recommended per capita health expenditure of minimum $84 per capita for low income countries, if the country is to increase access to health care and improve quality of services.
11.	Inadequate funding for preventive interventions at community level. No commensurate funding for recurrent costs for utilities and/or maintenance arising from the raise in costs as well as construction of new buildings and equipment especially for hospitals.	
12.	Poor / inadequate infrastructure (including staff accommodation).	
13.	Challenge of the alignment of off-budget funding to sector priorities.	The MoH needs to improve coordination of donors and ensuring alignment to country strategies to the Paris Declaration principles for more aid effectiveness.
14.	Unsatisfactory level of support supervision at all levels. Many districts lack capacity in terms of man power, transport and other logistical requirements to conduct regular and effective support supervision.	Operationalise the Regional Superviosry structure

2.6 Local Government Performance

The Uganda District League Table (DLT) was launched 2003 with a primary purpose of comparing performance of districts to determine good and poor performers; providing information to facilitate understanding of good and poor performance and to enable application of corrective measures, increasing LG ownership of achievements, and encouraging replication of documented good practices. Over the years the use of DLT has gained importance in the overall health sector monitoring and it is an important tool for managers and policy makers as a starting point for a comprehensive review of national and individual district performance.

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

2.6.1 District League Table (DLT) Performance

During FY 2016/17, the number of districts increased from 112 to 116. The new districts are Kagadi and Kakumiro from Kibaale, Omoro from Gulu and Rubanda from Kabale. The districts are used as the units of analysis with key objectives of comparing performance between districts; provide information to facilitate the analysis for good and poor performance at districts and thus enable corrective measures which may range from increasing the amount of resources (financial resources, human resources, infrastructure) to the LG or more frequent and regular support supervision.

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

The objectives of the DLT are;

- 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 NHA or JRM with political, technical and administrative leaders of districts.
- To encourage good practices – good management, innovations and timely reporting.

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

There was an improvement in the overall DLT score from 63.9% in 2015/16 to 66.2% in 2016/17 FY. Remarkable improvement was registered in the proportion if HIV+ pregnant women not on HAART initiated in ART from 68.3% in 2015/16 to 90.1% in 2016/17. It is also worth noting that there was almost no improvement in ANC4th visits and IPT_2 coverage and a decline in the maternal deaths audited from 36.9% in 2015/16 to 23.9% in 2016/17.

TABLE 25: TRENDS IN NATIONAL AVERAGE PERFORMANCE IN THE DLT INDICATORS

Financial Year	PCV3 (%)	ANC4+ (%)	IPT2 (%)	Deliveries (%)	HIV+ pregnant women initiated on ART (%)	Latrine Coverage (%)	Fresh Still Births per 1,000 Deliveries	Maternal Deaths Audited (%)	TB Treatment Success Rate (%)	Patients diagnosed with Malaria that are lab confirmed (%)	Approved posts filled with qualified personnel	Monthly reports sent on time (%)	Completeness monthly reports (%)	Timeliness of Quarterly OBT reporting (%)	*% score*
2015/16	91.9	37.3	54.9	55.2	68.3	74.9	12.7	36.9	78.9	63.7	71.1	79.4	96.5	34.4	***63.9***
2016/17	92.9	37	54.4	58.2	90.1	76.7	10.2	23.9	80.4	68.9	71.7	88	94.3	9.1	***66.2***

The top ten best performing districts in FY 2016/17 as ranked by the percentage (%) score computed by (total score)/90*100 are; Adjumani, Gulu, Mbale, Kiboga, Kamwenge, Oyam, Kampala, Bushenyi, Koboko and Kabarole.

The lowest performance levels were noted in Bududa, Budaka, Nakapiripirit, Napak, Kakumiro, Buliisa, Moroto, Bulambuli, Kaabong, Buvuma and Amudat.

Table 26 shows the district performance their total scores and ranks. 66% of the districts scored above the national average of 66.2%. The detailed DLT can be seen in the Annex.

TABLE 26: DISTRICT PERFORMANCE AGAINST THE DLT

District	% Score	Rank		District	% Score	Rank
Adjumani	80.9	1		Mbarara	68.0	59
Gulu	78.5	2		Nwoya	67.9	60
Mbale	76.6	3		Arua	67.9	60
Kamwenge	76.6	3		Rubanda	67.8	62
Kiboga	76.5	5		Bundibugyo	67.6	63
Kampala	75.1	6		Abim	67.6	63
Kabale	74.6	7		Pallisa	67.2	65

District	% Score	Rank		District	% Score	Rank
Oyam	74.3	8		Kween	67.2	65
Kabarole	74.2	9		Nebbi	67.2	65
Koboko	74.0	10		Hoima	67.1	68
Nakaseke	73.9	11		Butambala	67.1	68
Bushenyi	73.9	11		Bukomansimbi	67.0	70
Moyo	73.7	13		Kiryandongo	67.0	70
Ngora	73.6	14		Ntoroko	66.8	72
Rukungiri	73.1	15		Bukwo	66.6	73
Serere	72.5	16		Masindi	66.3	74
Lyantonde	72.5	16		Sironko	66.3	74
Maracha	72.4	18		Kalungu	66.3	74
Kamuli	72.4	18		Sembabule	66.0	77
Kisoro	72.4	18		Gomba	66.0	77
Kasese	71.8	21		Omoro	65.9	79
Mitooma	71.8	21		Bugiri	65.6	80
Kyenjojo	71.7	23		Kaliro	65.6	80
Kyegegwa	71.7	23		Lamwo	65.4	82
Katakwi	71.5	25		Kiruhura	65.3	83
Kaberamaido	71.3	26		Mubende	65.2	84
Luwero	71.2	27		Kotido	65.2	84
Amuria	71.1	28		Bukedea	65.2	84
Otuke	71.1	28		Ntungamo	65.0	87
Namutumba	70.8	30		Luuka	65.0	87
Lira	70.4	31		Apac	64.8	89
Kanungu	70.3	32		Kalangala	64.7	90
Kibuku	70.2	33		Nakasongola	64.4	91
Rubirizi	70.1	34		Kitgum	64.2	92
Jinja	70.0	35		Alebtong	64.1	93
Kapchorwa	70.0	35		Rakai	63.9	94
Amuru	69.9	37		Mayuge	63.8	95
Dokolo	69.8	38		Kyankwanzi	63.7	96
Buhweju	69.8	38		Lwengo	63.6	97
Kayunga	69.6	40		Pader	63.5	98
Tororo	69.5	41		Iganga	63.0	99
Masaka	69.5	41		Amolatar	63.0	99
Kumi	69.1	43		Buikwe	63.0	99
Kole	68.9	44		Manafwa	62.6	102
Sheema	68.9	44		Namayingo	62.5	103
Soroti	68.8	46		Kagadi	62.5	103
Mityana	68.8	46		Wakiso	61.1	105
Buyende	68.6	48		Bududa	61.0	106
Isingiro	68.6	48		Budaka	61.0	106
Kibaale	68.6	48		Nakapiripirit	60.6	108

District	% Score	Rank		District	% Score	Rank
Yumbe	68.6	48		Napak	60.5	109
Mpigi	68.6	48		Kakumiro	60.4	110
Mukono	68.5	53		Buliisa	59.0	111
Agago	68.5	53		Moroto	56.0	112
Butaleja	68.3	55		Bulambuli	55.7	113
Zombo	68.2	56		Kaabong	54.6	114
Ibanda	68.2	56		Buvuma	53.0	115
Busia	68.0	58		Amudat	46.8	116
National Average					**66.2**	

2.6.1.1 Most Improved Districts

Between the FY 2015/126 and 20016/17 the districts of Koboko, Adjumani, Sironko, Otuke, and Kisoro showed the most improvement (about 10% league table points each) and the districts of Rakai, Namayingo, Kaabong, Lamwo, Iganga and Buikwe showed most decline. In a number of the districts in the latter position incomplete submission of data contributed to the decline.

The marked improvement in Koboko and Adjumani districts is likely to be attributed to the high refugee influx in the region. For example, Koboko improved from the bottom 10 in 2015/16 to the top 10.

TABLE 27: IMPROVEMENT IN THE DLT SCORE

District	2016/17	2015/16	Difference
Koboko	74.0	57.7	16.3
Adjumani	80.9	65.0	16.0
Sironko	66.3	54.2	12.1
Otuke	71.1	59.2	11.9
Kisoro	72.4	62.0	10.3

Table 28 shows the trend of individual district performance in the league table for the top 10 and the bottom 10 positions for the two years 2015/16 and 2016/17. The districts of Gulu and Kabarole have remained among the 10 ten districts for the last 2 years. Koboko district has moved from being among the bottom 10 in 2015/16 to the top 10 in 2016/17. Further analysis needs to be undertaken to explain the varied performance of most districts in the top ten.

Districts in Moroto region and the new districts tend to perform poorly. For the new district issues could be attributed to management issues.

TABLE 28: DLT TRENDS DURING THE HSDP PERIOD

DLT Position	2015/16	2016/17
Top 10	Lyantonde, Rukungiri, Mpigi, Gulu, Amuria, Lamwo, Katakwi, Serere, Kabarole and Buyende	Adjumani, Gulu, Mbale, Kamwenge, Kiboga, Kampala, Kabale, Oyam, Kabarole and Koboko
Bottom 10	Wakiso, Sembabule, Bulambuli, Kotido, Koboko, Moroto, Napak, Sironko, Amudat and Buvuma	Bududa, Budaka, Nakapiripirit, Napak, Kakumiro, Buliisa, Moroto, Bulambuli, Kaabong, Buvuma and Amudat.

In conclusion, overall there was improvement in the DLT performance and thus implied improvement in health services utilization. The 2 indicators where the districts registered worst performance were Maternal Death Audit reporting and timely submission of quarterly financial reports (OBT). This is an indication that the management function at district level needs to be strengthened to ensure timely reporting. In the area of service delivery, there is still need to support all districts in areas of MCH specifically in improving the ANC 4^{th} visit attendance, IPT_2 and IPT_3 up take. This will require more community based interventions geared at mobilizing the community to adapt early health seeking behaviors e.g. ANC attendance during the first trimester.

Factors like refugees and other public health emergencies can have a positive or negative effect on the performance indicators and therefore there is need to establish clear monitoring mechanism in such situations.

2.7 Health Facility Performance

The health facility performance was measured in terms of Standard Unit of Output (SUO)[1], and quality. The SUO is a composite measure of outputs that allows for a fair comparison of volumes of output of hospitals that have varying capacities in providing the different types of patient care services. The SUO attempts to attribute the final outputs of a hospital a relative weight based on previous cost analyses taking the outpatient contact as the standard of reference. The SUO converts all outputs to outpatient equivalents by weighting the services taking the outpatient contact as the standard reference. The basis of this parameter rests on the evidence that the cost of managing one inpatient is 15 times the cost managing one outpatient, one immunization 0.2 times more, one delivery 5 times more and one (ANC+MCH+FP) client 0.5 times the cost of managing one outpatient.

2.7.1 Performance of the National Referral Hospitals

The country has two national referral hospitals; Mulago National Referral Hospital and Butabika National Mental Referral Hospital. Butabika is a specialized hospital for mental health services. The SUO for the 2 hospitals improved to 1,768,991 in 2016/17 from 1,697,350 in 2015/16.

TABLE 29: SUO FOR NATIONAL REFERRAL HOSPITALS

Services	National RHs		Mulago NRH		Butabika NMRH	
	2015/2016	2016/2017	2015/2016	2016/2017	2015/2016	2016/2017
Admissions	88,427	94,379	85,941	87,473	2,486	6,906
Patient Days	330,645	496,725	254,544	255,747	76,101	240,978
Beds	2,115	1,943	1,343	1,343	550	550
OPD Total	219,574	266,426	164,722	194,529	54,852	71,897
Deliveries in unit	23,674	11,884	11,455	11,884	-	-
Total ANC visits	41,113	26,739	41,113	26,739	-	-
Postnatal Attendances	1,928	11,186	1,928	11,186	-	-
FP	6,588	4,842	6,409	4,723	179	119
Immunization	40,931	30,380	40,292	29,560	639	820
SUO	**1,697,350**	**1,768,991**	**1,543,649**	**1,594,126**	**92,551**	**175,957**

Source: MoH DHIS2

2.7.1.1 Efficiency of the national Referral Hospitals

The first efficiency indicator is utilization of beds, a more efficient hospital should have a high Bed Occupancy Rate (BOR), and similarly the Average Length of Stay (ALoS) should

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

be shorter for better efficiency. However, WHO defines optimum bed efficiency as 85% BOR. Table 30 shows variation across the hospitals. The average BOR decreased to 70% in 2016/17 from 82% in the previous year. Butabika hospital had BOR of 120% compared to Mulago which remained at 52%.

The ALoS for the two National referral hospitals was 5 days in 2016/17. Mulago had ALoS of 3 days whereas Butabika had ALoS of 31 days. The nature of the patients attended to at Butabika justifies the longer stay at this institution.

Maternal deaths reported in Mulago NRH declined to 78 in FY 2016/17 compared to 92 in 2015/16. Maternal death risk in Mulago improved from 803/100,000 deliveries in 2015/16 to 656/100,000 deliveries. This is still high and needs to be reduced further. Similarly, the number of fresh still births reduced to 56/1,000 deliveries in 2016/17 from 89/1,000 deliveries in 2015/16.

TABLE 30: EFFICIENCY PARAMETERS FOR NATIONAL REFERRAL HOSPITALS

Services	National RHs		Mulago NRH		Butabika NMRH	
	2015/2016	2016/2017	2015/2016	2016/2017	2015/2016	2016/2017
Admissions	88,427	94,379	85,941	87,473	2,486	6,906
Patient Days	330,645	496,725	254,544	255,747	76,101	240,978
Beds	2,115	1,943	1,343	1,343	550	550
Deliveries in unit	23,674	11,884	11,455	11,884	-	-
Caesarian Sections	519	5,265	519	5,265	0	0
Major Operation	1,027	11,634	1,027	1,1657	0	0
IPD Deaths	4,452	3,077	4393	2,984	59	93
Fresh Still births	89	56	892	567	0	0
Macerated still births	561	550	561	550	0	0
Newborn deaths	547	841	547	841	0	0
Maternal Deaths	92	78	92	78	0	0
BOR/100	82%	70%	52%	52%	38%	120%
ALoS (days)	33	5	5	3	3	31
Maternal Deaths Risk/100,000	803	656	803	656	-	-
FSB Risk/1,000	78	48	78	48	-	-

Source: MoH DHIS2

2.7.2 Regional Referral Hospital Performance

The RRHs are meant to provide specialized services for a region of approximately 2,000,000 people in additional to general services for the host districts. The budget performance of the RRHs was good for all RRHs as shown in table 31. This excludes the value of medicines supplied to these hospitals by the NMS.

TABLE 31: FINANCIAL PERFORMANCE FOR THE RRHS

Hospital	Wage (Ug. Shs. '000,000)		Nonwage (Ug. Shs. '000,000)		Development (Ug. Shs. '000,000)		Total (Ug. Shs. '000,000)		Budget performance	
	Released	Spent	Released	Spent	Released	Spent	Released	Spent	15/16	16/17
Arua	3.09	3.09	2.32	2.32	1.06	1.06	6.47	6.47	112%	100%
Fort Portal	3.55	3.55	1.54	1.41	1.06	1.06	6.15	6.02	96%	98%
Gulu	3.28	3.28	1.73	1.73	1.06	1.06	6.08	6.08	94%	100%
Hoima	4.14	4.14	1.92	1.91	1.06	1.06	7.12	7.11	90%	100%
Jinja	4.58	4.58	1.99	1.98	1.06	1.06	7.62	7.62	97%	100%
Kabale	2.72	2.72	1.70	1.65	1.06	1.06	5.48	5.43	106%	99%
Lira	2.82	2.82	1.36	1.23	3.06	3.06	7.24	7.12	98%	98%
Masaka	3.95	3.95	3.10	3.05	5.06	5.06	12.11	12.05	90%	100%
Mbale	2.79	2.79	1.49	1.44	1.06	1.06	5.34	5.29	93%	99%
Mbarara	3.23	3.23	2.19	2.00	1.06	1.06	6.48	6.28	110%	97%
Moroto	3.40	3.40	1.22	1.22	1.56	1.56	6.17	6.17	109%	100%
Mubende	3.44	3.44	1.12	1.12	1.06	1.06	5.62	5.62	91%	100%
Soroti	2.83	2.83	1.03	1.02	1.06	1.06	4.91	4.90	106%	100%
Naguru	4.25	4.25	1.03	1.02	1.06	1.06	6.33	6.33	92%	100%
Total	**48.07**	**48.07**	**23.74**	**23.1**	**21.34**	**21.34**	**93.12**	**92.49**		**98%**

The SUO of the RRHs is shown in table 32. The total SUOs from the RRHs and Large PNFP Hospitals was 9,837,521 in 2016/17 compared to 9,956,067 in 2015/16.

TABLE 32: SUO FOR THE RRHS

Services	RRHs	
	2015/2016	2016/2017
Admissions	432,064	437,833
OPD Total	2,731,170	2,510,783
Deliveries in unit	85,814	103,131
Total ANC visits	195,659	210,111
Postnatal Attendances	119,217	139,332
FP	35,487	35,362
Immunization	221,742	228,437
SUO	**9,860,730**	**9,837,521**

Source: MoH DHIS2

Mbale RRH continues to produce significantly higher SUOs than other RRHs mainly owing to the much higher number of admissions (58,387) compared to other RRHs. OPD attendance at Mbale RRH is rather lower than most of the RRHs which may imply that the lower level facilities and probably private clinics in Mbale region are functional and providing adequate PHC services to decongest the RRH. This is an area that requires further analysis.

TABLE 33: SUO PER RRH

RRH	Admissions	OPD	Deliveries	Total ANC visits	Postnatal	Total family	Immunization	SUO 2016/17	SUO 2015/16
Mbale	58,387	84,733	9,123	4,739	16,237	2,892	11,235	***1,022,283***	*1,000,426*
Masaka	32,890	265,142	9,369	14,902	3,694	2,105	15,741	***819,087***	*709,114*
Mbarara	33,484	194,244	8,787	9,792	16,498	1,451	8,759	***755,751***	*718,777*
Fort Portal	30,154	178,966	6,953	11,403	11,063	2,672	14,466	***682,422***	*692,127*
Gulu	33,951	135,678	4,176	8,886	2,520	2,136	8,436	***674,146***	*759,313*
Lacor	33,616	108,845	4,669	9,053	6,849	-	10,966	***647,148***	*646,574*
Jinja	25,381	203,401	4,987	10,597	7,554	3,345	8,806	***621,023***	*590,719*
Arua	22,939	176,466	6,902	17,673	8,323	4,376	17,114	***573,502***	*584,993*
Hoima	23,993	153,136	7,362	10,149	5,635	1,823	11,579	***561,389***	*527,436*
Soroti	25,496	132,400	3,238	4,867	3,843	2,894	8,825	***539,784***	*498,721*
Mubende	26,343	98,803	4,696	11,009	5,068	1,791	7,847	***526,983***	*544,106*
Lira	18,815	101,498	5,864	14,137	19,736	2,304	16,331	***435,056***	*531,113*
Mengo	11,810	202,936	4,994	15,290	15,789	753	17,919	***425,345***	*424,556*
Lubaga	13,666	146,365	5,152	21,280	5,717	258	26,538	***397,628***	*396,050*
Naguru	13,546	106,597	8,569	25,298	1,603	2,114	14,356	***366,728***	*387,102*
Nsambya	14,096	70,369	4,279	9,874	5,703	-	22,065	***319,063***	*315,406*
Kabale	9,643	98,893	3,199	5,586	1,239	3,532	3,982	***265,027***	*375,236*
Moroto	9,623	52,311	812	5,576	2,261	916	3,472	***205,156***	*254,298*
Total	**437,833**	**2,510,783**	**103,131**	**210,111**	**139,332**	**35,362**	**228,437**	**9,837,521**	*9,956,067*

Source: MoH DHIS2

2.7.2.1 Efficiency of the RRHs

Table 34 shows variation across RRHs. The average BOR is 105%, the lowest is 59% at Kabale and highest is 383% at Lira RRH. There is need to investigate the very high BOR at Lira RRH (there is a possibility of this being a data quality issue i.e. over reporting). Hospitals with BOR between 80% and 90% are considered optimally operating while those below that or above that need to make corrective actions to attain optimum state.

The ALoS is similarly higher in Lira RRH at 29.7% which further points to data quality issues and lowest at Mbale and Mubende RRH at 2.4 days.

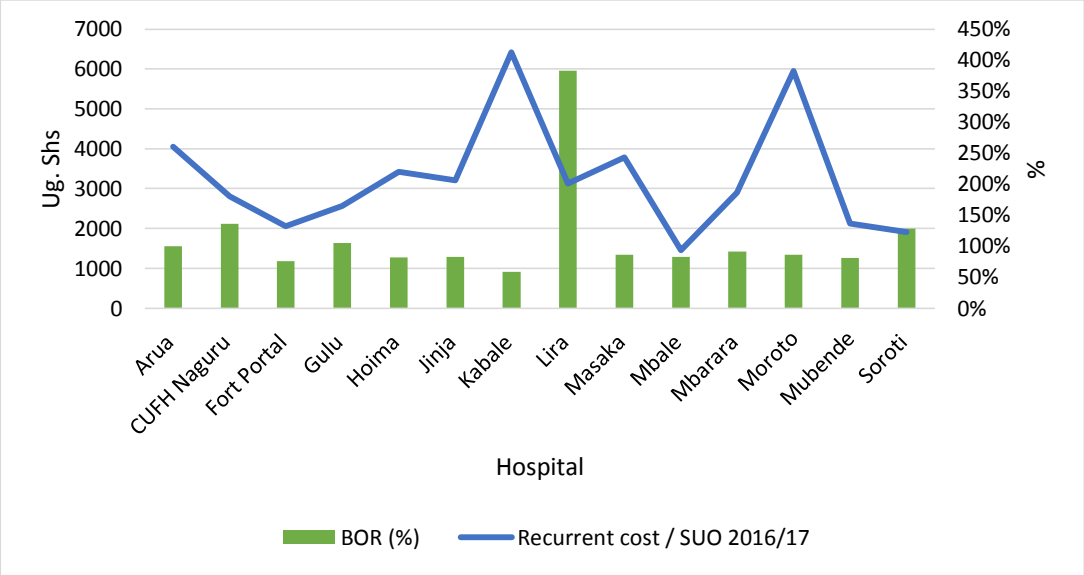
The recurrent cost per SUO and the recurrent cost per bed are shown in the table 34 and figure 17. The average recurrent cost per SUO is Ug Shs. 2,932 otherwise explained as – 1 outpatient equivalent takes Ug Shs. 2,932 to produce. The minimum recurrent cost per SUO was shown by Mbale hospital (Ug Shs. 1,458) and the maximum Ug Shs. 6,414 shown by Kabale hospital. The average recurrent cost per bed per year is Ug Shs. 5,335,745. The minimum was Ug Shs. 3,274,725 shown by Mbale hospital and the maximum is Ug. Shs. 10,300,000 at CUFH Naguru hospital.

TABLE 34: EFFICIENCY PARAMETERS FOR RRHS AND LARGE PNFP HOSPITALS IN 2016/17

RRH	Beds	In Patient Days	SUO	BOR (%)	ALOS (Days)	Recurrent Cost (PHC Non-Wage) 2016/17	Recurrent Costs per SUO 2015/16	Recurrent cost / Bed 2016/17	Recurrent cost / SUO 2016/17
Arua	278	101,067	573,502	100	4.4	2,320,000,000	4,045	8,345,324	4,045
CUFH Naguru	100	49,633	366,728	136	3.7	1,030,000,000	2,809	10,300,000	2,809
Fort Portal	384	107,178	682,422	76	3.6	1,400,000,000	2,052	3,645,833	2,052
Gulu	350	133,627	674,146	105	3.9	1,730,000,000	2,566	4,942,857	2,566
Hoima	310	92,999	561,389	82	3.9	1,920,000,000	3,420	6,193,548	3,420
Jinja	467	140,649	621,023	83	5.5	1,990,000,000	3,545	4,261,242	3,204
Kabale	246	52,774	265,027	59	5.5	1,700,000,000	6,414	6,910,569	6,414
Lira	400	559,401	435,056	383	29.7	1,360,000,000	3,126	3,400,000	3,126
Masaka	330	103,816	819,087	86	3.2	3,100,000,000	3,785	9,393,939	3,785
Mbale	455	137,439	1,022,283	83	2.4	1,490,000,000	1,458	3,274,725	1,458
Mbarara	452	150,124	755,751	91	4.5	2,190,000,000	2,898	4,845,133	2,898
Moroto	172	54,286	205,156	86	5.6	1,220,000,000	5,947	7,093,023	5,947
Mubende	212	62,957	526,983	81	2.4	1,120,000,000	2,125	5,283,019	2,125
Soroti	267	124,256	539,784	128	4.9	1,030,000,000	1,908	3,857,678	1,908
Total	**4,423**	**1,870,206**	**8,048,338**			**23,600,000,000**			
Average	***590***	***133,586***	***574,881***	**105**	**5.0**	***1,685,714,286***		**5,335,745**	***2,932.28***

Source: MoH HMIS and Hospital Financial Reports

FIGURE 17: RECURRENT COST / SUO AND BED OCCUPANCY RATE IN RRHS



2.7.2.2 Quality Parameters at the RRHs

The average Caesarean Section (C/S) rate in the RRH was 28% in 2016/17 FY. Soroti RRH and Nsambya hospital had a C/S rate of 48%, Lubaga 38% and Mengo 37%. The lowest C/S rate was in Masaka RRH at 7% far below the expected 15%.

Maternal Mortality continued to be a major challenge in RRHs. The facility based MMR for RRHs in FY 2016/17 was 350 per 100,000 hospital deliveries compared to 343.2 per 100,000

in 2015/16. Fort Portal, Hoima and Soroti RRHs had the highest MMR of 719, 693 and 618 per 100,000 respectively while Gulu and Kabale had the lowest MMR of 48 and 63 per 100,000 respectively.

Fresh Stillbirths at RRHs also continued to be a major challenge with the highest of 35/1,000 deliveries in Hoima RRH followed by Mubende at 34/1,000, then Mbale and Jinja RRHs at 27/1,000 hospital deliveries. Lubaga and Gulu RRH had the lowest FSB rate at 7/1,000.

TABLE 35: QUALITY OF CARE PARAMETERS FOR RRHS AND LARGE PNFP HOSPITALS 2016/17

Hospital	Beds	Caesarian Sections	Major Surgery	Deaths	Fresh Still births	Maternal deaths	Macerated still births	Newborn deaths	C/S Rate	Maternal Death Risk/100000	FSB Risk/1000
Arua	278	1,959	3,490	1,161	138	20	213	1	28%	290	20
Fort Portal	384	1,947	3,603	1,232	152	50	147	90	28%	719	22
Gulu	350	653	2,160	454	31	2	59	5	16%	48	7
Hoima	310	2,329	3,747	820	256	51	134	48	32%	693	35
Jinja	467	1,698	3,489	1,133	133	13	133	99	34%	261	27
Kabale	246	830	1,228	211	42	2	38	45	26%	63	13
Lacor	482	1,273	4,253	994	62	16	71	-	27%	343	13
Lira	400	1,213	2,170	757	130	13	101	27	21%	222	22
Lubaga	236	1,975	3,061	371	35	18	51	107	38%	349	7
Masaka	330	657	970	2,136	95	45	167	190	7%	480	10
Mbale	455	2,429	5,292	1,501	249	29	170	71	27%	318	27
Mbarara	452	3,122	6,543	1,506	189	24	122	32	36%	273	22
Mengo	260	1,872	5,702	221	41	9	70	38	37%	180	8
Moroto	172	186	330	186	11	5	13	20	23%	616	14
Mubende	212	1,264	2,241	629	158	27	146	178	27%	575	34
Naguru	100	1,851	2,860	290	104	10	121	58	22%	117	12
Nsambya	279	2,033	4,622	445	45	7	41	27	48%	164	11
Soroti	267	1,554	4,378	755	68	20	49	21	48%	618	21
Total	**5,680**	**28,845**	**60,139**	**14,802**	**1,939**	**361**	**1,846**	**1,057**		**350**	**19**
Average	***316***	***1,603***	***3,341***	***822***	***108***	***20***	***103***	***59***	***28%***	***351***	***18***
Minimum	***100***	***186***	***330***	***186***	***11***	***2***	***13***	***-***	***7%***	***48***	***7***
Maximum	***482***	***3,122***	***6,543***	***2,136***	***256***	***51***	***213***	***190***	***48%***	***719***	***35***

Source: MoH DHIS2

2.7.3 General Hospital Performance

Information that is analyzed under general hospital performance was for the 114 public, PNFP and PHP hospitals that report regularly through the MoH in DHIS2. The 4 PNFP large volume hospitals (Lubaga, Mengo, Nsambya and Lacor) have been excluded as they have been analyzed with RRHs.

The total SUO from General Hospitals in FY 2016/17 declined from 17,692,056 in FY 2015/16 to 17,418,297.

TABLE 36: SUO FOR HOSPITALS

Services	General Hospital	
	2015/2016	2016/2017
Admissions	804,850	797,216
OPD Total	4,180,522	3,882,611
Deliveries in unit	204,702	194,111
Total ANC visits	445,389	461,640
Postnatal Attendances	214,728	286,694
FP visits	118,183	132,495
Immunization	640,203	609,936
SUO	**17,793,973**	**17,418,297**

Source: MoH DHIS2

Iganga Hospital had the highest SUO 580,406 followed by Kitgum Hospital with 390,879. The lowest ranked hospitals are predominantly private hospitals with no or irregular reporting through the national system. The detailed performance of each of the regularly reporting general hospitals is shown in the Annex.

TABLE 37: TOP 10 PERFORMING GENERAL HOSPITAL USING THE SUO PARAMETERS IN 2016/17

	Hospital	Admissions	OPD Total	Deliveries	Total ANC visits	Postnatal Attendances	Family planning	Immunization	SUO
1.	Iganga	23,560	178,146	6,928	12,942	8,326	2,139	12,799	**580,406**
2.	Kitgum	19,809	73,004	2,701	4,998	5,899	716	5,856	**390,879**
3.	Mityana	16,984	87,112	6,486	11,749	3,725	3,310	9,992	**385,165**
4.	Kalongo Ambrosoli Memorial	20,446	32,373	3,453	5,883	3,330	1,609	5,479	**362,714**
5.	Apac	12,875	117,540	2,144	8,220	1,823	452	6,839	**327,586**
6.	Tororo	13,910	70,462	7,002	8,790	8,545	480	9,177	**324,981**
7.	Kamuli	15,152	74,654	2,294	7,890	7,458	3,424	8,976	**324,911**
8.	Kagando	17,980	26,941	2,428	6,377	2,776	2,240	6,825	**315,977**
9.	Kawolo	13,229	82,146	4,117	10,797	9,197	3,144	9,114	**314,053**
10.	KIU Teaching	16,997	31,139	2,499	6,196	7,588	1,038	3,929	**306,106**

Source: MoH DHIS2

2.7.3.1 Quality Parameters at the General Hospitals

The number of C/S in general hospitals declined for 52,552 in 2015/16 to 48,695 and similarly the number of major operations declined from 92,087 to 87,274. Inpatient deaths declined to 14,331 in 2016/17 from 24,657 in 2015/16.

The average C/S rate in the general hospitals was 25% in 2016/17 FY. Gulu Independent Hospital had the highest C/S rate of 76% which needs to be verified, followed by Mbarara Community hospital at 62%, Nakasero Hospital at 59%, Mayanja Memorial at 57% and Bethany Women & Family Hospital at 55%.

TABLE 38: 20 GENERAL HOSPITALS WITH THE HIGHEST C/S RATE IN 2016/17

Hospital	No. of Deliveries	No. of C/S	C/S Rate
Gulu Independent	21	16	76%
Mbarara Community	366	227	62%
Nakasero	1,465	868	59%
Mayanja Memorial	1,809	1,027	57%
Bethany Women and Family	185	102	55%
Virika	973	503	52%
Ruharo Mission	736	379	51%
Rushere Community	514	248	48%
Buluba	1,264	603	48%
St. Karoli Lwanga Nyakibale	1,663	781	47%
Kagando	2,428	1,129	46%
Kuluva	1,139	524	46%
Nyapea	1,292	591	46%
St. Joseph Kitovu	1,755	794	45%
Villa Maria	1,070	479	45%
Ngora Ngo	405	180	44%
Mount Elgon	196	83	42%
Comboni	1,280	532	42%
Amai Community	229	95	41%
Ibanda	2,142	886	41%
Ishaka Adventist	1,446	591	41%

Source: MoH DHIS2

TABLE 39: QUALITY INDICATORS FOR THE GENERAL HOSPITALS IN 2016/17

Services	General Hospital	
	2015/2016	2016/2017
Caesarian Sections	52,552	48,695
Major Operation	92,087	87,274
IPD Deaths	24,657	14,331
Fresh Still births	3,303	3,027
Macerated still births	3,147	3,131
Newborn deaths	3,718	2,548
Maternal deaths	391	412
C/S Rate	-	25%
Fresh still birth risk / 1,000	-	16
Maternal Deaths risk per 100,000	212	198

Source: MoH DHIS2

Maternal Mortality continued to be a major challenge in the general hospitals as well. The hospital based maternal mortality risk for general hospitals in FY 2016/17 declined to 198 per 100,000 hospital deliveries compared to 212 per 100,000 hospital deliveries in 2015/16. Dabani hospital had the highest maternal mortality risk at 1,442 per 100,000 deliveries, followed by Masafu GH at 840/100,000, Aber hospital 755/100,000 and Maracha 737/100,000. See Annex for each hospital details.

TABLE 40: FACILITY BASED MATERNAL MORTALITY RATIO FOR GHS IN 2016/17 FY

Hospital	Deliveries	Maternal Deaths	Maternal Mortality Risk per 100,000
Dabani	624	9	1,442
Masafu	1,786	15	840
Aber	2,253	17	755
Maracha	1,085	8	737
Kabarole	704	5	710
Angal St. Luke	2,453	17	693
St. Joseph Kitovu	1,755	12	684
Nyapea	1,292	8	619
Ibanda	2,142	13	607
Villa Maria	1,070	6	561

Source: MoH DHIS2

The fresh still birth rate for general hospitals was 16 per 1,000 hospital deliveries. Amai Hospital and Buluba hospital reported the highest fresh still birth rates of 61/1,000 and 55/1,000 respectively.

TABLE 41: 10 GENERAL HOSPITALS WITH THE HIGHEST FSB RATE 2016/17

Hospital	Deliveries	Fresh Still Births	Fresh Still Birth rate / 1,000 deliveries
Amai Community	229	14	61
Buluba	1,264	69	55
Kamuli Mission	2,080	105	50
Dabani	624	30	48
Gulu Independent	21	1	48
Bamu	389	18	46
Maracha	1,085	42	39
St. Joseph Kitovu	1,755	66	38
Kuluva	1,139	37	32
Villa Maria	1,070	34	32

Source: MoH DHIS2

13 general hospitals reported BOR above 100%, with Apac Hospital reporting the highest BOR of 178%. Some general hospital had high ALoS notably Kagando Hospital, St. Joseph's Kitgum, Kuluva and Murchison Bay with ALoS of 7 days which far above the target of 3 days.

TABLE 42: HOSPITALS WITH HIGH BOR

	Hospital	BOR
1.	Apac	178%
2.	Iganga	171%
3.	Kagando	164%
4.	Kaabong	155%
5.	Nakaseke	133%
6.	Kitgum	121%
7.	Mityana	115%
8.	Kiryandongo	115%
9.	Kagadi	114%
10.	Kapchorwa	112%
11.	Kalongo Ambrosoli Memorial	104%
12.	Masafu	103%
13.	Bwera	102%

Source: MoH DHIS2

2.7.4 Health Centre IV Performance

The HC IV serves as the first referral facility providing comprehensive obstetric and newborn care services in Health Sub-Districts (HSDs) where there is no Hospital. HSDs on average cover a population of 100,000 people. The main objective of the HSD concept was to reduce maternal and perinatal mortality by increasing access to comprehensive obstetric and newborn care services. Of the 206 recognized public and private health facilities at HC IV level in the country 186 were analyzed based on the HMIS report 108. In 2016/17 FY 70.4% (131/186) of the reporting HC IVs carried out C/S an increase from 63% in 2015/16. A total of 83 out of 186 (44.6%) HC IVs carried out C/S and offered blood transfusion during FY 2016/17 and are thus considered to have been providing CEmONC services. 88 out of 186 (47.3%) HC IVs provided blood transfusion services rising from 41% in FY 2015/16.

FIGURE 18: TRENDS IN HC IVS PERFORMING C/S AND BLOOD TRANSFUSION

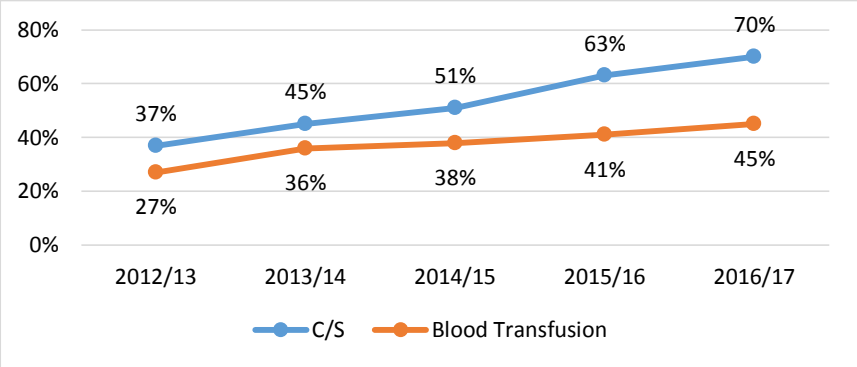


TABLE 43: HC IVS PERFORMING C/S IN 2016/17

Health Facility	No. C/S	%
1. Mukono T.C.	1,414	9.43%
2. Rwekubo	795	5.30%
3. Rukunyu	715	4.77%
4. St. Paul	553	3.69%
5. Mukono CoU	502	3.35%
6. Mpigi	489	3.26%
7. Bishop Asili Ceaser	355	2.37%
8. Kakindo	322	2.15%
9. Serere	297	1.98%
10. Kyegegwa	274	1.83%
11. St. Ambrose Charity	272	1.81%
12. Amuria	267	1.78%
13. Rugazi	255	1.70%
14. Kibiito	246	1.64%
15. Kabuyanda	235	1.57%
16. Kyabugimbi	235	1.57%
17. Rwesande	219	1.46%
18. PAG Mission	214	1.43%

Health Facility	No. C/S	%
67. St. Franciscan	68	0.45%
68. Shuuku	66	0.44%
69. Bukulula	58	0.39%
70. Dokolo	56	0.37%
71. Busiu	52	0.35%
72. Nsiika	52	0.35%
73. Buyinja	51	0.34%
74. Wakiso	50	0.33%
75. Butebo	46	0.31%
76. Kangulumira	46	0.31%
77. Kigandalo	45	0.30%
78. Apapai	44	0.29%
79. Bugangari	42	0.28%
80. Kihiihi	41	0.27%
81. Nakasongola	41	0.27%
82. Ruhoko	41	0.27%
83. Buwasa	40	0.27%
84. Kiruhura	40	0.27%

Health Facility	No. C/S	%
19. Busaru	212	1.41%
20. Kassanda	202	1.35%
21. Kakumiro	198	1.32%
22. Kabwohe	194	1.29%
23. Kiganda	183	1.22%
24. Luwero	183	1.22%
25. Bishop Masereka Ch. Found.	180	1.20%
26. Kibaale	169	1.13%
27. Benedict Medical centre	166	1.11%
28. Azur	162	1.08%
29. Namwendwa	159	1.06%
30. Magale	157	1.05%
31. Buwenge	155	1.03%
32. Anyeke	147	0.98%
33. Budadiri	143	0.95%
34. Kakuuto	134	0.89%
35. Nyahuka	133	0.89%
36. Budaka	132	0.88%
37. Namayumba	129	0.86%
38. Mungula	114	0.76%
39. Ntara	114	0.76%
40. Ishongororo	112	0.75%
41. Kasangati	112	0.75%
42. Ssembabule	112	0.75%
43. Mitooma	110	0.73%
44. Aduku	108	0.72%
45. Aboke	106	0.71%
46. Bukuku	106	0.71%
47. Muyembe	105	0.70%
48. Bwijanga	104	0.69%
49. Busia	102	0.68%
50. Bufumbo	101	0.67%
51. Budondo	92	0.61%
52. Tokora	92	0.61%
53. St. Joseph Kyamulibwa	90	0.60%
54. Bumanya	87	0.58%
55. Rubaare	87	0.58%
56. Kaberamaido	84	0.56%
57. Rwashamaire	83	0.55%
58. Ntwetwe	80	0.53%
59. Adumi	77	0.51%

Health Facility	No. C/S	%
85. Nabilatuk	37	0.25%
86. Kapelebyong	34	0.23%
87. Amolatar	33	0.22%
88. Kazo	32	0.21%
89. Kebisoni	30	0.20%
90. Butenga	28	0.19%
91. Buwambo	28	0.19%
92. Namatala	25	0.17%
93. Kinoni	24	0.16%
94. Bugobero	22	0.15%
95. Kibuku	22	0.15%
96. Pakwach	21	0.14%
97. Kojja	20	0.13%
98. Bukomero	16	0.11%
99. Bukwa	16	0.11%
100. Kiwangala	16	0.11%
101. Obongi	16	0.11%
102. Kiyumba	15	0.10%
103. Padibe	15	0.10%
104. Kalagala	14	0.09%
105. Chahafi	13	0.09%
106. Karenga	13	0.09%
107. Ogur	13	0.09%
108. Pajule	13	0.09%
109. Karugutu	12	0.08%
110. Rubuguri	12	0.08%
111. Kidera	10	0.07%
112. Buhunga	9	0.06%
113. Kyannamukaaka	9	0.06%
114. Lalogi	9	0.06%
115. Ndejje	8	0.05%
116. Semuto	8	0.05%
117. Ngora Gvt	6	0.04%
118. Nyimbwa	6	0.04%
119. Omugo	6	0.04%
120. Atirir	5	0.03%
121. Princes Diana	5	0.03%
122. Alebtong	4	0.03%
123. Ayira Health Services	4	0.03%
124. Nankoma	3	0.02%
125. Kyantungo	2	0.01%

Health Facility	No. C/S	%
60. Wagagai	74	0.49%
61. Kyarusozi	73	0.49%
62. Busesa	72	0.48%
63. Kalangala	71	0.47%
64. Kotido	71	0.47%
65. North Kigezi	70	0.47%
66. Bwizibwera	68	0.45%

Health Facility	No. C/S	%
126. Midigo	2	0.01%
127. Bugamba	1	0.01%
128. Kikyo	1	0.01%
129. Kitwe	1	0.01%
130. Kiyunga	1	0.01%
131. Rubaya	1	0.01%
Total	**14,994**	**100%**

Source: MoH DHIS2

The detailed outputs and outcomes from HC IVs are provided in the Annex. HC IVs generated a total of 14, 432, 943 in FY 2016/17 compared to 13,780,782 SUOs in 2015/16. Mukono T.C HC IV had the highest number of admissions and immunizations conducted. Kisenyi had the highest OPD attendances, deliveries, ANC and postnatal care attendances. The highest family planning visits were at Wakiso HC IV.

TABLE 44: SHOWING THE AVERAGE, LOWEST AND HIGHEST NUMBER OF SERVICES PROVIDED AND SUO FOR HC IVS

HC IV	Admissions	Patient Days	OPD	Deliveries	Total ANC	Postnatal	Total family planning	Immunization	SUO
Average	3,158	7,580	22,369	981	3,796	1,645	1,366	4,621	78,440
Lowest	104	46	3,479	2	65	7	-	73	8,151.5
Highest	9,842	46,102	130,836	10,585	36,376	16,296	52,534	39,591	350,570
Total 2016/17	**571,653**	**1,371,999**	**4,115,947**	**180,514**	**698,426**	**301,039**	**248,616**	**850,236**	**14,432,943**
Total 2015/16	***526,206***	***1,294,582***	***4,274,028***	***170,670***	***662,512***	***232,474***	***240,838***	***856,086***	***13,759,597***

In FY 2016/17 Kisenyi HC IV had the highest SUO for HC IV level with 350,570 SOU followed by Mukono Town Council H C IV with 247,355 SUO. The detailed performance for each HC IV is shown in the Annex.

TABLE 45: TOP 10 PERFORMING HC IVS USING THE SUO PARAMETERS IN 2016/17

	HC IV	Admissions	Patient Days	OPD	Deliveries	Total ANC	Postnatal	Total family planning	Immunization	SUO
1.	Kisenyi	9,431	12,268	130,836	10,585	36,376	16,296	4,946	14,895	350,570
2.	Mukono T.C.	9,842	19,650	37,917	7,245	18,362	2,113	2,118	39,591	247,355
3.	Kumi	7,631	14,562	58,965	898	3,449	3,893	5,440	7,683	187,118
4.	Busia	7,867	13,171	45,208	2,410	10,715	1,437	2,829	10,848	184,963
5.	Anyeke	7,803	21,176	51,680	1,058	2,857	559	1,496	2,883	177,055
6.	Luwero	6,908	12,412	45,035	2,578	11,551	376	998	9,247	169,166
7.	Serere	7,915	24,553	28,869	1,784	4,584	4,256	870	4,927	162,457
8.	Amuria	7,661	25,014	29,350	1,899	2,755	2,793	696	3,914	158,013
9.	Rukunyu	7,525	19,821	22,043	2,025	2,997	4,108	1,134	5,554	151,040
10.	Mpigi	6,348	10,857	34,643	2,566	8,365	1,696	1,322	9,049	150,400

The bottom 10 HC IVs using the SUO parameters in 2016/17 are, Bushenyi, Bukasa, Kamukira, Mbarara Municipal Council, Bukwa, Nyamirami, St. Franciscan, Kataraka, Ntuusi and Hiima. Hiima HC IV conducted only 2 deliveries and 73 immunizations in the entire year. Kamukira and Mbarara Municipal Council HC IV do not provide inpatient services and

TABLE 46: BOTTOM 10 HC IVS USING THE SUO PARAMETERS FY 2016/17

HC IV	Admissions	Patient Days	OPD	Deliveries	Total ANC	Postnatal	Total family planning	Immunization	SUO
Bushenyi	257	423	20,383	203	2,048	672	741	1,611	27,175
Bukasa	383	765	18,191	157	1,091	511	428	2,106	26,462
Kamukira			22,947	172	1,655	934	2,060	1,433	26,352
Mbarara Municipal Council			14,492	525	6,714	7,866	897	5,500	25,591
Bukwa	1,035	2,666	4,783	144	883	1,270	315	2,400	23,197
Nyamirami	643	458	10,004	222	1,117	358	481	1,902	22,353
St. Franciscan	866	1,657	4,936	179	339	532	-	950	19,630
Kataraka	104	46	15,171	112	1,370	411	855	1,356	18,876
Ntuusi	339	417	10,171	243	2,650	384	731	1,934	18,526
Hiima	115	222	6,255	2	65	7	217	73	8,152

Source: MoH DHIS2

15 HC IVs had a BOR above 100% and may require expansion given that their average length of stay was 3 days. PAG mission HC IV had an ALoS of 7 days which may need to be explored further.

3 Annexes

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

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

3.1.1 Health promotion, disease prevention, and community health initiatives

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

3.1.2 Environmental Health

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

The LGs received two conditional grants from treasury for water and sanitation i.e. the District Water and Sanitation Development Conditional Grant (DWSDCG) plus the District Hygiene and Sanitation Conditional Grant (DHSCG). Ug Shs. 1.43 billion of the DWSDCG was used to construct public sanitation facilities at markets and rural growth centres. Ug Shs. 2 billion was disbursed to 91 districts under the DHSCG, with each district receiving approximately Ug Shs. 23 million.

Most districts worked on creating demand for improved sanitation, working in two sub-counties using either Community Led Total Sanitation (CLTS) or Home Improvement Campaigns (HIC) as approach. The use of CLTS has increased over time, with more than 90% of the districts that receive the DHSCG implementing CLTS in the FY 2016/17, while the rest used HIC; all approaches have open defecation free (ODF) villages as the ultimate outcome.

3.1.2.1 Key programme performance indicators/ targets against HSDP M&E framework

The USF program supports hygiene and sanitation promotion in 30 districts using the CLTS Approach. During the FY 2016/17, 612 villages were triggered. For this reporting period, 910 villages achieved ODF status. There was a significant increase in the number of villages declared ODF (82%) largely as a result of improved understanding of the ODF verification process resulting from the training on ODF verification.

The use of Follow up Mandona method of monitoring triggered villages has enabled many villages to achieve Open Defecation Free status.

The achievements on hand washing facilities and households hand washing with soap now stands at 77% and 96% respectively of the 6 year targets. 42,132 new hand washing facilities were constructed.

TABLE 47: STATUS OF MONITORED INDICATORS

Indicator	2015/16	FY 2016/17		Cumulative Total Achieved	6 Year Target	Achieved (%) against 6 year targets
	Achieved	Target	Achieved			
Villages triggered	7,560	317	612	8,172	7,577	108
Villages declared ODF	5,311	2,779	910	6,221	7,577	82
People living in ODF areas	3,414,000	1,443,800	539,400	3,953,400	4,550,000	87
New latrines constructed	293,104	29,022	15,218	308,322	319,223	97
Additional Population using latrines	1,491,205	119,423	75,090	1,566,295	1,596,113	98
New hand washing facilities	508,471	267,313	42,132	550,603	715,030	77
Households hand washing with soap	581,541	233,162	103,376	684,917	715,030	96
Latrine coverage (%)	95%	100%	96%	96%	100%	96%

At national level, Ministry of Water and Environment implemented sanitation promotion for the communities that benefited from new water supply systems. These included communities using the Nyarwodho Gravity Flow Scheme (GFS), solar-powered mini piped water systems, Lirima GFS, Bukwo GFS, and Bududa GFS. Furthermore, construction of 120 institutional and 24 public climate-resilient sanitation facilities is ongoing (40% completion) in the districts of Bukedea, Kumi, Pallisa, Soroti, Butaleja, and Budaka.

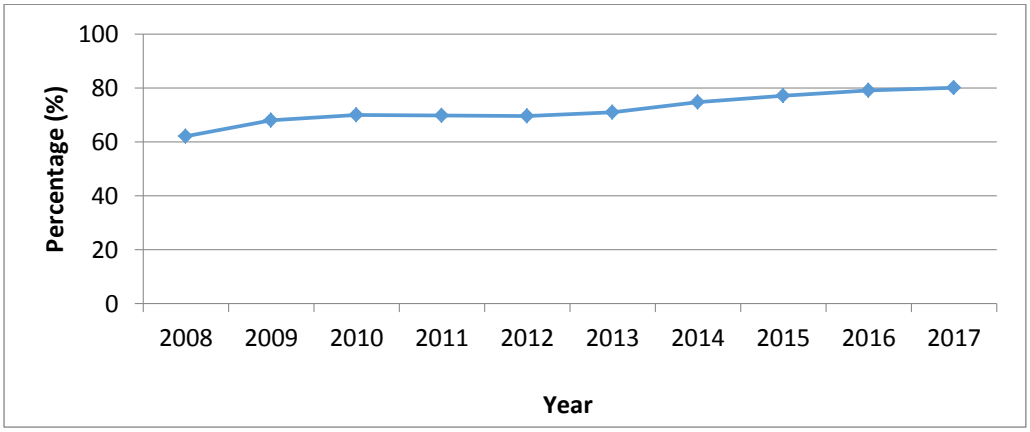
The program also managed to achieve the targets on new latrines constructed and the additional population using latrines as indicated in table 47 (97% and 96% respectively). In the USF program area 15,218 new latrines were constructed and an additional 539,400 people are now living in ODF environment.

Golden Indicator No 4: Access to Household Sanitation

The golden indicator for rural sanitation is "the percentage of people with access to improved sanitation". In the FY 2016/17, access to rural sanitation, according to district reports was 80% an increase of 1 percentage point from last year's coverage. Figure 20 below shows the national latrine coverage trend over a 10-year period (2008 - 2017).

During FY 2016/17, an estimated 307,416 new toilets were built with an additional 965,670 people gaining access to household toilets. The sector leveraged an estimated Ug Shs. 46 billion from households building their own toilets.

FIGURE 19: SANITATION COVERAGE TRENDS OVER A 10-YEAR PERIOD



The National Housing and Population Census (2014) estimates that 10% of the rural population lack access to a toilet facility, while 58% use unimproved toilets. The variation between the access figures is attributed to a difference in definition which should be harmonized especially now that the sector needs to set a baseline for the SDG agenda.

The quality of facilities needs to be addressed urgently if Uganda is to meet the sanitation SDG targets. This calls for enforcement of the appropriate standards for both household and institutional sanitation while giving adequate attention to the entire sanitation service chain including fecal sludge management. Approaches like CLTS that do not prescribe technologies should be reinforced with aggressive sanitation marketing to avail quality sanitation goods and services at affordable prices as nearby as possible.

Golden Indicator No 4: Pupil to Latrine/Stance Ratio in Schools

School sanitation is measured on the basis of "pupil to stance ratio". The national standards recommend a pupil to stance ratio of 40:1 (pupil: stance). This year, the pupil: stance ratio has increased to 71:1 from 70:1 in FY 2015/16 meaning that pupils have to queue for longer in order to access a toilet facility at any given time. Out of the 111 districts (excluding Kampala) only 4 districts meet the national school sanitation standards.

Access to hand washing in schools has continued to be low with only 35% of the schools having hand washing facilities, which puts the lives of the pupils at risk of suffering from faecal related diseases leading to absenteeism.

Golden Indicator No 8: Hand Washing

The golden indicator on hand washing is "percentage of people with access to hand washing facilities". The access to hand washing in rural areas is estimated to be 37%, indicating a 1% increase from FY 2015/16. According to the NSDS, 2015; only 7% had hand washing facilities with both soap and water. This implies there is an increase by 30% since the hand washing campaign was launched in 2007.

Only 20 districts reported to have access to hand washing rate of over 50%, up from the 18 districts that reported the previous FY. This figure is not even representative of the actual practice of washing hands after using the toilet which is estimated to be lower.

Hon. Minister of Health and Executive Director of WSSCC with GSF & USF staff on a mission visit in Lira District, Dec 2016.

3.1.3 Health Promotion and Education

Achievements

- There is notably increased community awareness and demand for health services like immunization
- Increased political will by leaders at various level: RDC, LC 5 Chairpersons and Religious leaders
- Constant engagement of political and civic leadership to lobby for support to health promotion programmes.
- With support from UNICEF, have aired many radio spot messages on selected media stations country wide covering different health areas.
- 10 radios spot messages produced on: Family planning. Malaria prevention and control, Breastfeeding, Adolescent health, measles, polio, HPV and ANC on 30 radio stations country wide.
- Social mobilization using film vans carried out to increase community awareness in 102 districts on Meningitis, Malaria, Hepatitis B, SMC, Trachoma, HIV, HCT, Viral load, PMTCT, Fistula, Bilharzia & IRS.
- Carried out technical review of IEC materials on Immunization, family planning, EMTCT, Bio Mass smoke, Eye health and ANC.
- Distributed materials on Yellow Fever, Cholera, measles, HPV, ANC, Eye care and health promotion hand books in 30 districts of eastern, western and central region.
- Held 10 regional orientation meetings for DHOs, DHEs, DEOs & CDOs on HPV social mobilization which covered all the 112 districts.

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

Innovations

- ❖ Development of the National Umbrella Strategy for Health Promotion/ Social Behavior Change Communication for the sector is ongoing.

3.1.4 Maternal and Child Health

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

3.1.4.1 Sexual and Reproductive Health and Rights

The sexual and reproductive health rights interventions are aimed at reducing maternal mortality, perinatal mortality, and total fertility rate, and improving sexual and reproductive health of the people which are all key elements for achieving the SDG 3.

- Conducted integrated technical Sexual Reproductive Health Review (SRHR) meetings on Integration of SRHR into HIV interventions.
- 6 general hospitals received On-job Mentoring on RH indicators and its data management.
- Conduct technical spot checks on MPDR and support supervision in the districts of Kotido, Kaabong, Moroto, Oyam, Mubende, Kanungu, Katakwi and Yumbe.
- Technical supervision was conducted in 3 districts of Adjumani, Moyo, and Yumbe. Four health facilities were visited in each district.
- Twelve (12) health workers were mentored in FP in 4 facilities. Visited in districts of eastern region (Bududa, Kibuku, Bukedea and Kaberamaido).
- Hands-on skills building implemented in the 4 districts of Soroti, Gulu Iganga and Pader. The Gap areas of focus included Long Term PF, Goal-oriented ANC, Use of Partographs, AMTSL, EmONC, PAC, MPDR, etc.

- Conduct training of 129 health workers on BEmONC/PAC service provision based on Human Rights approach in 25 UNFPA supported districts.
- Mentorship tool inclusive of ASRH / HIV and a framework for mentorship has been developed.
- The safe Motherhood day was well commemorated on 17th October 2016, in Mukono District, with the minister as Guest of Honor.
- 78 midwives have been fully recruited and salaries paid directly through the MoH. On-job mentorship and training conduct for the recruited Midwives by AOGU.
- 110 health care service providers from 22 districts trained on clinical management of GBV
- MPDR Guidelines reviewed.
- Quality of care Improvement Standards for MNCH for Uganda developed.

3.1.4.2 Newborn and Integrated Child Survival and Development

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

a) Newborn Health Care
b) Infant and Young Child Feeding
c) Prevention of Malaria
d) Management of Common Childhood Illness
e) Immunization
f) Early Diagnosis and Treatment of HIV
g) Elimination of Mother to Child Transmission
h) Provision of Safe Water and Sanitation facilities
i) Early Childhood and Adolescent Development

These interventions are delivered through family and community, population oriented and individually oriented clinical services with a focus on five strategic shifts: focusing on increasing access of high impact interventions, high mortality and high burden populations or geographical sites, multi-sectoral approach and mutual accountability.

The major child health interventions undertaken during the FY included;

a) Accelerated implementation of sharpened plan for maternal, newborn and child health including improving antenatal and postnatal care by providing comprehensive services, improving malaria prevention and management, essential newborn care

training and integrated community case management of common childhood illnesses, providing early infant HIV testing and counseling and Nutritional supplements.

b) The child Days strategy to provide supplementary packages in October and April each year continued and countrywide the proportion of children covered was 79% and 85% in October and April respectively. This low coverage is attributed to increased district focus on outreaches and revamping the EPI program in the country.

c) Intensification of community child health activities through the VHT and other structures, including Integrated Community Case Management (ICCM) in 75 districts and recently a newer focus on community TB and HIV activities.

d) Dissemination of quality newborn and child health service standards including regular facility based assessments.

e) Training of health workers in newborn resuscitation in order to improve newborn health and survival has continued and a total of 2,350 health workers were trained bringing the percentage of health workers trained to 39% within the last two years.

f) The nutrition program has also been scaled up with the aim of preventing severe macro and micro nutrition.

3.1.5 Control of Diarrhoeal Diseases

To promote and coordinate priority interventions for prevention and control of diarrheal diseases of epidemic potential (cholera and dysentery) in Uganda to the level where they are no longer of public health importance.

The number of districts reporting cholera outbreaks reduced from 26 districts during 2015/2016 to 4 districts in 2016/2017. Affected districts were mainly along the country borders, fishing communities and those hosting Sudanese refugees. The outbreaks were a results of cross border infections, inadequate access to social services due congestion in the refugee camps and lack of access to safe water and sanitation services.

- All districts (Adjumani, Yumbe, Buliisa, Amuru) reporting cholera outbreaks were supported and outbreaks controlled. Last confirmed cholera outbreak was in November 2016 in Buliisa district.
- 15 other cholera prone districts were supported to strengthen preparedness by development and implementation of actions plans.
- 15 districts in central, northern and eastern Uganda were supervised, gaps identified and corrected.
- National cholera guidelines updated and launched in June 2017.

Best practices and innovations

- Motorization of boreholes serving South Sudanese refugees to increase access to safe water.
- Installation of chlorine dispensers in some of cholera affected districts in Eastern Uganda.
- Development of district cholera preparedness plans

3.1.6 UNEPI key outputs during FY 2016/17

- HPV social mobilization conducted in 10 EPI regions: Mbarara, Jinja, Central (1), Masaka (2), Hoima, Mbale, Soroti, Lira, Gulu and Arua.
- 43 Solar fridges installed and cold chain equipment maintained in 39 districts. Ug. Shs. 32M was covered by GoU
- Cold chain capacity assessment conducted in 3 newly created districts (Rubanda, Kakumiro and Kagadi). Omoro district was not assessed due to inadequate funds.
- Immunization TNA conducted. 20 districts and 49 health facilities assessed (Mpigi, Rakai, Busia, Kaberamaido, Kamuli, Kumi, Mbale, Tororo, Abim, Apac, Dokolo, Gulu, Koboko, Zombo, Kabale, Kibaale, Mbarara, Mitooma, Ntungamo).
- 3 rounds of intensified routine immunization conducted in 13 districts (Kamuli, Iganga, Luuka, Kaliro, Mayuge, Butaleja, Kamwenge, Hoima, Masindi, Moyo, Amudat, Kalungu and Lwengo).
- Immunization campaign targeting 1-2 year olds in 39 high risk districts conducted.
- Mentorship and on-job training for the operational level health workers in 12 poor performing districts conducted. Districts include: Bukomansimbi, Kalungu, Busia, Buliisa, Bushenyi, Mitooma, Mbarara, Moroto, Kumi, Moyo, Nakasongola and Bulambuli.
- Supportive supervision in selected districts (20 districts) conducted. The districts include: Bududa, Bukedea, Amuru, Apac, Kitgum, Kabale, Kanungu, Ntungamo, Rukungiri, Sheema, Rubirizi, Wakiso, Yumbe, Kibaale, Kiryandongo, Bundibugyo, Kabarole, Kamwenge, Kasese and Hoima
- Leaders from 39 districts (CAO, DHO, FP immunization) sensitized in Kampala.
- National TOT and OPL conducted in 6 districts Kibuku, Namutumba, Kalungu, Yumbe, Sheema and Pader.
- IIP manual finalized. 8,000 booklets printed and distributed by Districts via NMS. Monitoring done by NSTOP to verify that booklets were delivered and found 100% accurate.
- Immunization financial sustainability plan for 5 years developed.
- 3 measles outbreaks including those in Bugiri, Jinja and Buvuma have been investigated and responded to. 18 AFP detected during the quarter from the four sub regions
- Cold chain training for 122 DCCT/CCA in 116 districts conducted in Lira district.
- JAR completed and report presented to HPAC.

- Procurement of required vaccines - DTP-HepB-Hib: 5,151,200 target. Procured 6,664,350. There was need to increase the buffer and avoid stock outs; HPV: 4,880,300 target. Procured 2,236,853. Country had in country stocks.; PCV-10: 4,880,300 target. Procured 8,341,800. There was need to increase the buffer and avoid stock outs; IPV: 1,549,100 target. Procured 1,034,600. Global shortages; country receives in line with ration allocated; and Rota: 2,575,600 target. Procured 0. We had planned to introduce but t because of global stocks.
- 19 medicine stores constructed but at different physical status levels. Lot 1: 88% (Napak, Alebtong & Agago), Lot 2: 92% (Ntoroko, Rubirizi, Sheema, Buhweju, Isingiro, Lyantonde & Lwengo), Lot 3: 98% (Buikwe, Pallisa, Luuka, Serere, Nakapiripit & Bukwo), Lot 4: 96% (Nakaseke, Buliisa & Zombo).
- Civil works ongoing for construction of 26 staff houses at different physical progress levels: Lot 1: 83% (Bulambuli (2), Namutumba (1), Bugiri (2), Namayingo (2) & Mayuge (2) Lot 2: 93% (Kakumiro (1) & Kagadi (01), Bundibugyo (2), Kasese (2), Kanungu (2), & Kisoro (2) and Lot 3: 99% (Mukono (2), Wakiso (1), Kalangala (2) & Buvuma (2).

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

3.1.7 Tuberculosis and Leprosy control

TB remains a major public health problem affecting a third of the world population of whom 10.4 million developed active TB in 2015. Uganda is one of the 30 high TB/HIV burden countries.

The NTLP updated its Strategic Plan for 2015/16-2019/20, finalized manuals for TB & leprosy and quality Improvement in TB care, and initiated quality improvement projects for DR-TB care at 15 all DR-TB initiation sites across the country. The MoH launched the National Coordination Committee for TB & Parliamentary caucus for TB.

Paediatric TB: The number of children under 15 years of age that were notified with TB increased in 2016/2017, compared with 3, 130 in 2015/2016. The proportion of TB cases less than 15 years of age also increased from 7.4% in 2015/2016 to 9%, the target for in 2016/2017, though it remained below the expected proportion of 15-17%.

TB Treatment Outcomes: Of the 25,102 new PBC cases notified in 2015/2016, 80% were successfully (TSR) treated (48% cured) and 10% were lost to follow up. This represents a slight improvement in over treatment outcomes from 79% TSR and 11% lost-to-follow-up in 2015/2016. Though the death and treatment failure rates stagnated at 5% and 1%.

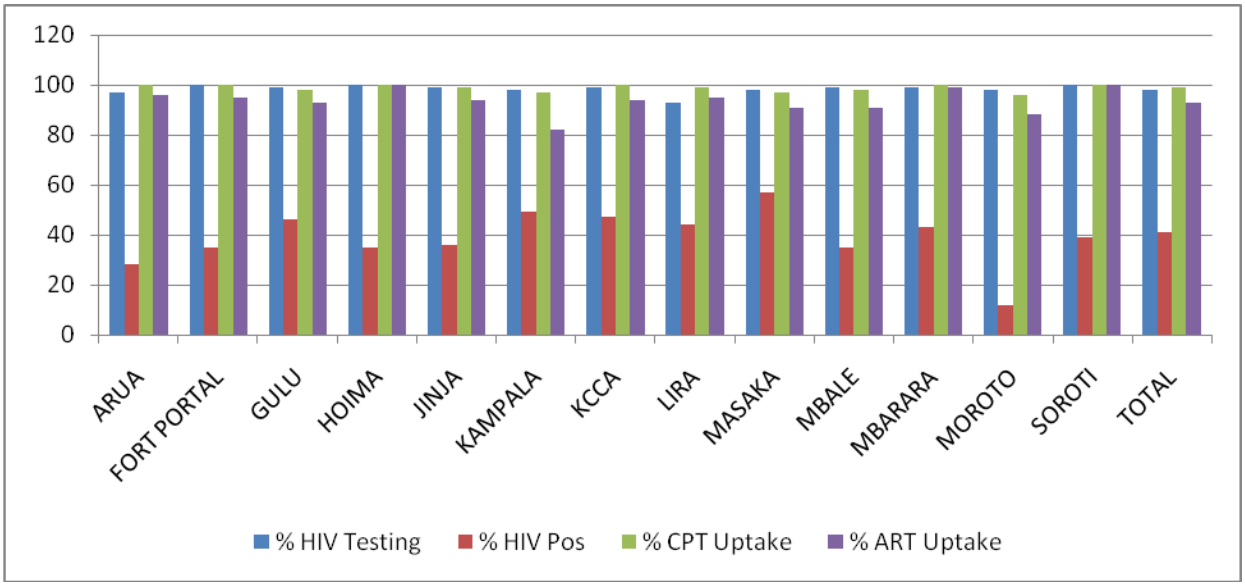
TB Case Notifications: There was a reversal of the steady decline trend in TB case notification since 2011, with an improvement in patient notification from 43, 858 in 2015/2016 to 45,900 in 2016/2017.

TABLE 48: TB NOTIFICATION BY REGION FOR 2016/2017

Region	New and Relapse Patients	Others	Total
Arua	3,036	168	3,204
Fort Portal	2,839	130	2,969
Gulu	2,817	103	2,920
Hoima	2,909	107	3,016
Jinja	3,526	51	3,577
Kampala	6,298	171	6,469
KCCA	7,344	141	7,485
Lira	3,017	88	3,105
Masaka	2,513	52	2,565
Mbale	2,719	51	2,770
Mbarara	4,420	134	4,554
Moroto	1,841	163	2,004
Soroti	1,222	40	1,262
Total	**44,501**	**1,399**	**45,900**

TB/HIV Collaborative activities: Of the 2016/17 TB cohort, HIV test results were documented in 98% (target 98%); and 99% and 93% of those HIV + were on CPT and ART (target 99% and 90%) respectively. The HIV co-infection rate among TB patient dropped from 41.5% to 41%. All the TB/HIV indicators improved this period (HCT-97.3%, CPT-97.8% in 2015/2016), with a marked improvement in ART enrolment from 88.3%.

FIGURE 20: REGIONAL PERFORMANCE ON KEY TB/HIV INDICATORS FOR 2016/2017



Programmatic Management of Drug Resistant TB (PMDT): During the FY, the 15 treatment initiation sites were maintained across the country. The 12-month enrolment for July 16-Jun 2017 was 380 patients at the 15 MDR-TB sites bringing the total number ever enrolled to 1322 patients by end of June. There were 395 patients diagnosed with the 121 genexpert machines by end of June 2017. The treatment success rate was 85% and 74% for the 2012 & 2013 and 2014 cohorts respectively. Contact tracing was done for those patients and 21 TB cases (4 drug resistant) were detected.

To improve the quality of TB care, the NTLP developed a Quality Improvement manual to guide health workers to implement quality improvement in TB care, including tools for mentorship of the health providers in TB care. In collaboration with the implementing partners, the NTLP between March and June 2017 assessed the quality of MDR TB care at the 15 MDR-TB treatment facilities and carried out mentorship of the facility teams to implement QI projects to address gaps identified in MDR TB care. A dashboard was produced, highlighting the poorly performing indicators which were targeted for follow up mentorships.

TABLE 49: MDR TB QUALITY OF CARE PERFORMANCE DASHBOARD (JAN - MAR 2017)

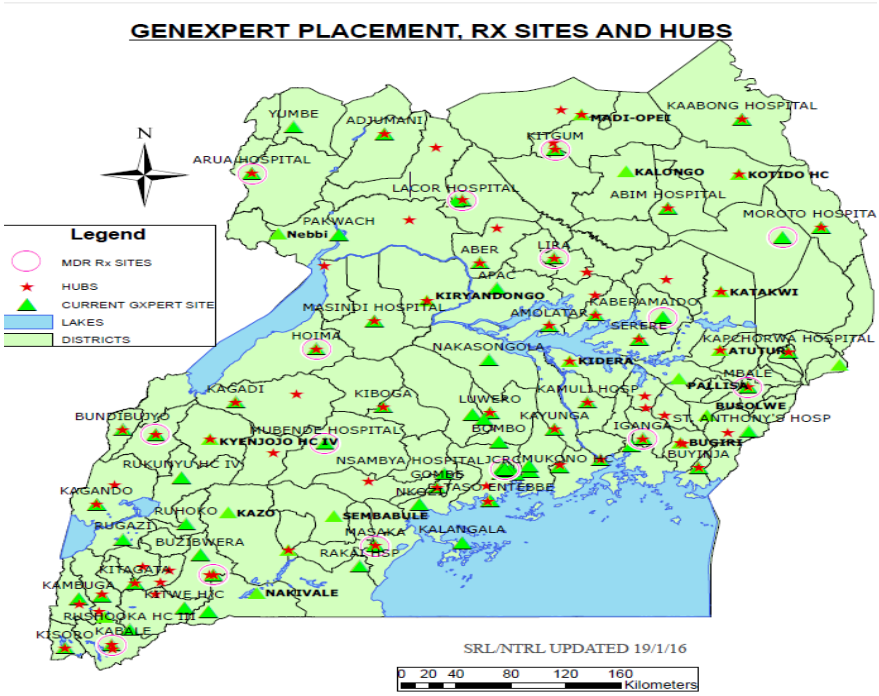
Legend								
	0-59%)		60-89%		90-100%)		No data	
Facility	Previously treated TB cases with Gene Xpert test/DST	Diagnosed MDR-TB patients enrolled on 2nd line treatment	MDR-TB patients registered 6 months ago with baseline culture/DST	MDR-TB patients in care who are on DOT	MDR-TB patients with monthly smear and culture results	MDR-TB patients with contacts traced and screened for TB	MDR-TB/HIV co-infected patients in care started/receiving ART	MDR-TB patients in care assessed for nutritional status
1	100%	100%	100%	100%	100%	100%		100%
2	78%	100%	50%	100%	100%	100%		100%
3	70%	100%	56%	100%	100%	100%	100%	100%
4	76%	100%	100%	100%	100%	0%	100%	100%
5	43%	100%	100%	100%	100%	0%	100%	100%
6	69%	100%	92%	100%	92%	75%	100%	100%
7	92%	100%	100%	100%	100%	0%	100%	100%
8	100%		67%	100%	0%	100%	100%	100%
9	100%	100%		100%	57%	0%	100%	100%
10	30%	93%	46%	100%	36%	0%	100%	100%
11	87%	89%	97%	73%	0%	35%	95%	100%
12	82%	75%	100%	100%	25%	25%	100%	100%
13	100%	80%	75%	75%	0%	75%	50%	100%
14	70%	100%	0%	0%	25%	0%	100%	0%
15	100%							

Isoniazid Preventive Therapy (IPT): The NTLP strengthened services for Isoniazid Preventive Therapy TB & HIV care settings. Of 521 health units that received isoniazid form the national medical stores, 413 (79%) were trained (355) and mentored (58) on IPT during the reporting period. Additionally, the NTLP received support to print 1,500 IPT registers

(900 by METS and 600 by MEEPP). By June 2017, 196 (37%) and 169 (32%) of health facilities had received IPT registers and IPT job aides. Furthermore, the country received 4,384 & 6,688 packs of isoniazid 100mg & 300mg sufficient for 2.436 U-5 children & 24,969 PLHIV respectively most of which the NMS had distributed to health facilities across the country.

Leprosy: Leprosy continues to be endemic in Uganda. During the FY, 246 (up by 12%) new leprosy cases were notified, a case detection rate of 0.64/100,000. Of these 85% were MB, 40% and 8% were women and children aged less than 15 years respectively. 42 districts (38% down from 51% the previous year) notified at least one new leprosy patient. However, given that leprosy just like TB cases are notified by the facility/district that diagnosed them rather than by the district of origin, the number of districts from which the leprosy cases originated during the report period could be greater than 42. As a result, a total of 14,847 pre-ART clients were reported to have been started on isoniazid prophylaxis between July 2016 and June 2017 (DHIS2). Additionally, of 12,953 under-5-year-old contacts of smear positive TB patients, 1,880 (15%) were enrolled on isoniazid preventive therapy.

Laboratory network: The laboratory network in the country includes 1,543 DTUs and 121 with Xpert/MTB/RIF in 115 health facilities for diagnosis of drug sensitive and DR-TB. The country has achieved HUB coverage of 62% in 88 districts. Over 96% of Xpert machines were functional, but with 12% of modules non-functional. A proportion of 89% of the AFB microscopy participated in external quality assessment (EQA) with 8.5% labs that reported major errors.



Conclusion: The TB performance indicators results for 2016/2017 show positive trend in the right direction, but efforts need to be multiplied, technology needs to be harnessed,

innovations embraced and resources need to be quadrupled if the goals of End TB Strategy are to be achieved by 2035.

Challenges

- The records show that 51% of the PLHIV with a positive TB test were not started on TB treatment.
- The country still receives very limited stocks of isoniazid for meaningful programme coverage.
- The reporting system does not capture IPT completion data.
- There is poor airborne TB infection control implemented at health units across the country as evidenced by the raising trend of health workers notified with TB during the reporting period. A total of 170 health workers were notified with TB during that period.

3.1.8 Malaria Control and Prevention

Malaria remains a major public health challenge in Uganda as the country with Uganda having the fourth highest number of annual malaria cases accounting for 4% of the estimated 220,500,000 global cases in 2016 (World Malaria Report 2016 pg. 41).

FIGURE 21: DEATH DUE TO MALARIA

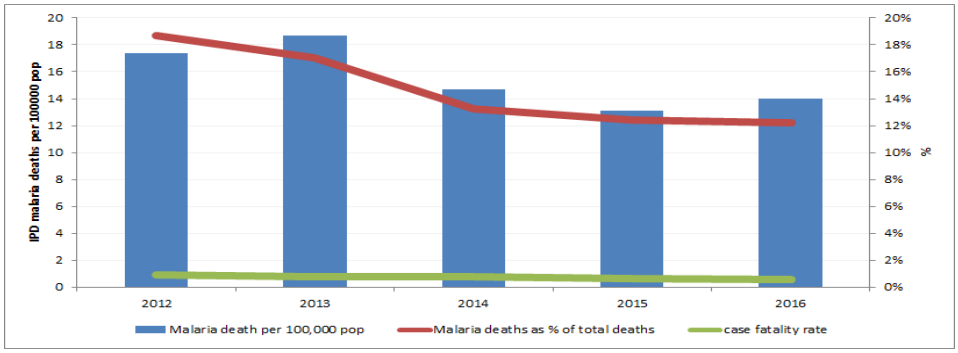
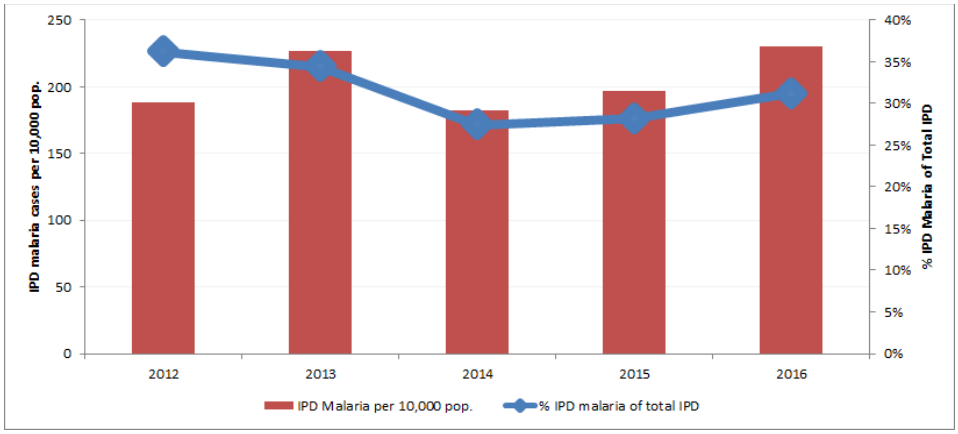


FIGURE 22: INPATIENT MALARIA CASES



3.1.8.1 Procurement and Distribution of LLINS:

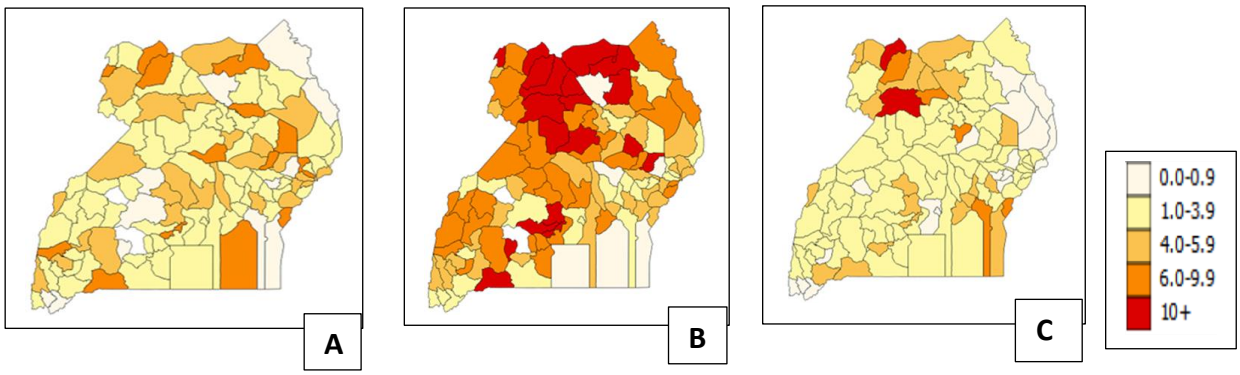
Long lasting insecticidal nets (LLINs) and used to protect the population against the infectious mosquito bites. LLINs are distributed through ANC, EPI, Schools, private providers and commercial outlets and a total of 4,778,467 were distributed through routine channels (1,442,500 (2015); 2,004,411(2016); 1,214,480 (2017) and 117,076 for primary schools in Tororo (2,012,016)).

Besides routine channels, LLINs are distributed to the general population through mass campaign. A total of 24,019,282 were secured for distribution in 2017. The LLIN mass campaign commenced in the in February, 2017 with a national launch which was held in Apac district and min launches in Kamuli and Masaka Districts. Only seven (7) out of the 116 districts are yet to be covered (Kampala, Wakiso, Bundibugyo, Kasese, Mbarara, Sheema, Kagadi.) These LLINs have been procured by the Global Fund, Presidential Initiative (PMI), DFID and the Against Malaria Foundation (AMF).

Indoor Residual Spraying (IRS)

Pirimiphos-methyl 300g for IRS plus personal protective equipment were procured. One round of IRS was conducted in the ten (10) epidemic districts in the northern part of the country. In addition to the six districts that sprayed earlier on, Gulu, Omoro, Apac, Pader & Kitgum sprayed in quarter four of the FY 2016/17. The expected number of people protected from IRS in Northern Uganda is 2,745,458. In addition, IRS has continued in the ten (10) districts of eastern Uganda in FY 2016/17. These include districts are: Tororo, Bugiri, Mayuge, Serere, Pallisa, Budaka, Butaleja, Kaberamaido and Kibuku. The rest are in the north and these include; Amolatar, Dokolo, Lira, Otuke and Alebtong.

FIGURE 23: WEEKLY MALARIA CASES AND REPORTING RATES IN 10 NORTHERN UGANDAN DISTRICTS



3.1.8.2 Case management

One of the three goals of Uganda's Malaria Reduction Strategic Plan (UMRSP) is to reduce malaria incidence from 484 in 2010 to 150 per 1000 by 2016 and malaria deaths by at least 50% of 2010 levels by 2016. The country is making progress towards this goal. From 2010 to 2017, malaria mortality reduced by 61% from 59 to 23 per 100,000 pop.

The country continues to ensure the availability of commodities for malaria control and treat. Rapid diagnostic kits (RDT) for testing malaria and anti-malarial medicines have been

procured. An additional 1,284,395 doses of ACTs, 1,266,100 doses of artesunate and 2,129,840 RDTs were procured. Distribution is routine, basis basing on the NMS bimonthly distribution schedule. The availability of ACTs in public and PNFP facilities has continued to improve with up to 93.3% experiencing no stock-out of ACTs as of June 2017. Besides, external quality assurance (EQA) for Malaria Microscopy and RDTs has been done, trainings in the integrated management of malaria in public, PNFP in more than thirty-five (35) districts were conducted. Data use in selected health facilities and clinical audit trainings in targeted HC IVs and hospitals in all districts. The country continued to manage malaria cases under the Integrated Community Case Management (ICCM) strategy was at the end of June fully implemented in 60 districts, and partially in 23 districts.

3.1.8.3 Behavior Change Communication

The programme was able to; develop a communication strategy for malaria, strengthen its community engagement efforts, organize world malaria day celebrations as well as participate in radio talk and TV shows across the country. The programme was also able to brief Parliamentarians on malaria where the speaker of parliament was engaged as a malaria champion. The programme has been able to develop standardized messages for malaria to be used by all for communication on key issues.

3.1.8.4 Programme Management

Quarterly performance reviews as well as thematic TWG meetings have been regularly conducted. Integrated support supervision to districts and health facilities was done to maintain oversight of interventions and to provide technical assistance where and as required. Besides, three sub recipients; Ones Enterprise, HEPS and First Pharmacy were contracted to implement a number of activities that among others include; integrated management of malaria trainings in the private sector, behavior change communication as part of social marketing for subsidized ACTs in the private sector and monitoring the availability, accessibility and price of subsidized ACTs.

3.1.8.5 Mobilization Resource for Malaria Control

The NMCP under its mandate of mobilizing resources for malaria control continued to mobilize resource for malaria control. On top of the GoU allocation and the US $ 33 which is contribution from the Presidential Malaria Initiative (PMI), the Global Fund availed fund for malaria control amounting to 149, 401,782 for malaria control for the period 2016 – 2017 as seen below;

TABLE 50: SUMMARY OF THE MALARIA GRANT

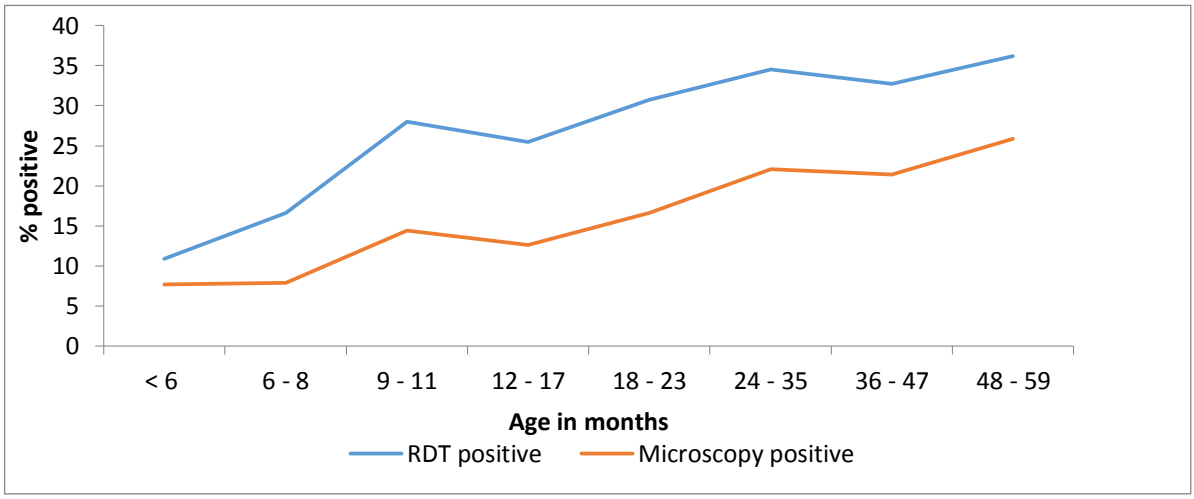
Module	2016	2017	Total
Vector control	69,212,170	4,085,477	73,297,647
Case management	39,187,743	34,959,233	74,146,976
HSS – HIMS and M&E	708,980	29,988	738,968
Program management	682,288	535,903	1,218,191
Total	**$109,791,181**	**$39,610,601**	**$149,401,782**

In addition, Uganda has submitted a successful funding application to the Global Fund to Fight AIDS, TB and Malaria and has secured a grant of US$ 188,322,878 to fund malaria control efforts in the period of three years (2018 – 2020). In addition, the Malaria Action Planning for Districts, a new project funded by DFID and PMI commenced work in it supports malaria control in forty-eight (48) districts in central, western and northern Uganda.

Challenges

- Increasing incidence of malaria among children aged 5 – 12 years**.** Available evidence indicates that fever incidence among children >5years is on the increase. RDT and microscopy positivity showed a linear relationship between age and parasitemia over the first 5-years. Hence, the increased fever cases being reported may be due to malaria.

Trend in test positivity by age



- **There has been an increase in the number of refugees and internally displaced persons:** As of end of July 2016, Uganda was home to 1,026,043 registered refugees and asylum seekers (UNHCR Uganda Flash Update on South Sudan emergency response, Mar 6, 2017), a figure that has continued to increase given the ongoing instability within the region around Uganda. This unprecedented increase in the influx of people has put pressure on health service delivery.

- Non-adherence to test results still remains a major challenge. A proportion of patients with negative malaria tests receive ACTs while a small proportion still receive treatment without testing.

- Wide spread of resistance to pyrethroids and carbamates. This threatens the effectiveness of malaria control interventions.

3.1.9 Prevention and Control of HIV and AIDS

3.1.9.1 Epidemiology

The 2016 Uganda HIV Impact Assessment (UPHIA) established an HIV prevalence that was estimated at 6.0% down from 7.3 % in 2011. From UPHIA, the number of people in the country estimated living with HIV was estimated at 1,300,00.

The trend of new HIV infections (incidence) has continued to decline. New infections fell to an all-time low of approximately 60,000 in 2016, indicating that the target of a 40% reduction of new HIV infections by 2015 relative to 2010 that was set in the National HIV Prevention Strategy has been met. Our data also indicate that the number of children born with HIV infection in Uganda declined by 86% between 2011 and 2015, the biggest fall in any of the 22 high burden Countries. At the end of 2015, only 4,000 new pediatric HIV infections occurred in the Country. The Country is at the verge of epidemic control and on the right path to the Fast Track UNAIDS target of ending AIDS by 2030.

3.1.9.2 Progress in the Public Health Response

IEC Messages Development and Dissemination

The Program has continued to implement IEC/BCC activities to support primary prevention interventions as well as uptake of services. In partnership with Communication for Health Communities (CHC) project, HIV messages were developed and disseminated through a variety of channels. The messages were aired on 47 radio stations, 4 Television stations, Road-side bill boards in 116 districts and 300,000 posters and 250,000 leaflets on different themes. The Program also conducted 4 IEC/BCC coordination meetings to review performance of work plans. The stakeholders included CHC, UHMG, Reproductive Health Uganda (RHU), AIDS Information Centre (AIC), Baylor College, UAC and Strengthening TB and HIV/AIDS Eastern Uganda Project (STAR E).

Condom Programming

During the reporting period, 59 million male condoms were procured and distributed in the public and private sector. This represents 85% short fall in in projected annual need. This gap was compounded by delayed deliveries from the Global Fund and National Drug Authority (NDA) post shipment testing and clearance. A recommendation for branding of the public sector condoms that was made by an earlier assessment were addressed during the year. A branded *"Hot Pink"* colored foil for public sector condoms has been made and is being distributed in place of the silver foil brand that was previously used.

An assessment of the comprehensive condom programming was conducted with support from the Global Fund in conjunction with the Makerere University School of Public Health. The assessment revealed significant achievements in supply and commodity security; improved availability, access and utilization. Furthermore, there was better public trust in condoms supplied by government and the public sector brand "*Hot Pink*" was one of the most preferred.

HIV Counseling and Testing

In 2016, HIV testing services were provided to a total of 11,742,311 individuals including 10,292,539 adults and 1,449,772 children. The target of testing 9,523,170 during the year was surpassed. The sero-positivity rate among adults and children was 3.1% which continued the trend observed from previous years.

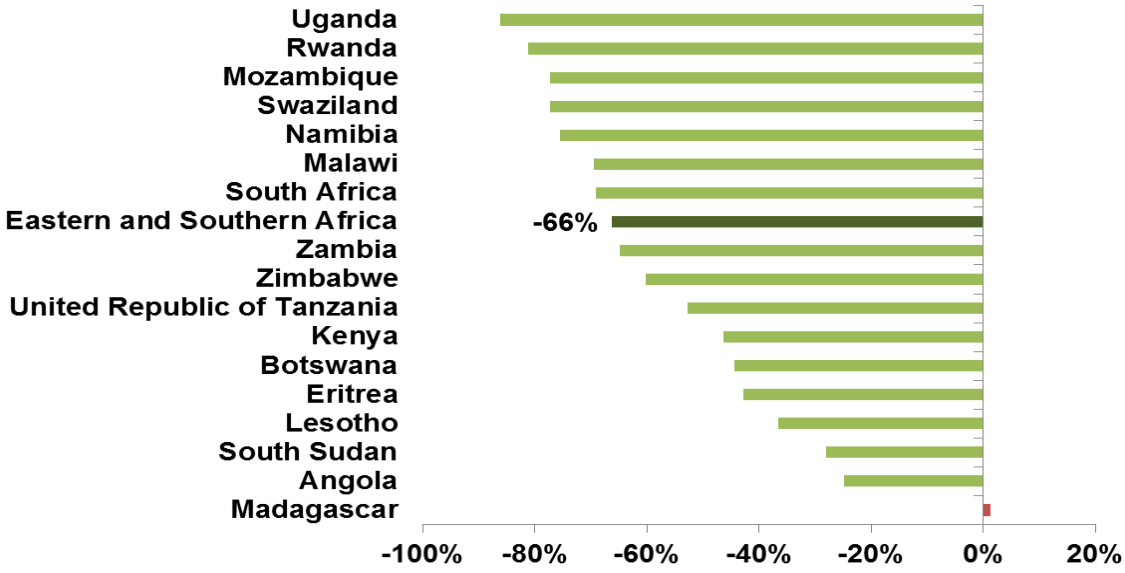
The Program revised the HIV Counseling and Testing Policy. The new Policy emphasizes approaches for targeted testing to improve yield and linkage to prevention and care services. New and superior testing algorithms have also been included following a review by the Uganda Virus Research Institute. The new policy been disseminated during the dissemination of the Consolidated Guidelines for the Prevention and Control of HIV and AIDS.

The Program also conducted and disseminated results of three HIV self-Testing studies. The studies indicated that HIV self-testing is feasible and acceptable. We are in the process of synthesizing the findings of the studies with a view of placing an addendum in the HIV testing Services policy and guidelines for HIV self-testing.

3.1.9.3 Elimination of Mother to Child Transmission

By the end of 2016, all district in the country were implementing Option B+. PMTCT services were offered in 3,637 health facilities of all levels. These were comprised of 16 referral hospitals, 133 general hospitals, 191 HC IVs, 1,186 HC IIIs, and 2,327 HC IIs. PMTCT service delivery in health facilities is supported by the Government and international development partners through various Implementing Partners (IPs) according to geographical areas assigned during rationalization of HIV/AIDS services.

FIGURE 24: PERCENTAGE CHANGE IN NEW HIV INFECTIONS AMONG CHILDREN (0-14 YEARS), EASTERN AND SOUTHERN AFRICA 2010-2015- SOURCE UNAIDS

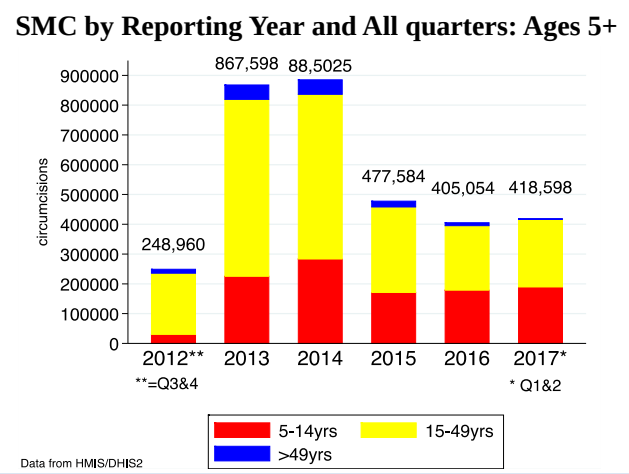


The Country is at the verge of virtual elimination of mother-to-child transmission. Our data indicate that the number of children born with HIV infection in Uganda declined by 86% between 2010 and 2016. At the end of 2016, only 4,000 new pediatric HIV infections occurred in the Country. The mother to child transmission (MTCT) rate at 6 weeks fell under 2% in 2016, from a high of 11% in 2010, while that including breast feeding was also at an all-time low at the end of 2015 (2.9% from a high of 27% in 2010).

The Country has appointed a committee to conduct data validation as part of the WHO mechanism for certification of eMTCT. The committee will provide an independent report on how far the Country's eMTCT targets have been achieved.

3.1.9.4 Safe Male Circumcision

The Program set a target of circumcising one million young men annually for 2010 to 16. During 2016, a total of 405,054 young men were circumcised in facilities across the country bringing the total number of circumcised males since 2012 to 2,604,823 or 62.0% of the initial target of 4.2 million young men to be circumcised by 2015. These services were provided in 851 facilities (10 referral facilities, 103 hospitals, 150 HC IVs, 273 HC IIIs, 212 HC IIs, 84 clinics, 18 and specialized clinics.



Following wide scale consultation with WHO and other partners, the policy of at least two anti-tetanus booster immunization doses four weeks apart before the SMC procedure has now been reviewed to one TT shot for the surgical male circumcision procedures. The two dose TT policy has however been maintained for the non-surgical circumcision procedures such as PREPEX.

The Uganda Population based HIV Impact Assessment (UPHIA) also measured indicators on circumcision. The proportion of men aged 15-49 years that are circumcised has increased from 26% in 2011 to 43% in this survey. The proportion of men circumcised ranges from 14% in Mid Northern region to 69% in Mid-Eastern region. The prevalence of male circumcision was highest among young people 15 – 29 years at over 45%.

3.1.9.5 Care and Treatment

By July 2017, a total of 1,824 facilities countrywide submitted HIV/AIDS care services and commodity logistics reports through DHIS 2. Based on these reports, active ART clients had increased to 1,028,909 from 984, 931 reported at the end of 2015. Based on program data,

with 1,028,909 enrolled on ART by the end of June 2017, ART coverage among HIV-infected adults and children was estimated at 73%. Consistent with previous trends, approximately 93% (964,232) of clients are adults aged 15+ years, and 64,677 are children. Similarly, consistent with reports at the end of June 2017, the proportions of clients on first, second and third-line ART regimens were 96.2% (989,672), 3.8% (38,883) and <1% (354) respectively.

The number of individuals in pre-ART care at the end of the June 2017 fell to 28,081 (reported from 1,120 facilities), from 59,061 at the end of March 2017 (reported from 1453 facilities). This is consistent with expectations from the new HIV Test and Start guidelines that the Ministry rolled out during the previous quarter. Among these clients, 1,488 were children below 15 years.

TABLE 51: ACTIVE ART CLIENTS IN FACILITIES COUNTRYWIDE: JUNE, 2017

	Number	%
No. of clients on ART	1,028,909	
Adults (15 + years)	964,232	93.7
Children(<15 years)	64,677	6.3
First Line	989,672	
Adult (15 + years)	930,412	94.0
Children(<15 years)	59,260	6.0
Second Line	38,883	
Adult (15 + years)	33,496	86.1
Children(<15 years)	5,387	13.9
Third Line	354	
Adult (15 + years)	324	91.5
Children(<15 years)	30	8.5

3.1.9.6 Strategic Information

In the reporting period, the MoH, together with partners conducted the UPHIA. The Survey was implemented with the support from ICAP at Columbia University and the CDC. The other partners included the Uganda Virus Research Institute (UVRI), Uganda AIDS Commission, Uganda Bureau of Statistics, WHO, UNAIDS, Westat and ICF Macro.

The results from UPHIA indicate that the prevalence of HIV among adults aged 15 – 49 years in Uganda is 6%. Among children under age five years, HIV prevalence is 0.5%, while among those aged 5 – 14 years, it is also 0.5%. Based on the survey results, the total number of adults and children of all ages living with HIV in Uganda is estimated to be approximately 1.3 million.

Adult HIV prevalence was higher among women at 7.5% compared to 4.3% among men. It was also higher among residents of urban areas (7.1%) compared to 5.5% in rural areas. The magnitude of HIV varied considerably among the ten geographic regions in the survey, from a low of 2.8% in West-Nile; 3.4% in North East region; 4.4% in East Central (or Busoga region); 4.8% in Mid-East region; 5.5% in Mid-West region; 6.6% in Kampala; 7.4% in Central 2 (Greater Mubende, Luwero and Mukono); 7.6% in Central 1 region (greater Masaka); to 7.7% in South Western region. This is similar to the findings of the 2011 Uganda AIDS Indicator Survey (UAIS) when Mid-Eastern showed the lowest, and Central 1 the highest estimated HIV prevalence.

The HIV prevalence among young people 15 – 24 years was 2.1% (0.8% in men and 3.3% among women). Among adults, HIV prevalence is lowest in those 15-19 years. It is highest among men aged 45 to 49, at 14.0%. Among women, HIV prevalence is highest in the age groups of 35 to 39 years and 45 to 49 years, at 12.9% and 12.8%, respectively.

Among women and men, HIV prevalence declined from 8.3% and 6.1% in 2011 to 7.5% and 4.3% in 2016 respectively. In urban areas, it declined from 8.7% to 7.1% while in rural areas it fell from 7.0% to 5.5%. These declines in HIV prevalence may be due to a decreasing number of new infections in recent years due to the impact of the intensified HIV prevention and treatment services in the country.

The 2016 UPHIA also established the rates of suppressed HIV viral load (VLS) which is a marker of effective treatment. UPHIA showed that adults age 15 - 49 years had a VLS of 57.4%; this finding shows that with support from development partners such as PEPRAR, the Global Fund and other programs, the GoU's HIV programme is having an impact and making great progress toward the UNAIDS and national goal of having population level VLS of at least 73% by 2020.

3.1.10 Epidemiological Disease Surveillance (ESD)

The following activities were achieved during the FY 2016/17 mainly with support from WHO, CDC and AFNET;

- EPI-IDSR support supervision in 8 districts in Hoima region (Hoima, Buliisa, Kiryandongo, Kibaale, Kakumiro, Mubende, Kiboga, Kagadi focus was on polio surveillance (silent districts, understanding of case definitions and case investigations).
- IDSR support supervision and HMIS monitoring in Kamuli and Jinja with a focus on underreporting for weekly surveillance report
- Conducted IDSR technical support supervision in 10 districts of Mityana, Amuru, Kagadi, Kabale, Bukedea, Kaberamaido, Lyantonde, Rakai, Pallisa and Buyende.
- IDSR training in 4 districts of Butambala, Gomba, Kayunga and Mukono.
- District level epidemiology training for 6 districts of Kasese, Gomba, Bukomansimbi, Bundibugyo, Kamwenge and Kibaale.

- FETP frontline training for 14 districts of Mukono, Nakasongola, Kayunga, Nakaseke, Amuru, Apac, Arua, Kitgum, Oyam, Pader, Luwero, Mpigi, Rakai and Kalangala.
- Regional Rapid Response Team for eight districts (08) in the Masaka region (Kalangala, Kalungu, Lwengo, Sembabule, Lyantonde, Bukomansimbi, Rakai, and Masaka). A total of 46 health workers were trained.
- Trained front liners (DHTs) in 10 districts of Bukedea, Soroti Katakwi, Budaka, Amuria, Kumi, Lira, Busia, Butaleja and Kaberamaido. A total of 46 health workers were trained.
- National Level Evaluation for the IDSR Strategy.
- National level training for ToT for Rapid Response Teams Training. 36 Health workers from MoH HQ were trained by WHO AFRO.
- Pilot Community Based Disease Surveillance (CBDS) training in 5 districts of Adjumani, Arua, Kamwenge, Kyegegwa and Masaka.
- All rumored outbreaks were verified and appropriate action taken in real time.
- Investigated and responded to Avian flu H5N8 in 3 districts (Wakiso, Kalangala and Masaka. Epidemic of Avian flu H5N8 epidemic was reported among wild and domestic bird in 3 districts between 2nd and 8th January 2017; UVRI confirmed the presence of Highly Pathogenic Avian Influenza (H5N8) in all the samples collected on the January 13, 2017. The multi-sectoral Rapid Response team supported the district teams to control the epidemic in wild and domestic birds and there were no human cases reported. Surveillance is still on going by MAAIF before the outbreak end is declared.
- Disseminated 52 weekly bulletins. Dissemination and feedback to the districts and other stakeholders with regards to the priority diseases for reporting. This activity is jointly executed by DHI and EOC who support data analysis and cleaning. ESD role is to write and disseminate and also further verify any data discrepancy with the districts.
- ESD was part of the Joint External Evaluation (JEE) Exercise. This was an assessment by WHO for the Countries capability in implementation of IHR (2005). The country has developed some capacities in implementation of IHR regulations e.g. Real Time surveillance, reporting but still lacking other capacities like IHR communication and coordination, Preparedness, Points of Entry, Zoonotic diseases, antimicrobial Resistance and food safety. National Action Plan for addressing the identified priorities.

3.1.11 Vector Control

- Bilharzia mass treatment impact assessment surveys in four districts.
- Advocacy meeting with top district leadership in 13 bilharzia endemic districts.
- Conducted Supervision for Mass treatment in all the 45 bilharzia endemic districts.
- Bilharzia infection and age intensity study follow up in 8 districts
- Carried out Bilharzia prevalence, intensity and associated morbidity in 3 districts of Hoima, Nebbi and Buliisa.
- Lymphatic filariasis post treatment surveys carried out in 12 districts.
- Trained Laboratory technicians and NTD Focal persons on use of LF Test kits in 19 districts.

- Supervised 8 sleeping sickness treatment centers (Namungalwe, Adjumani hospital, Moyo Hospital, Omugo HC IV, Yumbe hospital, Lwala Hospital and Dokolo HC IV, Atiak HC IV).
- Screened 12,000 people in sleeping sickness endemic communities and refugee camps in the 4 districts of Arua, Moyo, Yumbe and Adjumani. No cases found but suspects are followed every 3 months.
- Active screening in two National Parks of Queen Elizabeth and Murchison falls and National conservation areas and surrounding districts. Screened 2,750 people. No active HAT case confirmed. 46 health facilities identified for surveillance.
- Conducted Trachoma impact assessment in 13 districts.
- NTD Communication strategy developed.

3.1.12 Disability

- Sensitized communities on rehabilitative health care and provided assistive devices to the disabled as we Commemorated International Disability Day in Adjumani district on 3/12/2016.
- Created awareness on older persons' health care and carried out a health camp and treated 300 older persons as we commemorated Older Persons Day in Pader District on 1st October 2016.
- Promoted Eye health services. Held eye camp and treated over 500 eye care patients including eye surgery as we commemorated World Sight Day in Mbarara district in October 2016.
- International Day of Older persons Abuse was commemorated in Entebbe.
- Provided 16 wheelchairs to people with disabilities in Zombo district and regional centers 25 Soroti, 85 Kotido, 100 Gulu, 115 Lira and 100 Arua regions.
- Printed Eye health advocacy strategy, Fourth Eye Care Plan and Eye Health Clinical Guidelines and officially launched them in October 2016.
- Disseminated the National Wheelchair Standards and Guidelines to the Adjumani and Arua and also carried out follow up of the wheelchair beneficiaries in those districts. Supported by UNHCR and World Vision.
- Conducted support supervision, Mentoring, follow up of ENT workers in Kabale, Kanungu, Mbarara and Ntungamo districts and conducted support supervision, Mentoring, Follow up of Eye workers in Yumbe, Moyo, Arua, Adjumani, Kitgum and Mbale districts.

Partners activities that facilitated success

a) Introduction of early intervention project for Deaf Blind children in Wakiso district with support from Sense International. Children under 0 -3 years are being screened for visual plus hearing disabilities. Those who are both blind and deaf are provided with Comprehensive rehabilitation services.

b) "Seeing is Believing" program for childhood Blindness supported by Standard Chartered Bank through Sight Savers and Brien Holden Vision Institute.

c) Wheelchair provision to Persons with Disabilities (PWDs) in partnership with Rotary clubs and the Church of Jesus Christ of Latter –day saints.

d) Development, printing and dissemination of 4th Eye Health Plan, Eye Health Clinical Guidelines and Collaborative Strategy for Eye Health supported by Eye Health Partners. Sight Saver, Standard Chartered bank Brien Holden Vision Institute and Light for The World.

3.1.13 Integrated Curative Services

3.1.13.1 Palliative Care

- Finalisation process of palliative care policy in progress awaiting clearance of financial implications.
- Palliative care communication strategy finalised awaiting endorsement for printing.
- Palliative care activities coordinated and harmonised and updates shared from various stakeholders.
- Community sensitisation and awareness of palliative care achieved through a national event of football gala officiated by Minister of State for health (General Duties) at Old Kampala Primary School playground and media events.
- Provision of palliative care services and pain management improved.
- Strengthened collaboration with other line ministries e.g. Internal Affairs and Justice on Morphine use.
- Strengthened linkages with regional organisations such as open society initiative for Eastern Africa (OSIEA).
- Improved coordination with international organisations such international narcotics control board and international hospice and palliative care association.
- Provision of free morphine by Government to all accredited palliative care sites.
- Scale up of services from 91-94 districts.
- Introduced pain free hospital initiative to 3 RRHs namely Gulu, Mbale and Masaka plus Bombo Military Hospital.

3.1.13.2 Hepatitis B

Target population in the 39 districts - 4,944,102
Number tested so far - 2,107,412
Number of positives - 116,563
Number of Negatives - 1,987,405
First dose - 1,884,362 = 38%
Second dose - 1,482,895 = 30%
Third dose - 724,473 = 14.7%
The positivity prevalence 5.5%

- Printed and distributed Laboratory and Vaccination registers, vaccination cards, brochures in five different languages and tally sheets.
- Data collection done on vaccines and laboratory reagents delivered and the number of people tested and vaccinated against Hepatitis B.
- Quarterly support supervision conducted in the entire 39 district
- World hepatitis day marked in Dokolo district
- Two hundred (200) Health workers trained on the use of selexon machine technology
- 2,000 Health workers including nurses, laboratory technicians, doctors, midwives, and councillors trained on prevention, treatment and control of viral hepatitis B.
- Funds 88M was disbursed to the districts for social mobilisation.
- At least 4 meetings were held.

3.1.13.3 Obstetric Fistula

- Obstetric fistula repairs conducted in Hoima, Masaka, Arua, Mbarara, Mulago, Kamuli, Lacor, Kagando and lira hospital.
- Obstetric fistula activities coordinated, harmonised and experiences shared among the stakeholders.
- Public awareness on obstetric fistula management increased.

3.1.13.4 Hospitals and LLHFs

- Assessment of functionality of specialized clinics in hospitals clinics in Soroti, Mbale and Jinja RRH done.
- Verification of seconded staff to PNFP hospitals was done.
- Supervision was carried out in Arua, Kabale, Mbarara, Anaka, Kisiizi, Nakabalame, Itojo and Amai Hospitals.

3.1.13.5 Medical Board

- 53 workers examined and 30 recommended for early retirement
- 10 patients where recommended abroad for treatment.

3.1.13.6 Internship

- 964 medical interns were deployed to 33 internship centres.
- Four UMIC meetings conducted during the year.
- All 33 training internship centres were supervised and data was collected.

3.1.14 Nursing Department

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

- Conducted 5 technical support supervision visits in Masaka & Moroto RRH, Kitovu, Rukungiri, Kambuga & Amudat PNFPs Kiryandongo, Gombe & Nebbi, Kapchorwa, Katakwi, Kamuli and Entebbe Hospitals and Nabilatuk, Amuria, Bulambuli, Kaberamaido, Mpigi, Lyantonde, Luwero Oyam, Dokolo, Buyende and Rakai HC IVs. PFNP Corsu
- Ethical Code of conduct enforced, Infection control committees streamlined and documentation of patient vital signs strengthened.
- Carried out 2 Spot checks and technical support in various schools; Katikamu SDA, St Steven senior, Katakwi senior, Amuria primary and senior Bugema senior and primary, Nabuyonga primary, Joy primary, Nkoma SSS, Bulucheke girls senior, Bubulo girls senior. Strengthened care of chronically sick pupils/students and introduced school nurses into district health programs.
- Attended 3 meeting with African Regional (ARCK) integrated with MOES and discussed current policy guidelines and review of nursing and midwifery curriculums.
- Carried out 2 meetings in UNMC offices in Mulago complex with THETA. This was a new innovation for strategic direction supported by USAID. There was need for leadership and Governance for nurses and midwives.
- Held 1 meeting with nurses and midwives from the academia and discussed key indicators as stipulated in HSDP.
- Chaired nursing and midwifery disciplinary committee meetings and 32 certificates withdrawn due to forgeries, 5 students expelled and 1 tutor interdicted for abuse of office.
- Celebrated midwifery annual day event in Fort Portal and Nurses day annual celebrations in Kapchorwa grounds.

3.1.15 Uganda Blood Transfusion Services (UBTS)

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

During the FY 2016/17 amidst funding constraints, UBTS was able to collect a total of 239,220 units of blood against the target of 266,805. We also distributed blood to health care facilities a total of 224,176 safe units of blood.

A new structure that was approved by the Ministry of Public Service has been filled and about 80% of the staff has reported and deployment is on course.

UBTS Accreditation program

UBTS successfully went through the first stages of Accreditation program and is on step two. Officers were trained in various disciplines to fully prepare for the accreditation by the African society for Blood Transfusion (AFSBT).

Blood Services Information system (BSIS)

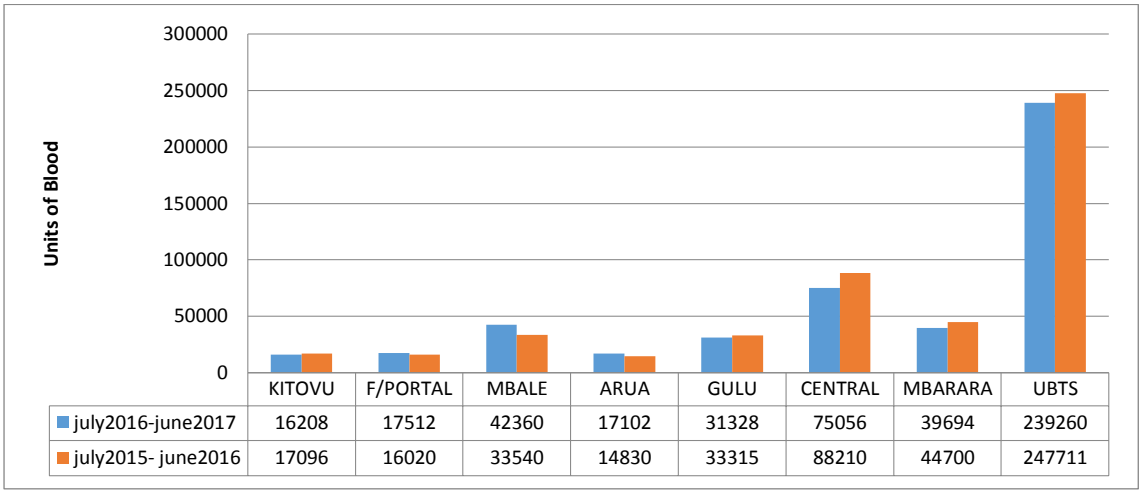
To further improve the quality of services within the National Blood Transfusion service. We acquired a new system e-delphyn that links collection, testing and distribution of blood and blood products. We are in the process of rolling the program to the rest of the regions and blood collection centers on getting funding.

Collaboration

UBTS also signed memorandum of understanding with Mbarara University of Science and Technology to start a course in Management of Transfusion Medicine after I identifying several gaps in transfusion practices with the accredited Transfusion Health care facilities.

Further, we signed a Memorandum of Understanding with NHSBT- a UK based Transfusion service to improve on staff skills and broaden capacity in transfusion practices.

FIGURE 25: BLOOD COLLECTION PERFORMANCE PER EACH RBB



	KITOVU	F/PORTAL	MBALE	ARUA	GULU	CENTRAL	MBARARA	UBTS
july2016-june2017	16208	17512	42360	17102	31328	75056	39694	239260
july2015- june2016	17096	16020	33540	14830	33315	88210	44700	247711

FIGURE 26: HIV SERO PREVALENCE AMONG DONORS AGAINST THRESHOLD JULY 2016 – JUNE 2017

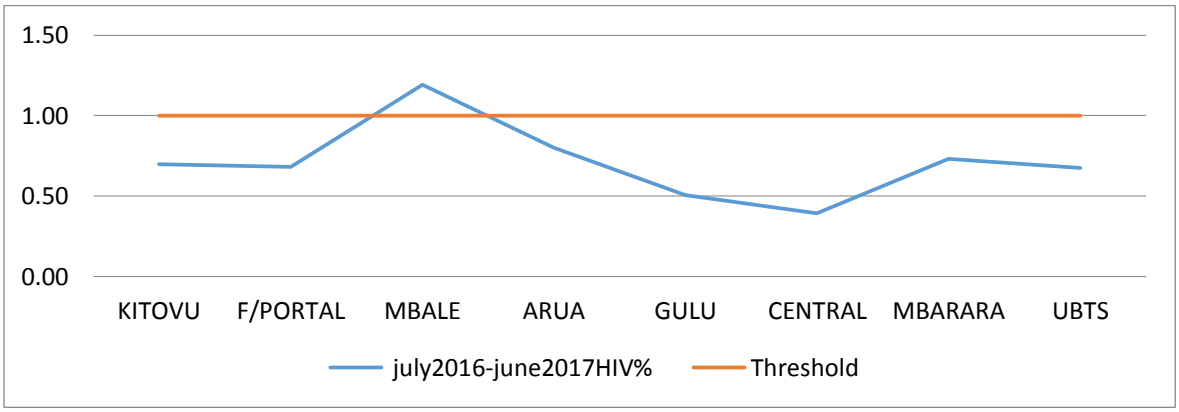


FIGURE 27: HEPATITIS B PREVALENCE AMONG DONORS FROM AGAINST THRESHOLD JULY 2016-JUNE 2017

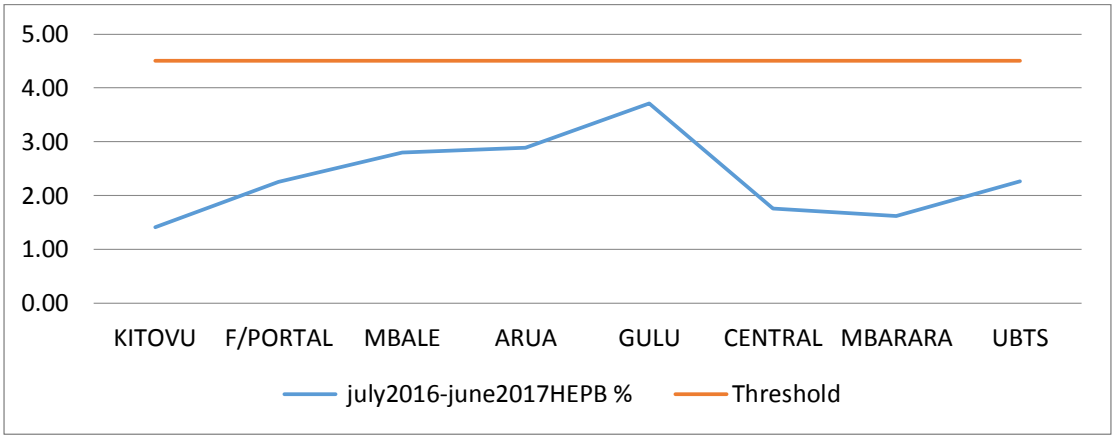
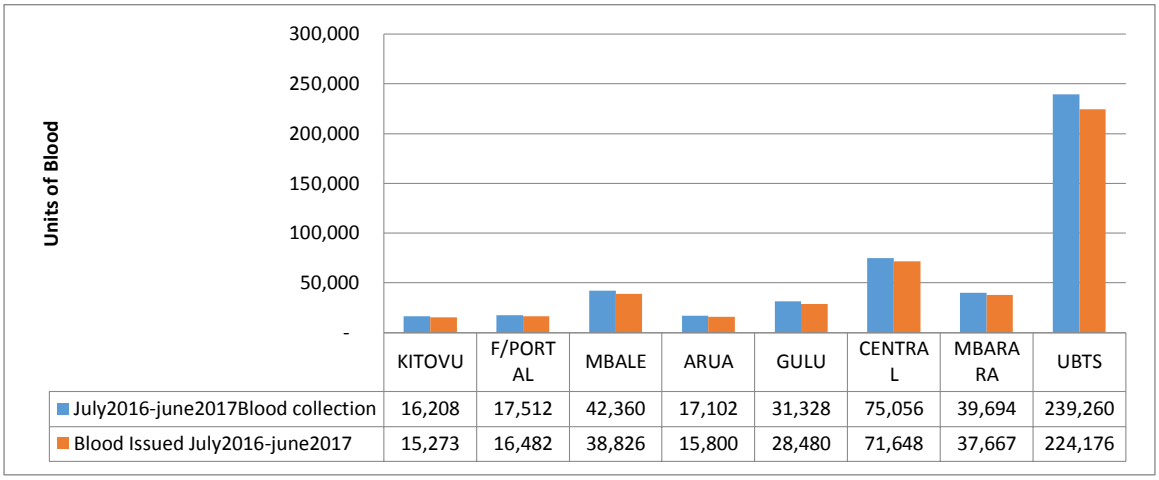


FIGURE 28: BLOOD COLLECTION AND DISTRIBUTION BY REGION JULY 2016 TO JUNE 2017



	KITOVU	F/PORTAL	MBALE	ARUA	GULU	CENTRAL	MBARARA	UBTS
July2016-june2017Blood collection	16,208	17,512	42,360	17,102	31,328	75,056	39,694	239,260
Blood Issued July2016-june2017	15,273	16,482	38,826	15,800	28,480	71,648	37,667	224,176

UBTS Challenges

- Inadequate Funding- UBTS is underfunded. A part from supporting operations, most of the staff were on contract and paid on PEPFAR budget. End of the project and with no government complementary funding has led to termination of staff who were being paid using PEPFAR funds. This brought personnel gaps and affecting operations. UBTS intends to close some blood collection centers. Those listed for closure are Rukungiri, Lira and Nebbi and Nakasero Ambassador House Blood donating centre in down town. This will reduce blood collection to the tune of 43,200 units of blood annually.
- Scaling down operations
    - Reduce daily Blood Collection Sessions from 22 days to 15 says per month.
    - Reduce the Number of Blood Collection Teams (Teams listed for closure Arua One Team i.e. Nebbi, Fort portal One Team, Mbarara one Team i.e. Rukungiri, Gulu one Team i.e. Lira).
- Un replaced old fleet. UBTS requires replacing at most three Motor vehicles per year based on the length of utilization.

3.1.16 Mulago National Referral Hospital

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

Currently there are 1,726 staff at Mulago, these are both clinical and non-clinical (support staff) against the approved establishment of 3,075.

TABLE 52: HUMAN RESOURCES OF DIFFERENT CADRES AT MULAGO NRH

Post	Approved	Filled	Vacancies	Percentage
Senior Consultant	70	21	49	30%
Consultants	107	35	72	32.7%
Medical Officer Special Grade	178	46	132	25.8%
Senior Medical Officer Special Grade	0	2	-2	
Medical Officer	52	75	-23	144.2%
Nursing Staff	1,930	883	1,047	45.7%
Allied Health	294	239	55	81.%
Others	444	425	19	95.%
Total	**3,075**	**1,726**	**1,349**	**56.2%**

TABLE 53: PERFORMANCE INDICATORS FOR INPATIENTS FY 2016/17

Indicators	Medical	Surgical	Pediatrics	Obs/Gyn	Emergency	Private
Patient days	249,026	219,736	107,288	26,232	24,491	23,292
Admissions	28,202	21,979	18,161	15,194	40,891	5,923
Bed occupancy rate (%)	128%	117%	124%	125%	130%	75%
Recovery Rate (%)	88%	90%	95%	99%	82%	98.5%
Self-discharge/ Runaway rate (%)	1%	2%	2%	0.3%	2%	0.5%

Acheivements in FY 2016/17

- A number of renovations, remodeling and constructions were also done in this period of time among which are: Construction of staff houses, the ICU Unit was remodeled and re-equipped the laundry department and extended piped oxygen to upper Mulago. Plastering and painting of 100 units of staff houses.
- New equipment was delivered under the ADB Project.

- Renovation of Lower Mulago Hospital is on course and will become a National Specialized Hospital.
- Construction of a new super specialized maternal and neo-natal unit is on course and is expected to be completed in October 2017; this too shall be part of the National Specialised Hospital.
- Five vehicles were procured to facilitate movement of staff to Kawempe and Kiruddu.

100 UNITS OF STAFF HOUSES

REMODELED ICU

3.1.17 Butabika National Mental Referral Hospital

Achievements 2016/17 FY

- 9,472 out of the planned 8,500 patients admitted
- 41,382 out of the planned 28,000 laboratory investigations conducted. The increase in laboratory investigations conducted was due to availability of enough reagents and an HIV/AIDS outreach activity carried out outside the Hospital.
- No x-ray investigations done due to lack of a functional x-ray machine.
- 1,949 out of 2,000 ultrasounds conducted
- All 9,472 inpatients provided with 3 meals a day
- All 9,472 inpatients provided with uniforms and beddings
- 2 researches undertaken - Nutrition status among patients in Butabika Hospital – Data collection and Causes of death in Butabika Hospital one-year audit.
- 34,140 out of the planned 32,000 patients attended to in the OPD
- 648 patients attended in the Alcohol and Drug clinic.
- 60 45 outreach clinics conducted in the areas of Nkokonjeru, Nansana, Kitekika, Kawempe, Katalemwa and Kitebi.

- 24 visits to Regional Referral hospitals (Moroto, Jinja, Mbarara, Mubende, Lira, Hoima, Masaka, Soroti, Mbale, Gulu, Kabale) mental health units.
- 489 patients resettled within Kampala/Wakiso and 578 resettled upcountry.
- 15,634 out of the planned 2,000 children immunized. The increase was due to the child health day and children from school surrounding the Hospital were immunized.
- Completed the Expansion of Private wing.
- Procured the Bio-safety Cabinet.
- Commenced the expansion of the Alcohol and Drug Unit.
- Procured kitchen utensils and assorted medical equipment.

3.1.18 Uganda Cancer Institute

In FY 2016/17 UCI achieved the following outputs;

- Prepared 10 research proposals on rheumatic heart disease.
- 10 publications on RHD Genetic, HI, Anticoagulant done.
- Hypertensive registry ongoing.
- RHD non-experts training completed in Gulu.
- Data on TB Pericardium cardiomyopathy collected and done.
- 63 out of the planned 100 Open Heart Surgeries performed.
- 396 out of the planned 500 interventions (54 closed heart surgeries and 342 cardiac catheterization procedures) done.
- 9,850 out of the planned 12,000 Echocardiographs (ECHO) performed.
- 7,874 out of the planned 11,000 ECG's performed.
- 1,184 out of the planned 1,200patients admitted.
- 522 out of the planned 500 patients in ICU/CCU attended to. The over performance was due to increased demand for critical care services, increase in the number of ICU beds from 2 beds to 4 beds and also establishment of an ICU nursing team to provide support to patients.
- 63 out of 100 stress tests performed.
- 107 out of 100 pacemakers programming performed. Low performance was due to breakdown of the stress test machine but a new stress test machine was procured at the end of the FY 2016/17.
- 57,559 out of 20,000 laboratory tests done. Over performance was attributed to the fact that the team started 24-hour laboratory service provision and 2 staff were recruited to provide support to the team.
- 180 out of 200 Holter monitoring performed.
- 1,352 out of 1,200 X-rays performed. Over performance was due to procurement of new equipment and the increased demand for the service especially in the critical care unit as well as.
- Super specialized skills transferred to UHI staff through in-house camps and expatriates facilitated.

- 2 doctors trained in anaesthesia in Egypt and Italy, 1 intensivist still on training in USA, 3 nurses trained in critical care and 2 doctors trained in cardiology.
- 12 Regional Referral Hospitals visited.
- Heart care support and education provided to 90 specialized groups.
- Assorted specialized surgical instruments, procedural instruments, machinery and equipment for Cath-lab, adult and Paediatric cardiology, laboratory, Perfusion, Physiotherapy and Anaesthesia departments procured.

The combined output of open heart surgeries, closed heart surgeries and cardiac catheterization interventions was 459 cases, that is 45.9% utilization of UHI capacity yet total government funding of UGX 4.0 billion (USD 1.1m) could support only 220 surgeries which is 22% of UHI capacity utilization. The balance of 239 cases operated was supported by internally generated funds (AIA) and donations of super specialized sundries from collaborating organizations.

3.1.19 Central Public Health Laboratories (CPHL) and National TB Refrence Laboratory (NTRL)

- CPHL and NTRL moved to their new rent-free facility at Butabika. Infrastructure built with support from PEPFAR through CDC (CPHL) and GOU with a loan from World Bank (NTRL).
- The Uganda National Health Laboratory Services Bill 2016 was passed by cabinet, published in the national gazette and presented on the floor of Parliament. Currently before the committee of health
- The national laboratory policy has been reviewed and lab strategic plan II developed to take care of new developments like Point of care testing. They policy and strategic plans are currently going through the approval processes of MoH.
- A national Lab day has been established to take place once a month where members of MoH Top Management converges at CPHL to discuss lab issues.
- The Early Infant Diagnosis and Viral Load laboratory at CPHL attained international accreditation to ISO15189 Standards through South African National Accreditation System (SANAS). This means the lab results are highly accurate, can be relied upon for patients' care, and are trusted all over the world.
- All the 100 hubs have equipment for CD4, Haematology, Chemistry, and TB Gene Xpert.
- Biomedical Engineers have been trained and certified to service and certify biosafety cabinets. This is service has always been sourced from Kenya and South Africa.
- The lab infrastructure has been upgraded in 80% of the hubs all over the country. Upgrade is still on-going in some facilities with support from PEPFAR supported IPs.
- Total tests done at CPHL: HIV Viral load testing; HIV VL = 804, 575; EID = 130,822. These met and surpassed the target of 600,000 tests for the year.
- Several disease outbreaks were investigated both within CPHL laboratories, and in collaboration with UVRI and other reference Labs. The following diseases were confirmed Cholera, Typhoid, Meningitis, yellow fever, CCHF, Measles, and Anthrax.

- Total lab tests for the whole country; Total tests: Chemistry = 3,051,742; Haematology = 4,872,481, Blood crossmatch (for transfusion) = 3,999,579; parasitology = 7,157,223; Serology = 6,598,905, CD4 = 1,064,372; Microbiology = 3,741,279. Obtained from DHIS2
- African Society for Laboratory Medicine (ASLM) audited 16 laboratories and 15 of them received certification in accordance with the WHO-AFRO SLIPTA standards. All the 16 laboratories are currently being fast-tracked for international accreditation.
- 89 of the 100 hubs enrolled on SLMTA/SLIPTA were audited; 14 attained star 3, 35 attained star 2, 22 got star 1 and 18 did not get any star. This is good progress towards attainment of star 3 for all the 100 hubs by year 2020.
- Increased number of motorbikes in the hubs from one to two. This is to take care of TB for gene x-pert and disease outbreak investigations.

3.2 Annex Two: Integrated Health Sector Support Systems

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

3.2.1 Planning and Policy

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

In FY 2016/17, the Department was able to coordinate, compile and submit sector planning and reporting documents including the Budget Framework Paper 2017/18, The Annual Work Plan 2017/18, the Ministerial Policy Statement 2017/18, the Health sector improvement plan to attain middle income status, quarterly progress (OBT) reports, the revised LG Health Planning Guidelines 2016, the PHC conditional grant guidelines 2017/18, the Health sector Negotiation issues with LG FY 2017/18 and prepared the AHSPR 2015/16. Finalized the 5-year Public-Private Partnership for Health Strategy (2017/18 - 2021/22).

The department conducted 4 regional planning meetings to enhance sector planning, held 2 regional JRM in Rwenzori and West Nile, held 8 SBWG meetings.

The department further carried out 8 support supervision visits to 45 LGs, disseminated the revised planning guidelines to all LGs; and carried out budget monitoring. Carried out technical supervision of capital development projects in 5 RRHs and 23 general hospitals to ensure infrastructure standards, quality and guidelines are adhered to.

The draft NHA report for the FYs 2014/15 and 2015/16 has been prepared awaiting further analysis by WHO and the Certificate for financial implications on the NHIS was issued to the sector by MoFPED.

6 project proposals developed and appraised by the department, including; the drive project proposal, the ADB support, the World Bank support, the Italian support to HSDP and the Belgian support to the HSDP.

Mapping development partner activities at National, Regional and district level is very crucial for coordination of Development Partner support to the sector. However, this was not achieved.

The sector has developed and reviewed a number of bills and regulations which are supposed to be presented to Cabinet but there was no much progress realized. Bills submitted to Cabinet include; Uganda Human Organ Transplant and Tissue Bill and the Uganda Health Service Management Institute Bill. Bills passed into Acts by Parliament were; Uganda Allied

Health Professionals Regulation, Uganda Cancer Institute Bill, 2015, Uganda Heart Institute Bill, 2015 and Uganda Immunization Act, 2016.

Policies finalized included; Palliative Care Policy, Rehabilitative and Health Care Policy and Uganda Immunization Policy.

Held one DHOs annual meeting to review decentralized health service delivery and prepared action points to improve service delivery at the lower level health facilities.

3.2.2 Health Information

MoH is currently implementing the electronic data collection, management and analysis at all levels of the health system aimed at improving on expediency, accuracy and feedback. The main platforms are DHIS2 and mTrac. Several stakeholders, (at district, health facility, MoH Departments, national level institutions, development partners, private sector and civil society) are involved in the generation and use of information for decision making for planning, management and accountability within the health sector. Engagement of all stakeholders is crucial for improvement of eHMIS in the entire health system.

Some of the data generated from the weekly surveillance reports are Epidemic conditions (Case and Deaths), maternal and perinatal deaths, malaria case management data, tracer medicines stock balance, eMTCT drugs stock balance. The MoH programs access the weekly data through DHIS2 and through weekly summary and take appropriate action. The action centers at Central level are ESD, Public Health Emergency Operation Center (PH-EOC), NMCP, RH Division, NTLP, Pharmacy Division (PD) and Health Monitoring Unit (HMU).

During this reporting period, there are some activities as stated below that were conducted to build awareness, improve data quality, data use and response among the various stakeholder;

i. eHMIS National Stakeholders workshop. The MoH through WHO support conducted a national stakeholder's workshop of 60 participants whose objective was to strengthen dissemination of information and receiving feedback for decision making purposes.
ii. Regional e-HMIS training. WHO supported the Division of Health Information to conduct four regional e-HMIS training for 122 districts. A total of 336 Participants including biostatisticians and surveillance focal officers participated in the 4-days training. The trainings aimed at strengthening technical skills of district teams to support health facilities to improve data collection, reporting (through mTRAC) or in DHIS2, utilization and feedback.
iii. Data validation on Malaria and Maternal Deaths data. Conducted data validation with focus on critical indicators in weekly surveillance (e.g. Malaria, Maternal Deaths) data submitted through the mTRAC system from 22 selected districts in Uganda.

iv. eHMIS orientation to district leadership: CAOs, DHOs, LC5s, BIOs, Secretaries for health and RDCs for evidence/informed decision making purposes. MoH through WHO support carried out four regional meetings in 116 districts of Uganda; these are Northern, Eastern, Western and Southern regions for the District leadership. A total of 672 participants were oriented.

v. Cascading Support Supervision. The Division of Health Information with support from WHO supported a cascaded mechanism with a phased-out approach by the DHT to the lower health facilities in all the 116 districts of Uganda.

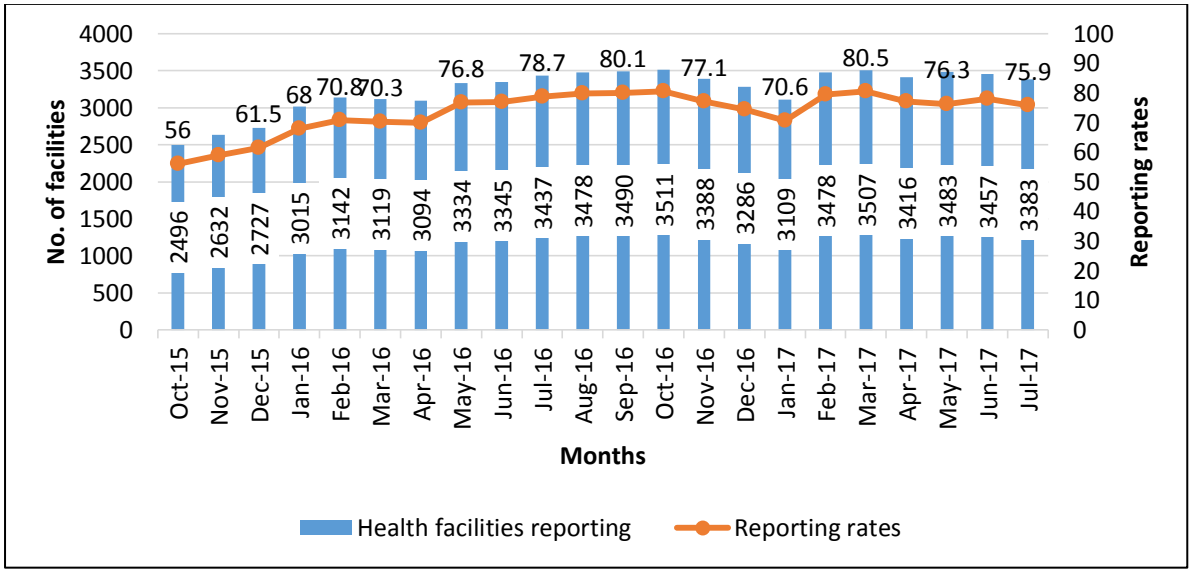
vi. Support Supervision of the 30 poorest reporting Districts

vii. Training on revised HMIS tools. Over 600 health workers were trained on the HMIS revised tools; additional mentoring and couching was done to improve reporting and data use at a facility level.

viii. Refresher training on Mtrac. Refresher training on mTRAC an SMS based application was conducted which is used by the health sector to facilitate timely submission of weekly surveillance data to all stakeholders to monitor disease trends, epidemic outbreaks and track medicines availability as well as Malaria case management.

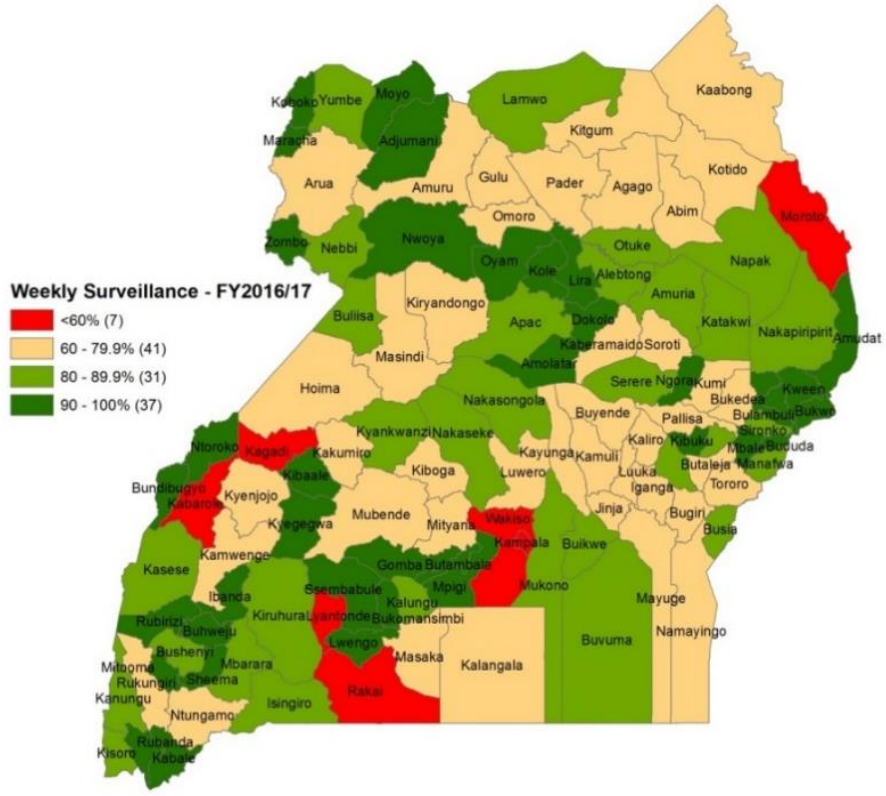
Over the past seven months, the weekly reporting from regions has stagnated at 59 - 77% in western region with an average reporting rate of 75% during this period.

FIGURE 29: TRENDS OF MTRAC SURVEILLANCE HEALTH FACILITY REPORTING BY MONTH



Efforts have been put in place to improve follow up and support the weak performing district. Below is map showing the reporting by district. Specific feedback and follow up is focused to the districts reporting <80%.

FIGURE 30: WEEKLY SURVEILLANCE REPORTING BY DISTRICT IN 2016/17



3.2.3 Sector monitoring and quality assurance

The key achievements were;

- The review of implementation of the MoH work-plan for 2016/17 FY in 3 out of the 4 quarters. The review reports were compiled and disseminated to the key stakeholders.
- 10 out of the 12 (83%) SMC meetings took place and around 27 policy related issues were adopted and forwarded to HPAC for further considerations and subsequent approval.
- 6 out of the 14 (43%) TWGs reported monthly to SMC while the rest did not meet regularly.
- Adapted the WHO MNCH standards for Quality Improvement (QI) and the road map for their implementation was finalized.
- Printed 5,000 copies of the Service standards and the service delivery standards and 10,000 copies of the National Infection Prevention and Control Guidelines which have been disseminated to 60% of the districts.
- The 3rd National QI Conference took place in August 2016 where the Health Sector Quality Improvement Framework and Strategic Plan 2015/16 to 2019/20 was launched by

the Hon. MOH in-charge of PHC. The framework has been disseminated to all the districts in the country during 2016/17 FY.

- Supervision took place in all the four quarters focusing on human resource, infrastructure, immunization, HMIS, governance and leadership, and availability of essential medicines and health supplies. Area Team support supervision for the 2nd quarter took place and the report was presented to SMC and HPAC. Impromptu QAID led supervision was conducted in the 3rd and 4th quarters which covered 75 (60%) districts.
- The Pre-JRM field visits took place in September 2016 and the report was shared during the JRM meeting.
- The review of the Health Sector support supervision strategy is underway and shall be completed and rolled out in 2017/18 FY.
- QI Teams have been established in all the districts and most health facilities in the country. The teams are being supported to become operational during the joint technical support supervision field visits with the health implementing partners.
- 5S implementation has been strengthened in the RRHs and with supported by JICA shall be rolled out in all health facilities in 2017/18 FY.
- Health Facility Quality Assessment Programme (HFQAP) has been carried out in 62 (49%) districts to establish the baseline. Assessment for the rest of the districts in the country shall be completed in 2017/18 FY before the annual assessment can become institutionalized.
- Knowledge Management Portal was established where the MoH server was upgraded with improved speed, navigation, photo gallery added and an automated archive. Capacity building for its effective use shall take place in 2017/18 FY.

3.2.4 Regulation

The Uganda Private Sector Support Program has over the years carried out initiatives to strengthen the capacity of three of the four professional medical councils to perform their licensure and regulatory functions. These councils are responsible for enforcing standards, validating continuing education requirements, and sanctioning providers who fail to comply with the necessary requirements. The four councils are: Uganda Medical and Dental Practitioners' Council (UMDPC), Uganda Nurses and Midwives' Council (UNMC), Allied Health Professionals Council (AHPC) and Pharmacy Council.

- The laws of the three councils have been reviewed and harmonized.
- New Amendment laws have been drafted with involvement of stakeholders.
- The design of a new common digital registration platform for standardized licensing procedures across councils has been completed and is operational on the ACHEST servers.
- Standards for inspection and licensing of facilities have been reviewed and the design as well as development of a common digital platform for the procedures was completed.
- Tools for quality assessment have been reviewed and updated.
- All the 3 councils have updated their CPD requirements.

- The CPD tracking function is fully integrated in the web based platform and linked to the licensing function.
- UMDPC and AHPC procured their permanent headquarters from their local collections.
- UMDPC opened operations for regional inspectors in 8 regions.
- Consensus build on the PPPP Bill, 2006 and the report submitted to Top Management for further action and final decision on a few contentious provisions.
- A total of 130 newly qualified pharmacists were during the period, which has increased the number of pharmacy practice units manned by pharmacists countrywide and improved the quality of pharmaceutical care and logistics management in those areas.
- The Board held four ordinary meetings and four special meetings contributing to improved efficiency of the secretariat resulting into shorter registration processes, from months to weeks from the time complete applications are received.

3.2.4.1 National Drug Authority

The key achievements this FY were;

- 11% increase in the number of pharmacies and local pharmaceutical manufacturers licensed, and 8% increase for drug shops;
- Increase of 2.4% in GMP inspections of foreign finished product pharmaceutical facilities and 6.7% for local facilities, resulting in increased access to good quality drugs in the Uganda.
- Adopted web-based, online review platform for tracking research applications (RHInnO) in order to improve efficiency in clinical trial activities.
- Drugs registered
    - Human- 4,989 (83.2%)
    - Veterinary- 521 (8.7%)
    - Human Herbal (foreign) - 138 (2.3%)
    - Veterinary Herbal (foreign) - 6 (0.1%)
    - Human Herbal (domestic) - 2 (0.01%)
    - Public health products- 25 (0.4%)
- Pharmacies inspected
    - 184 pharmacies inspected;
    - 144 pharmacy licenses approved
    - 31 applications Rejected
    - 9 applications Queried
- Public Health Facilities for Good Pharmacy Practices (GPP) - 34 public outlets were inspected
- Inspection and licensing of drug shops - 747 drug shops were approved
- Sensitization meetings were held with Inspectors of drugs, Enforcement officers, URA on ASYCUDA World and joint control on drug imports.
- Conduct cGMP inspection of foreign pharmaceutical manufacturing sites

    - 30 GMP inspections done: (07 complied first time, 23 were pending submission & review of CAPA)
    - 12 facilities assessed through document review
    - 28 GMP certificates issued
- Follow-up GMP inspection done for all 12 local pharmaceutical manufacturing facilities in Uganda.
- 5,420 Import permits granted and 177 Export permits granted
- Inspection of drugs at ports of entry (Nakawa, Entebbe & Busia/Malaba)
    - 5,543 consignments were inspected;
    - 5,503 Approved
    - 35 Queried
    - 03 Rejected
- Testing of samples (drugs, condoms, medical gloves & LLINs)

  Medicine samples:

  •Received 60

  •Tested 54

  •Failed 12

  Condom samples
    - Received & tested 257
    - Failed 23

  Medical Gloves samples
    - Received & tested 79
    - Failed 02

  LLINs samples
    - 15 received
- Sensitize health workers on ADR monitoring & reporting - press conferences held and 8 Radio and TV talk shows done.
- 20 ADRs largely ARV related were received
- 19 clinical trials inspected for GCP
- The Bill provides for the legal framework for the establishment of the National Food and Drug Authority. Is in its final drafting by the FPC. Expected to be ready for discussion by Cabinet in July 2017.

3.2.5 Pharmaceutical Supplies and Health Products

The following key outputs were achieved by the Pharmacy Division in the FY 2016/17;

- Supported the Global Fund Grant (January 2018 – December 2020) application writing and prepared supply plans and funding gap analyses for HIV, TB and Malaria Commodities. The value of funds requested for was $183m for ARVs, $23.9m for HIV test kits, $16.5m for other Laboratory commodities, $12m for condoms, $6m for Cotrimoxazole, $57m for ACTs, 46m for LLINs, and $11.7m for TB medicines.

- Supported transfer of stock across warehouses. Four transfers were effected from NMS to JMS. One transfer from MAUL to JMS. Low stock levels at JMS were attributed to shipment delays
- Conducted and updated quantification and supply plans for
    - Reproductive health, ARVs and Cotrimoxazole, TB medicines, Lab and malaria commodities (2016-2020)
    - Reprogrammed savings worth $6.6million from the HIV and TB Global Fund grants to procure ARVs. With USAID and the US Centers for Disease Control and Prevention, calculated the public sector ARV funding gap (US$ 34 million) and USD$ 8.2 for HIV Test kits for the period July 2017 to March 2018.
    - Placed orders for HIV tests kits to Global fund from savings under the additional PEPFAR $11.5m fund through the Global Supply Chain Program to support gaps in the public sector.
- AMU activities
    - Participated in the development of the Anti-Microbial National Action Plan
    - Revitalized the medicines therapeutic committees in regional referral hospitals however senior consultants are not keen to participate actively in these committees in some of the hospitals
    - Printed 40,000 copies of Uganda Clinical Guidelines and 10,000 copies of the Essential Medicines and Health Supplies List Uganda 2016.
- RMNCAH activities
    - Updated and disseminated the Reproductive Health Commodity Security Strategy and the Alternative Distribution Strategy. However, most DHO's/DHT's are still not aware of this strategy.
    - Conducted an annual assessment of RMNCAH commodity landscape
    - Finalized the Uganda National RMNCAH quantification and supply plans 2016-2020
    - Supported the development of the national comprehensive condom programming implementation plan 2015-2020.
- Development of tools and guidelines
    - Developed and disseminated 5,150 copies of the HMIS 105 Job Aid on how to correctly fill section six on medicines. These will have been distributed to over 3,000 health facilities with the aim of improving accuracy and completeness of HMIS reports.
- Rx Solution Scale-up
    - As part of computerizing the health facility stores, Installed Rx Solution in up to 200 health facilities, the challenge now is functionality of the system and power supply at some of the health facilities.
    - Procured and distributed 66 computers and accessories for strengthening facility level LMIS in 60 selected facilities (HC IIIs, HC IVs and Hospitals).

- Established in-patient pharmacies in Regional and some General hospitals to improve the accountability of medicines in the wards however the challenge is low staff levels.

- As part of capacity building, the following trainings were conducted;
  - Five-day HIV, TB and Laboratory logistics management training of 228 health workers.
- ARV logistics activities
  - Supported the roll-out of the test and treat consolidated ARV guidelines
  - Finalized the ART SPARS concept note development
  - Reviewed the ARV order and patient reporting form
  - Supported review of the training manual for the ARV differentiated delivery service model (DSD)
  - Conducted a verification exercise of ARVs delivered in comparison with what was ordered in 163 health facilities.
- SPARS activities. 3,318 Facilities started supervision, performance assessment and recognition strategy (SPARS) in 114 Districts, 21,451 visits were conducted leading to an improvement in medicines management with an average facility performance score of 18.8 out of 25 maximum score in the areas of stock and storage management, dispensing and prescribing quality, ordering and reporting.
- Prepared central level and facility level stock status reports that led to redistribution of commodities from overstocked facilities to understocked facilities, stock transfers at the central warehouses etc.
- Coordinated and conducted the monthly commodity security group meetings, medicines procurement management and technical working group meetings and M&E health commodity group meetings.

3.2.6 Health Infrastructure Development and Maintenance

In the FY 2016/17, the following were the accomplishments;

TABLE 54: INFRASTRUCTURE DEVELOPMENT PROJECTS STATUS

Project Name	Specific objective	Achievement	Challenges	Way Forward
Uganda Health Systems Strengthening	To improve sector management, Health infrastructure, Access to quality maternal and new born health, Family planning services	1 RRH and 8-GHs (Moroto RRH, Iganga, Entebbe, Mityana, Nakaseke, Kiryandongo, Moyo, Nebbi & Anaka GH) renovated, all works completed by June, 2017 & in use. Construction of 10 Theatres/ 16 Maternity Wards and Water Supply including 40,000 Litre Reservoir for 26 HC IVs (Aboke, Aduku, Atiak, Budaka, Budondo,	Maintenance and Operational Budgets need to be put in place for high value equipment like X-Rays, Autoclaves, dental equipment & the new buildings constructed for sustainability etc. Equipment supplied to some facilities not in use.	Improvement in equipment maintenance & redistribution be handled

Project Name	Specific objective	Achievement	Challenges	Way Forward
		Bugono, Buvuma, Buyinja, Bwijanga, Kabuyanda, Kasanda, Kibuku, Kiganda, Kikamulo, Kitwe, Kiyunga, Kyantungo, Mwera, Mwizi, Nankoma, Ngoma, Ntenjeru-Kojja, Obongi, Padibe, Pakwach & Rubare) completed by June, 2017 & in use. Medical Equipment and Hospital Furniture for 2 RRHs, 17 GHs and 27 HC IVs provided & in use. 19 Ambulances, 2 for RRH & 17 for GH distributed & in use. 46 General transport vehicles for 2 RRHs, 17 GHs and 27 HC IVs distributed & in use. Two (2) Mobile workshop vehicles in use at Mubende and Moroto RRH Two (2) more Mobile workshop vehicles procured for Jinja and Masaka RRH. To be delivered by end of September, 2017.		
Development of a Specialised Maternal and Neonatal Healthcare unit in Mulago National referral Hospital (Mulago III Project)	Contribute to improvement of access to specialized maternal and neonatal morbidity and mortality through construction of a 450-bed Hospital facility and equipping with state of art medical equipment and furniture and improvement of Services Quality through conducting specialized trainings of health workers as well as developing relevant hospital	Construction of 450 Bed specialised Maternal & Neonatal hospital is on course and is expected to be completed in October 2017. Civil works is 97% complete. Good quality of works has been achieved. 33 medical staffs have completed Specialised training and 6 others are currently undergoing training abroad.	Delay in release of GoU Counter - part funding to the project. - Delay in release of VAT refund to contractor and consultant may attract interest at some stage if not addressed now.	MoH to budget for funds to pay for Counterpart funding and VAT to avoid huge interests charged by the respective service providers, which may if not addressed in time, can escalate project costs.

Project Name	Specific objective	Achievement	Challenges	Way Forward
	management protocols.			
Support to Mulago Hospital Rehabilitation	Improve delivery of quality services, decongest, strengthen medical education and research capacity	Renovation of Mulago ongoing to be completed in 2017/18 FY		
Rehabilitation and expansion of Kayunga and Yumbe hospitals with support from Saudi Fund/OFID and BADEA	To deliver the Uganda National Minimum Health Care Package (UNMHCP)	Completed designs for civil works 80% complete with preparation of tender documents for procurement of medical equipment and hospital furniture	Delayed completion of the designs by the consultant	Follow up of processes towards signing the civil works contract by 30th November 2017
GAVI Vaccines and Health Systems Strengthening	To strengthen health systems& ensure universal access to the UNMHCP in order to reduce morbidity and mortality.	19 medicine stores constructed but at different physical status levels. Lot 1: 88% (Napak, Alebtong & Agago), Lot 2: 92% (Ntoroko, Rubirizi, Sheema, Buhweju, Isingiro, Lyantonde & Lwengo), Lot 3: 98% (Buikwe, Pallisa, Luuka, Serere, Nakapiripit & Bukwo), Lot 4: 96% (Nakaseke, Buliisa & Zombo). Civil works ongoing for construction of 26 staff houses at different physical progress levels: Lot 1: 83% (Bulambuli (2), Namutumba (1), Bugiri (2), Namayingo (2) & Mayuge (2) Lot 2: 93% (Kakumiro (1) & Kagadi (01), Bundibugyo (2), Kasese (2), Kanungu (2), & Kisoro (2) and Lot 3: 99% (Mukono (2), Wakiso (1), Kalangala (2) & Buvuma (2).		
Italian support to the HSSP and PRDP: Karamoja staff housing	Construction of 34 staff housing units at HC IIIs in Karamoja, assorted medical equipment to be provided by in-kind by donor	Construction started	Construction stalled at wall level due to procurement delays and delays in payment	
The Global Fund Grants to fight HIV/AID, Malaria and Tuberculosis	Scaling up prevention, Care, Treatment and Health System Strengthening. Support for the introduction of highly	Contract with Contractor for construction of a new warehouse for NMS signed in June and work to commence FY 2017/18. 83 motorcycles for the Lab hubs	Procurement took a long time as it involved design and build by the same contractor and so needed clearance	

Project Name	Specific objective	Achievement	Challenges	Way Forward
	Effective Artemisinin-Based Combination Therapy Treatment.	150 autoclaves for HC IIIs were procured	from PPDA, Solicitor General and GF	
ADB support to UCI	To address the crucial labour market shortages highly professionals in oncology sciences and cancer management in Uganda and EAC region.			
Rehabilitation of Lira, Gulu & Arua referral Hospitals	Improve effective delivery of an integrated UNMHCP	Assessment of proposed scope of work still ongoing.		
Spanish Debt Swap for renovation of Kawolo and Busolwe Hospitals	Improve effective delivery of an integrated UNMHCP	Works Commenced at Kawolo	Delayed Payments to Contractors and Consultants	Improve in document handling.
Infrastructure development under PHC	Improved infrastructure development in LGs	24 LGs were supported with funds to expand and renovate the following hospitals and HC IVs; Adjumani GH, Kitgum GH, Kabarole GH, Kiboga GH. Kapchorwa GH, Pallisa GH, Itojo GH, Kitagata GH, Bugiri GH, Atutur GH, Apac GH, Abim GH, Bundibugyo GH, Kaberamaido GH, Masindi GH, Kagadi GH, Kambuga GH, Tororo GH, Gombe GH, Bududa GH and Kaabong GH. Maracha HC IV and Rukunyu HC IV are upgrading to general hospitals.	Insufficient funds	
Construction and Equipping of the International Specialised Hospital of Uganda	Construction & Equipping of a 240 bed hospital Procurement of Specialised medical equipment Financing by the M/S Finasi/Roko SPV in final stages	Ground breaking ceremony was done and project commenced. MoH advertised for scholarships for health workers to be trained in specialities to be provided by the hospitals	Insufficient GoU allocations on the project that requires counterpart Funding to the tune of UGX 54.4 billion	
East Africa Public Health Laboratory	Improve training, Regional diagnostics & Surveillance.	Civil Works for NTRL at Butabika complete and functional. Documentation for contracting		

Project Name	Specific objective	Achievement	Challenges	Way Forward
Networking Project	Build capacity for operational research, and Knowledge Sharing	civil works at Lacor- Gulu, Mbarara, Arua and Mbale is work in progress.		

3.2.7 Directorate of Police Health Services

In the context of service delivery, the police community means and includes; officers and men of the Uganda Police Force (UPF), their immediate family members, the suspects in police custody and the community members surrounding the police establishments. Heath services are offered at the ninety-two (92) Police HCs at different levels; HC IV are four (04), HC III are ten (10) and HC II are seventy-eight (78) and these have been strategically located to handle the operational challenges in UPF. The Directorate further extends its services to the general population through medical emergency response and provision of Medico-legal services.

During the reporting period FY 2016/2017, the Directorate carried out a number of activities both at static sites and outreaches and the key ones among others are highlighted below;

(i) HIV and AIDS activities for prevention and control of the spread of HIV among the Police community and mitigation of its impact. Emphasis was on health education, HIV Counseling & testing, treatment of those found HIV positive, post exposure prophylaxis. Comprehensive HIV services were offered at Eleven (11) accredited ART sites located at Kibuli, Naguru, Mbarara, Rukungiri, Jinja, Mbale, ASTU-Katakwi, Gulu, Arua, Masaka and Hoima.

(ii) Maternal and child health services were also offered at three (03) maternity centers of Nsambya, Masaka and Jinja and seven antenatal care centers at Mbale, Tororo, Gulu, Arua, Hoima, Naguru, Hoima and Rukungiri.

(iii) Medical clinical services through clinical and laboratory diagnosis of diseases/conditions of out patients/clients, treatment of patients, referral of those who need specialized services and ensured availability of medicines, consumables and health facility equipment. This was achieved at the ninety-two (92) police HCs with twenty (24) medical laboratories, three (03) dental clinics at Nsambya, Naguru & Kabalye and on eye care site at Nsambya.

(iv) The Directorate engaged in medico - legal activities through postmortem examinations and examination of victims and suspects of different offences aimed at providing supporting scientific evidence before courts of law.

(v) Sanitation and hygiene promotion activities through community mobilization and awareness creation on various health issues, regular health inspections, and integrated vector management among the police establishments.

Key achievements for 2016/2017;

With funding from the GoU and implementing partners (USAID – Uganda HIWA project and JLOS), the Directorate managed to achieve among others the following key performances against set targets;

(i) 91 (98.9%) of the police HCs were supplied with medicines and other medical items directly from NMS.

(ii) Accredited and operationalized 5 (100%) Police ART sites of Gulu, ASTU Katakwi, Hoima, Mbarara, and Rukungiri police heath centers in addition to the six (06) ART sites at Nsambya, Naguru, Jinja, Arua, Mbale and Masaka.

(iii) Offered comprehensive ART services (as per the different HIV & AIDS program activity performance indicators) to the targeted community. Important to note is the 85,283 (159%) individuals who were counseled & tested for HIV of the targeted 53,576 individuals, 1,726 (104%) HIV positives were identified from those who received HTS services of the targeted 1,659 HIV positive individuals and 1,564 (149%) ART clients with viral load suppression of the targeted 1,048 ART clients.

Development partner's activities and how they have enhanced program performance
During the reporting period, the Directorate has been funded by Justice Law and Order Sector (JLOS) and USAID-UGANDA HIWA Project.

Justice Law and Order Sector (JLOS): Supported the police surgeons to perform postmortem examinations and examine suspects/victims of Gender Based Violence (GBV) across the country.

USAID-UGANDA Health Initiatives in Work Places Activity (HIWA) Project: It is a five-year project (2016 to 2020) that supports UPF in HIV and AIDs response in the police community. The project focuses on achieving the following Intermediate Results;

(i) Increased availability and access to comprehensive HIV/AIDS and other health services.

(ii) Improved quality of HIV and AIDS and other health services.

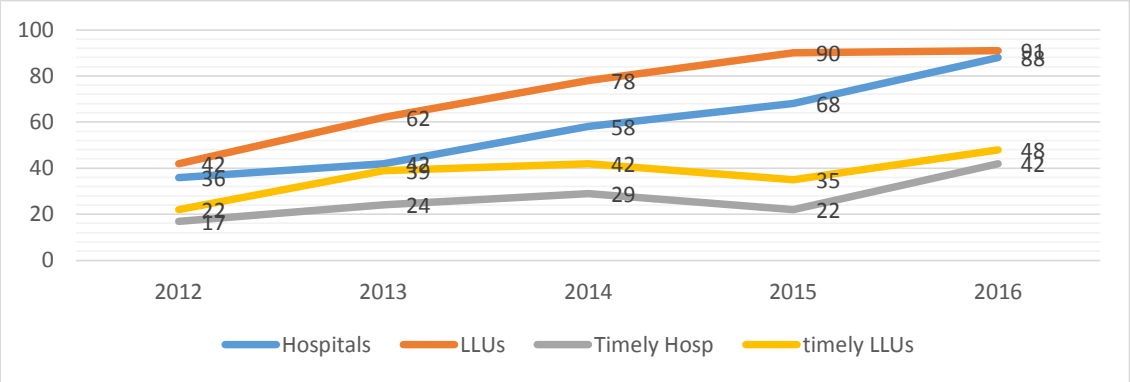
(iii) Increased uptake and utilization of HIV and AIDS and other health services.

3.2.8 Uganda Muslim Medical Bureau (UMMB) Performance for FY 2016/17

UMMB is a national organization established by the Uganda Muslim Supreme Council (UMSC) in 1999 to coordinate activities of Muslim non-profit health facilities.

By the end of the FY 2016/17 the membership of the bureau consisted of 52 health facilities, one Nurses and Midwifery training institution and one Medical Laboratory training institution. Construction of another health training institution in Yumbe District is underway.

FIGURE 31: UMMB NETWORK REPORTING RATES



3.2.8.1 HRH levels in the UMMB network

UMMB improved its management of HRH through iHRIS and this has been a great break through to oversee recruitment, retention and management of qualified health professionals at hospital and lower levels.

TABLE 55: STAFFING LEVELS AT UMMB FACILITIES BY JUNE 2017

Cadre	No.	Cadre	No.
Medical Officers	11	Dental Officers	02
Medical Clinical Officer	56	Darkroom attendants	01
Medical lab. Technologist	02	Enrolled comprehensive Nurses	45
Medical Lab. Technicians	22	Enrolled Midwives	46
Medical Lab. Assistants	37	Enrolled Nurses	83
Pharmacists	02	Nursing Officers	18
Dispensers	02	Midwife Officers	09
Radiographers	06	Nursing Assistants	90

Source- Ihris

3.2.8.2 OPD utilization

The UMMB network continued providing OPD services and there has been a steady improvement across FYs. This has been partly attributed to improved records management and reporting both to the secretariat and districts. Malaria still dominates the OPD as a case/diagnosis managed across all UMMB facilities established 28% in this FY.

TABLE 56: OPD ATTENDANCES IN UMMB FACILITIES SINCE 2013/14

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

3.2.8.3 Maternal and Child Health Services

UMMB has continued to be an advocate for adequate ANC services, safe delivery, child care including EID, post-natal services and family planning. Over the years, the performance of the network has been steadily improving in all the services with major capacity gaps addressed and improved recording and reporting of such services.

Table 57 highlights the performance for maternity services with only growth and improvement since 2014/15 FY. This is partly attributed to presence and availability of qualified midwives and Nurses (PREFA/CDC HRH support) extended to health facilities. Intensive mobilization of expectant mothers by VHTs and innovative strategies by some health facilities also played a role in increasing the clients in attending ANC services. There was an increase of 15% deliveries for 2016/17 FY.

TABLE 57: DELIVERIES IN UMMB FACILITIES

HF Levels	2014/2015		2015/2016		2016/2017	
	Deliveries	HIV+ Deliveries	Deliveries	HIV+ Deliveries	Deliveries	HIV+ Deliveries
Hospitals	3,426	118	3,973	102	4569	110
HC III - IVs	2,166	72	2,190	88	2519	78
HC IIs	880	7	636	12	731	17
Total	**6,472**	**197**	**6,799**	**202**	**7,819**	**205**

3.2.8.4 ANC Services

Great improvement in mother care has been witnessed in UMMB as qualified midwives and nurses are manning these clinics. 14% increase in 2016/17 in ANC is attributed to the above fact. ANC prevalence rate was also established at 1.1% and this is attributed to continuous community engagement by the facilities for sensitization for prevention of HIV/AIDs through HCT outreaches.

FIGURE 32: ANC SERVICES SINCE 2014/15 FY

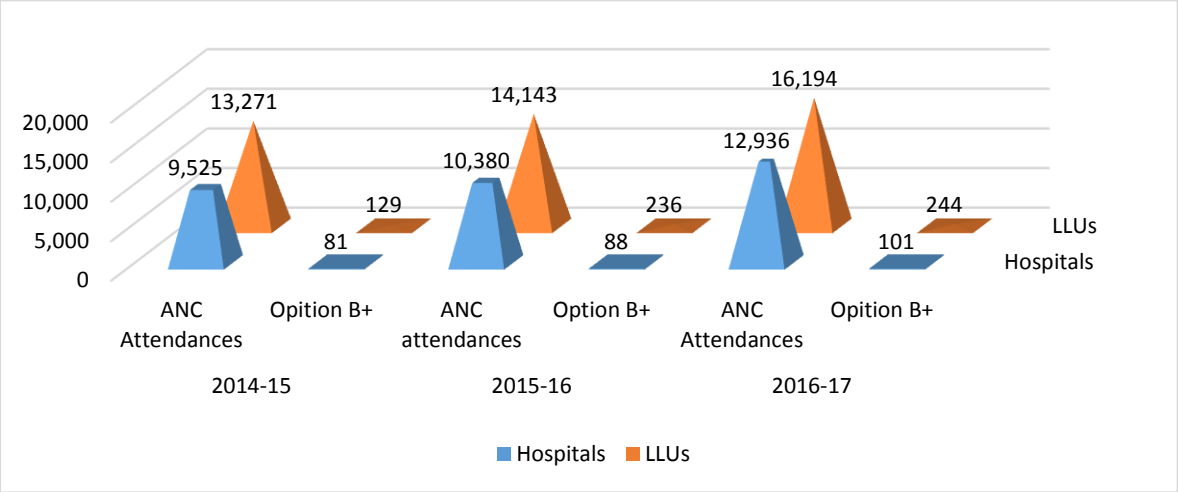


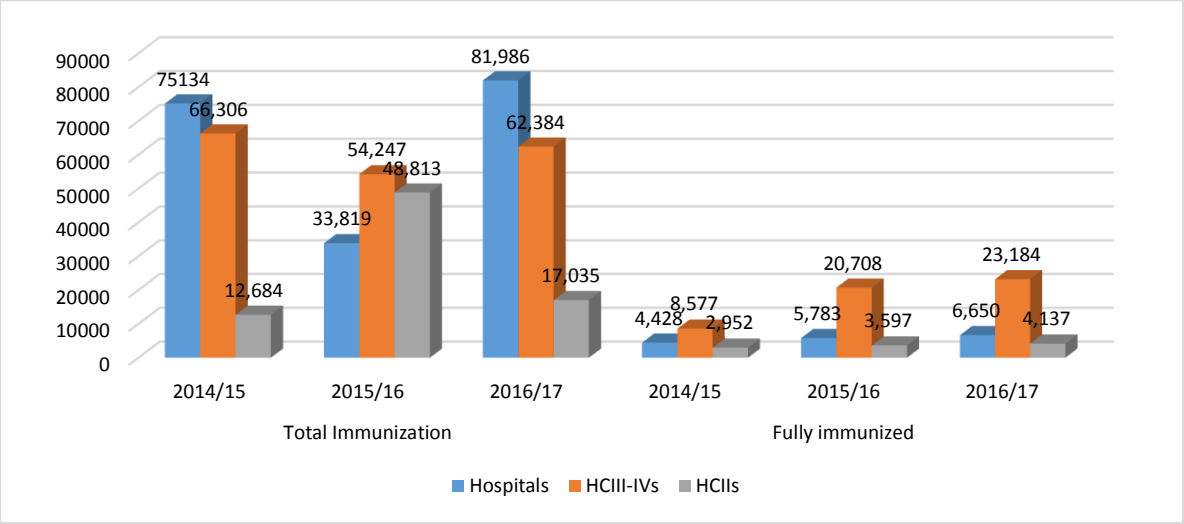
FIGURE 33: AN ANC SESSION AT LUGAZI MUSLIM HC

"We see our pregnant mothers as invited guests to a party and we are the host. It is our task to make Antenatal Care a little bit better, cost effective and offer this service with quality to achieve our mission." – Midwife at Lugazi Muslim HC

3.2.8.5 Immunization Services

Child immunization has continued to thrive in the UMMB network. Hospitals contribute more on this component compared to LLUs. HC IVs and IIIs have better completion rates compared to hospitals and HC IIs.

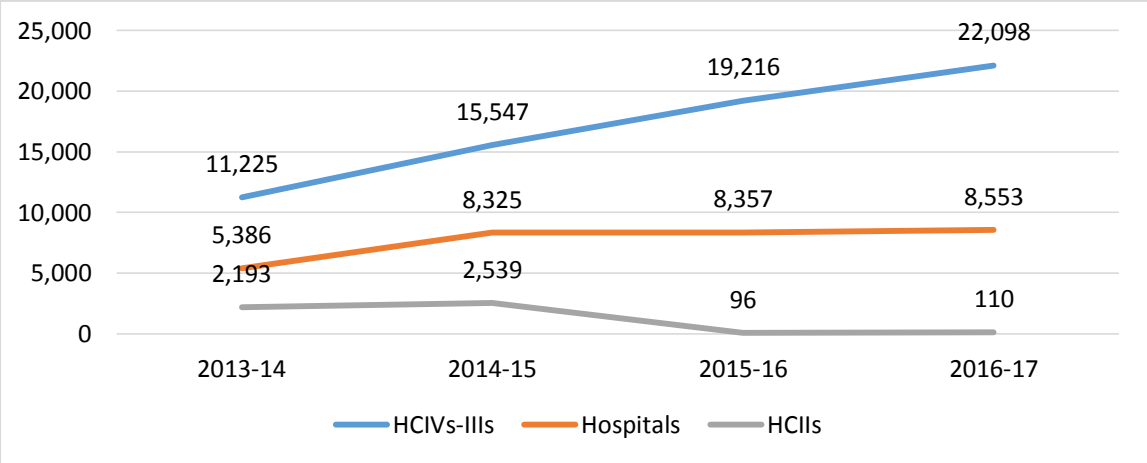
FIGURE 34: CHILD IMMUNIZATION IN UMMB FACILITIES 2016/17



3.2.8.6 INPATIENTS/ |ADMISSIONS

UMMB facilities have continued to provide this service as an integral part of the health care package. LLUs are dominating in terms of numbers of inpatients with 72% of the total inpatients in the network. The Bed Occupancy Rate (BOR) was established at 44% and the Average length of stay (ALoS) established at 2.5 days for the entire network.

FIGURE 35: ADMISSIONS IN UMMB FACILITIES



3.2.8.7 HIV/AIDs care and management

UMMB continued to provide AIDs care and management through its 15 ART sites and the data below shows the current number of clients in care and ART. The ART sites also adopted the Test and Treat approach as implemented by MoH.

By end of June, 2,052 clients were active on Cotrimoxazole (Pre-ART) and a total of 3,962 clients were active on ART. All the 2,052 clients were to be transitioned to ART at the beginning of July 2017.

3.2.8.8 Infrastructure

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

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

3.2.9 Uganda Protestant Medical Bureau (UPMB) performance 2016/2017

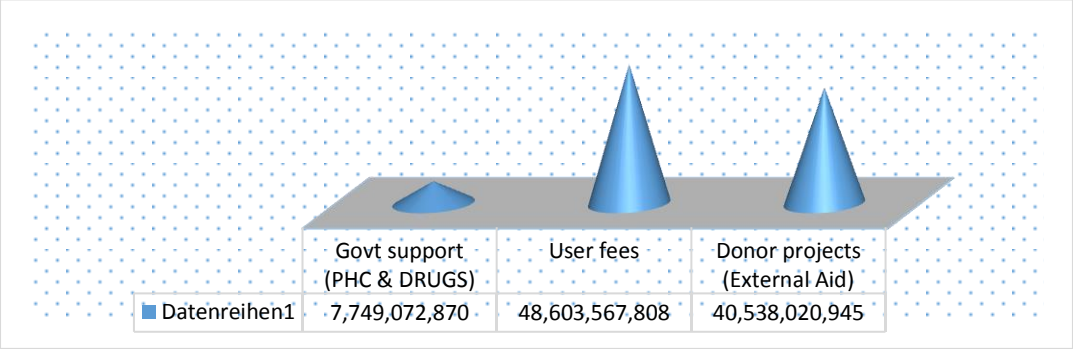
The Uganda Protestant Medical Bureau (UPMB) is a Christian national umbrella organization for Protestant, Adventist and Pentecostal Church founded member health facilities. Currently UPMB supports the activities of 294 health units (18 hospitals, 10 HC IVs & 266 Lower Level Health Facilities) forming 31% of the PNFP health care facilities in Uganda. UPMB also supports 15 Health Training institutions within the network. Joint Medical Stores (JMS) which is co-owned with UCMB, forms the logistical supplies arm of UPMB.

3.2.9.1 Health financing in the UPMB network in the FY 2016/17

During the FY 2016/17, UPMB Member Health Facilities realized a total of Ug Shs. 96,890,661,623/= with a 26.4% increase compared to last year's financials; the increase is mainly attributed to the increased fundraising (donor projects- external aid) especially growth in focus areas of HIV, Family Planning and MNCH funding & inclusion of 25 facilities in the Result Based Financing (RBF) under the MoH PNFP Project funded by Belgian Technical Corporation; and improved quality of services due to more qualified staffing in UPMB accredited facilities yielding more user fees.

A key observation was there in need to strengthen capacity in documentation by sensitizing health facilities on HMIS tools. Also UPMB has undertaken to upgrade its LLU to enhance service delivery.

FIGURE 36: INCOME BY SOURCE FOR RECURRENT OPERATIONS IN UPMB FACILITIES



3.2.9.2 UPMB contribution to the HSDP outputs

The results in table below show an improvement in UPMB facilities during the FY 2016/17 compared to the FY 2015/16 at the various levels of service delivery (i.e. hospitals, HC IVs & LLUs). With the roll out of the new HIV/AIDS guidelines, there was a great reduction of client active on PRE-ART due to implementation of test and treat in UPMB facilities. There were challenges in effective linkages to care, poor adherence, lost to follow up especially due to multiple drug access by the ART clients - client getting drugs from more than facility.

TABLE 58: PERFORMANCE OF UPMB FACILITIES DURING THE FY 2015/16 & FY 2016/17

Service	Hospitals		HC IVs		LLU	
	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17
OPD contacts	541,879	620,210	87,689	91,255	966,075	1,080,641
Immunizations	144,015	150,092	37,297	44,140	418,414	411,070
No of beds	2,298	2,429	600	578	1,071	1,119
Admissions	125,768	135,099	35,870	44,138	71,528	76,337
Total ANC visits	58,516	73,374	13,117	18,412	102,948	113,492
Deliveries in Unit	22,549	24,821	4,994	7,226	22,241	23,356
Total PNC	46,528	71,116	11,335	18,147	57,463	72,842
Total Family Planning users	36,704	50,701	6,996	15,583	126,408	124,492
No. tested for HIV	**177,978**	**185,940**	**44,985**	**40,594**	**208,569**	**212,884**
Tested for HIV & got results	**180,113**	**183,885**	**44,355**	**40,139**	**206,651**	**212,459**
Tested HIV positive	**6,623**	**5,370**	**1,270**	**1,403**	**6,295**	**6,866**
HIV+ Linked to care	**4,609**	**4,429**	**1,120**	**1,181**	**4,851**	**5,612**
Cumulative ever enrolled in HIV care	**190,224**	**220,445**	**32,550**	**36,416**	**131,516**	**151,078**
Active on PRE-ART	**15,877**	**8,232**	**1,384**	**905**	**21,942**	**18,029**
Cumulative ever started on ART	**139,500**	**160,156**	**21,054**	**24,075**	**84,024**	**97,906**
Currently Active on ART	**102,008**	**111,366**	**12,861**	**16,179**	**65,924**	**75,255**

3.2.9.3 Status of Human Resource for Health in UPMB MHF 2016/17

During the FY 2016/17, the health workforce in UPMB facilities grew to 6,092 (12.85% growth compared to FY 2015/16) of which 16.2% were government seconded health workers. The increase was due to increase in the number of seconded staff by government, increased revenues from user fees hence recruitment & retention of more qualified staff and more funding from donor projects including but not limited to SUSTAIN/ SDS, PHS, MILDMAY, BAYLOR, BTC among others.

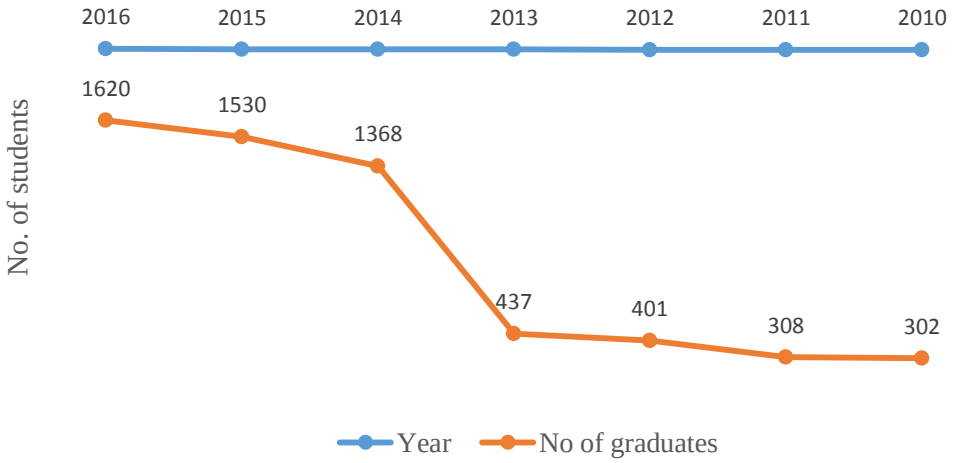
3.2.9.4 UPMB Health Training Institutions (HTI) contribution to the health work force

UPMB has a current membership of 15 HTIs affiliated to 15 MHFs (hospitals). The largest contribution of income for HTIs originated from school fees and bursaries due to the increased demand for the courses offered at the HTIs. However, there is need for more scholarships for health workers to upgrade their qualifications. With support from the UPMB secretariat and hospitals to which these this are affiliated, a total Ug Shs. 153,815,451 was secured as PHC grant to boost the revenue base of the HTIs.

3.2.9.5 HTIs student output trends

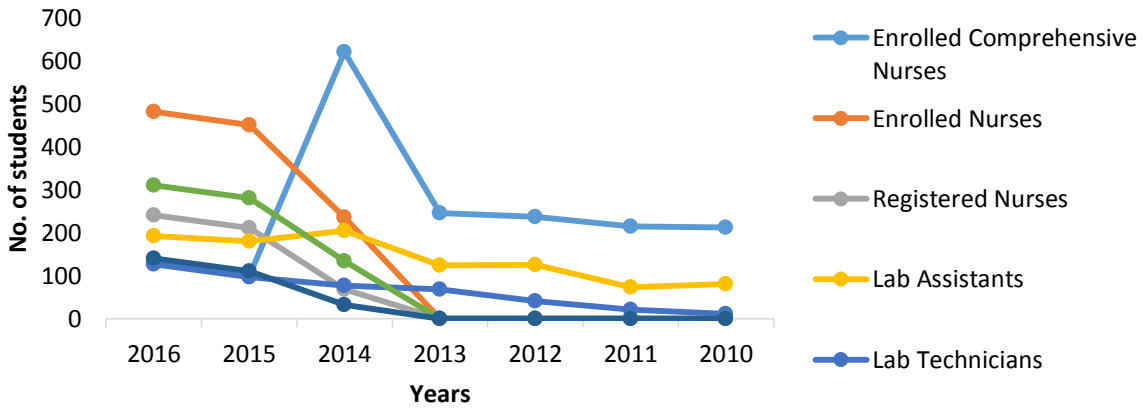
There was steady increase in the number of students graduating from the HTI and during the year 2016 a total of 1620 students graduated (with 89% average success rate) to be absorbed in to the health workforce.

FIGURE 37: TREND ANALYSIS OF HTI STUDENTS GRADUATED 2010 - 2016



During the year 2016, Enrolled Nurses were produced most in the member this; however, there was significance improvement in output for critical cadres especially midwives and laboratory assistants and technicians. This was in-line with GoU health workforce master plan to increase outputs for critical cadres.

FIGURE 38: TREND ANALYSIS OF HTI STUDENT OUTPUTS BY COURSE 2010-2016



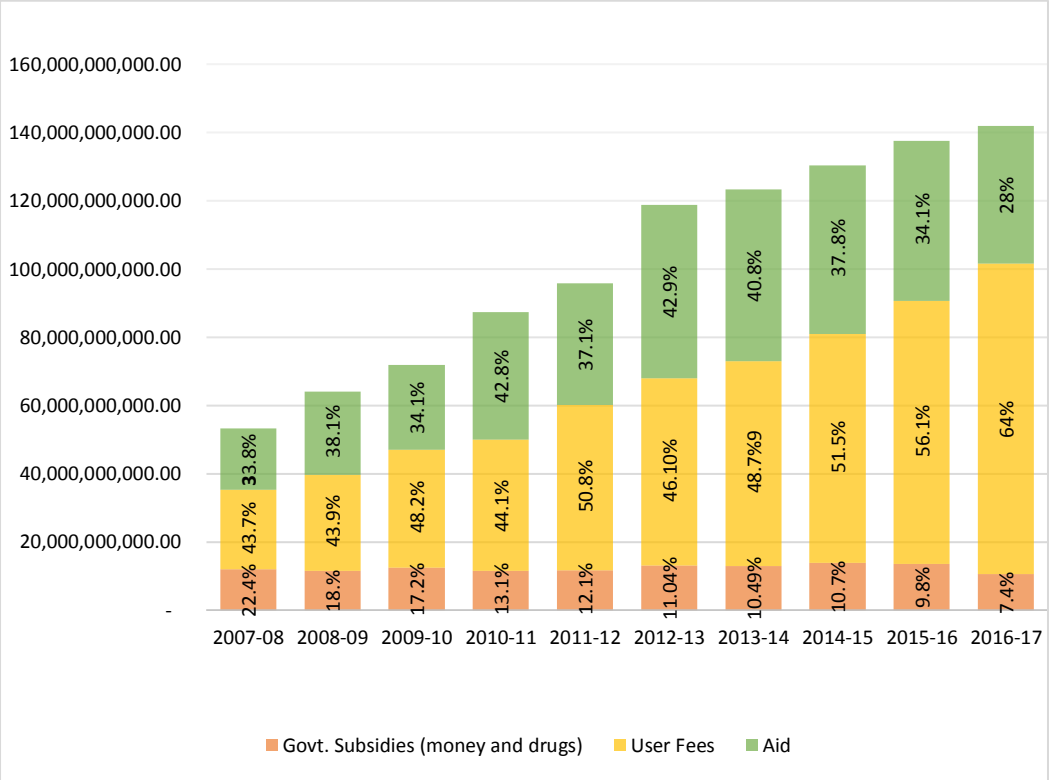
3.2.10 Uganda Catholic Medical Bureau (UCMB) performance

The Uganda Catholic Medical Bureau (UCMB) is a health department of the Catholic Church in Uganda and plays the principal roles of advocacy and lobby, coordination, mentorship & supervision and regulation of catholic health services in Uganda—which entail a broad range of initiatives and activities aimed at building and strengthening national health systems within a framework of complementarity. The Bureau coordinates, represents and supports 295 registered health facilities and 15 health training institutions. The health facilities comprise of 32 hospitals, 7 HC level IV, 180 HCs at level III and 75 HCs at level II.

3.2.10.1 Health Financing in UCMB Network: Financial Year 2016/2017.

The financial contribution from the UCMB facilities amounted to 161 billion shillings in the FY 2016/2017 compared to 153.7 billion realized in FY 2015/2016.This represents a 5% increase. The increase in total income was mainly due to collections from user fees and other internally generated income, which respectively increased by 18% and 28%. Donor funding decreased by 18% in FY 2016/2017. The Government subsidy in form of PHC Conditional Grant to UCMB health facilities and health training institutions for 7.4% of the budget for FY 2016/2017 while user fees accounted for 64% and donations were at 28% as shown in Figure 40.

FIGURE 39: TRENDS IN INCOME FOR RECURRENT COST IN UCMB NETWORK



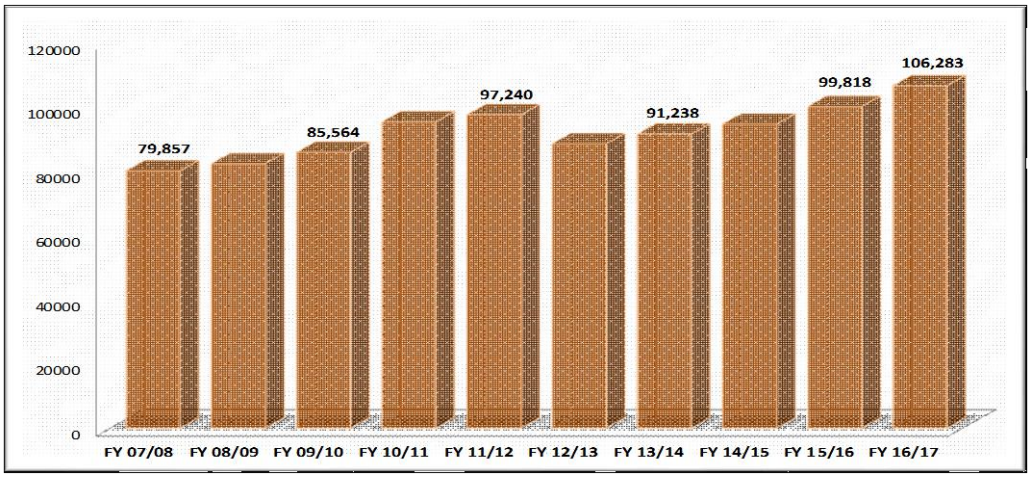
Source: Bureaux databases

3.2.10.2 UCMB CONTRIBUTION TO THE HSDP OUTPUTS

The output from the UCMB hospitals and Lower Levels depict the performance on the most important health indicators used for monitoring the HSDP performance for the FY 2016/2017. As shown in the graphs below there have been relative improvements in access to key services in UCMB health facility network over the years.

- **OPD services:** Total OPD attendances in UCMB health facilities in FY 2016/17 were 3,553,895, an increase by 22% from 2015/16. UCMB Lower Level Units registered a significant increase in OPD attendances in the year under review of 29.1% in the period—contributing greatly to network increase in OPD attendances.
- **Maternity services**: Total number of deliveries in the UCMB network of health facilities was 106,283 in 2016/17, an increase by 6% from 2015/16. UCMB Lower Level Units registered an 11% increase in deliveries while Hospitals registered a 2% increase in deliveries.

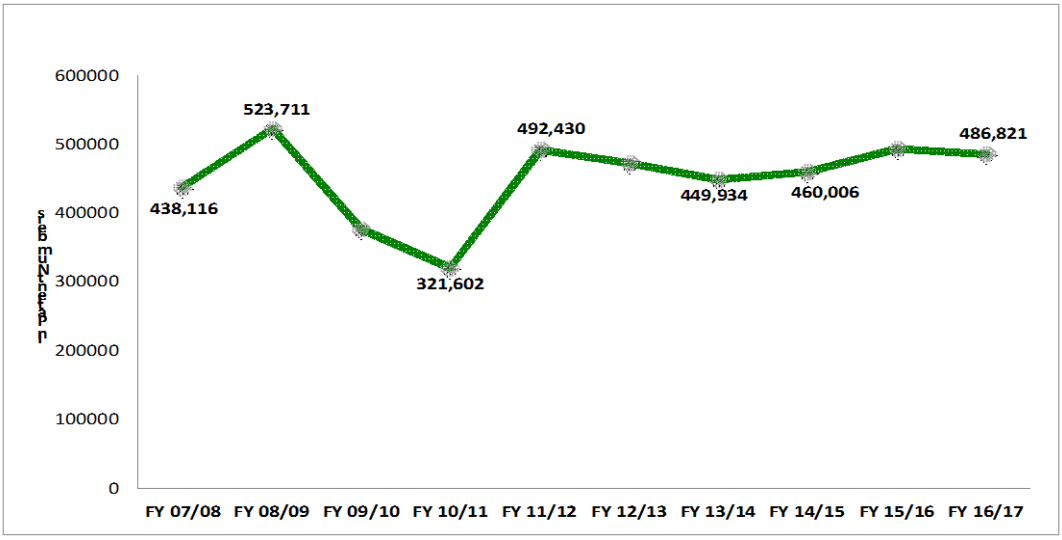
FIGURE 40: TRENDS OF DELIVERIES IN THE UCMB NETWORK OF FACILITIES OVER A 10-YEAR PERIOD.



Source: Bureaux databases

- **Child Care Services**: The number of immunization doses in the UCMB health facilities in FY 2016/17 was 2,143,544, which is a slight decrease by 0.2% in 2015/16. UCMB hospitals registered a 5.1% decrease in immunization in the period while Lower Level Units registered a slight increase at 1.9% in the period.
- I**n-Patient Care Services:** The total number of admissions in the UCMB health facilities in FY 2016/17 was 486,821 a slight decrease by 1% in 2015/16. There was a 5.1% decrease in total admissions in the UCMB hospitals while Lower Level Units registered an increase in admissions of 2.2% in the same period.

FIGURE 41: TOTAL ADMISSIONS IN UCMB HEALTH FACILITIES OVER A 10-YEAR PERIOD.



Source: UCMB Database

3.2.10.3 UCMB contribution to the National HIV response FY 2016/2017

UCMB provides comprehensive HIV services throughout its network of facilities with support from donors, mainly PEPFAR funded implementing partners. Overall, during the year the following services were offered.

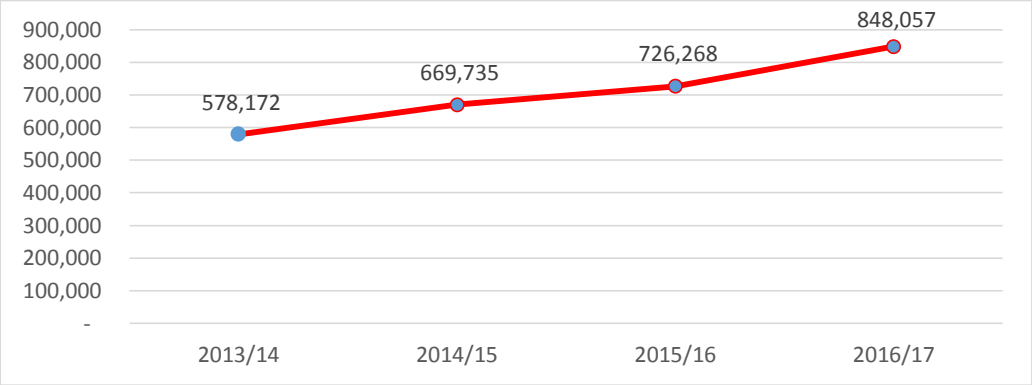
HTS & VMMC services: UCMB facilities counselled, tested and gave HIV results to a total of 848,018 individuals, representing 10% of the total country output for the year—and representing a 25.12% increase from FY 2015/16; of these 343,256 (40%) were men, and 122,877 (14%) were under 15 years of age. Overall, 24,524 (3% positivity rate), individuals were identified as HIV positive and 21,129 (86%) were documented as linked to care. A total of 70,820 couples were tested and received HIV results together, and 2141 (3%) were in discordant relationships. These were linked to appropriate services that would protect the negative partner, like initiating ART to the positive partner.

UCMB facilities circumcised a total of 45,521 men, and only 232 (0.5%) experienced adverse events, which were all locally managed. This was an increase by 72.7% from the FY 2015/16 while adverse effects reduced in the period.

Figure 43 shows the trends of clients receiving HTS in the UCMB network—which has increased by 46.7% in the last 4 years—thereby contributing to increasing access to quality HIV services.

In the same period, the average HIV Positivity Rate has reduced from 4.4% in FY 2013/14 to 2.9% in FY 2016/17 within the UCMB network health facilities, which is consistent with national trends of declining HIV prevalence rates.

FIGURE 42: NUMBER OF CLIENTS COUNSELLED, TESTED & GIVEN HIV RESULTS IN UCMB NETWORK



PMTCT services: UCMB supported facilities implement interventions to eliminate mother to child transmission of HIV. These included: HIV counselling and testing, initiating positive pregnant and lactating women on ART, follow up of mothers in the community, and male involvement. A total of 137,050 pregnant women attended ANC 1; of these, 98% were tested for HIV (includes those with known HIV results at entry in ANC); 5.8% (8076) were identified as HIV positive, and 96% (7735) were initiated on ART. The 4% (341) that were shown to have not started ART were a documentation issue, which will be addressed. A total of 48,307 men were tested and given results in PMTCT settings, out of whom 2% (925) were found HIV positive and enrolled into care.

HIV/ART: UCMB facilities enrolled 15,887 individuals in chronic care, 10% (945) being children <15 years; 5,818 (37%) were men. A total of 17,841 clients were newly enrolled on ART; 6% (1,044) of these were children under 15 years, and 36% (6,439) were men. Overall, a total of 95,452 clients were maintained on ART by end of the reporting period, 34% (32,358) being men. This translates into 9.4% of the total country ART caseload. The UCMB network posted an average 3.8% quarterly increase in clients active on ART in the FY 2016/17—thereby significantly contributing to access to quality Anti-retroviral therapy to the population.

3.2.10.4 STATUS HUMAN RESOURCE FOR HEALTH IN UCMB 2016/2017

The total health workforce in the UCMB network as at June 30th 2017 was 9,376, an increase by 3% for FY 2015/16.

TABLE 59: TOTAL NUMBER STAFF IN UCMB HEALTH FACILITIES IN 7 YEARS

Years	2010/11	2011/12	2012/13	2013/14	2014/15	2015/2016	2016/2017
Hospitals	5,068	5,355	5,435	5,502	5,618	5753	5974
LLUs	2,522	2,688	2,790	2,920	2,909	3354	3402
Total	**7,590**	**8,043**	**8,225**	**8,422**	**8,527**	**9,107**	**9,376**

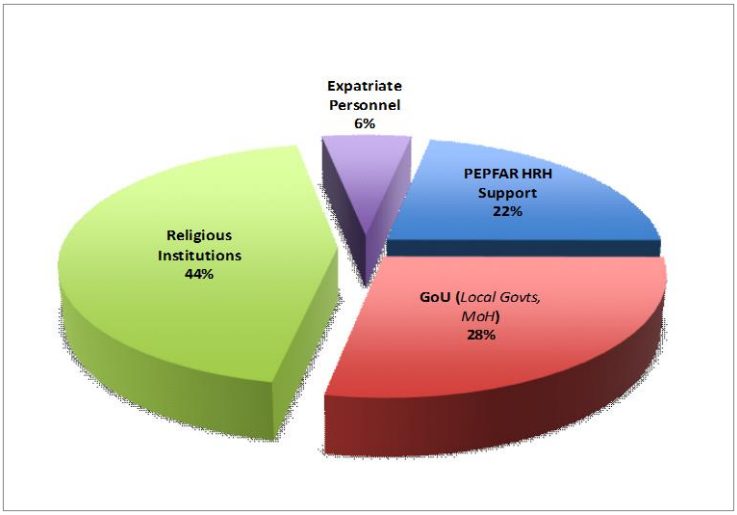
Data Source: UCMB facility annual staffing report

The proportion of the clinically qualified workforce has remained stable at 66%while the administrative staff, and support staff have also remained the same. There has been a decline from 8% to 6%that represent the 'non-qualified clinical' staff which mainly include nursing assistants, Nursing aides and Microscopists.

3.2.10.5 Health Worker Support in the Network

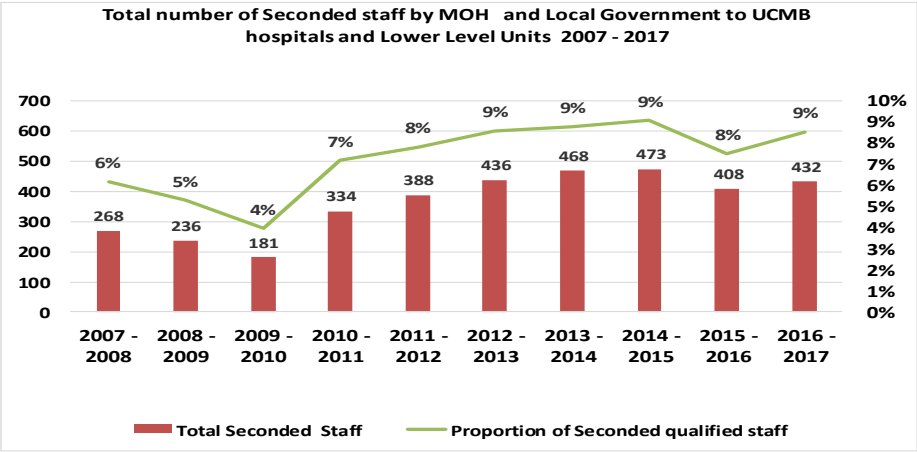
In FY 2016/17, the health facilities were able to privately employee 83 percent of the total health workforce. Seventeen (17) percent of the health workforce in the UCMB network is supported by GoU through LGs, and MoH through the internship system as well as religious institutions, agencies that offer support with expatriates and partners like SDS, SUSTAIN, Walter Reed, and Mildmay which facilitate the recruitment, placement and remuneration of staff with funds from PEPFAR.

FIGURE 43: CONTRIBUTION OF PERSONNEL FROM VARIOUS ENTITIES SUPPORTING UCMB HEALTH FACILITIES WITH PERSONNEL



The PEPFAR HRH support to UCMB accounts for 22% of the partners' support to HRH in the network.

FIGURE 44: SECONDED STAFF BY GOU AND LGS TO UCB HEALTH FACILITIES



3.2.10.6 UCMB Health Training Institutions Contribution to HRH Development

UCMB coordinates 15 Health Training Institutions (HTIs), with the objective to train an optimal range of health care personnel of high moral and professional standards for PNFP health care facilities and national health care institutions. The contribution of UCMB HTI to the national health work force in both certificates and diploma programs over a 4-year period is shown in table 60.

TABLE 60: UCMB - HTI PERFORMANCE BY PROGRAMME IN 4 YEARS

Programmes	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016	Cumulative Number of Graduates	Percentage share by Program
Certificate Nursing	148	176	230	349	354	1,537	24%
Certificate Midwife	137	250	292	401	435	1,884	29%
Certificate Comprehensive Nursing CCN	145	131	33	39	0	986	15%
Certificate Clinical Laboratory	85	109	48	91	114	636	10%
Diploma Nursing	29	37	43	56	13	318	5%
Diploma Midwifery	0	0	0	0	0	70	1%
Diploma Nursing-Extension	39	67	55	50	48	429	7%
Diploma Midwifery-Extension	62	35	49	39	89	435	7%
Diploma Medical Clinical Laboratory	22	9	27	39	67	224	3%
E-Learning (EM)			14	0	0	14	0%
Total		**814**	**791**	**1,064**	**1,120**	**6,533**	

The total annual health workforce output by UCMB HTIs has progressively increased—by 68% in the last 5 years, thus contributing to workforce development. In the 5-year period, 34% of the total annual outputs were Certificate Midwives, followed by Certificate Nurses (28%). The increase in the production of certificate midwifery cadres was mainly due to support from Ministry of Health with support from partners such as through the Baylor-SAINTS project and the UNFPA. Diploma graduates (Nursing, Midwifery and Laboratory) account for 20% of the total annual outputs from the UCMB HTIs.

3.3 Annex Three: Progress in Implementation of the 22nd RJM Aide Memoire

Milestones	Priority Actions	Status of Implementation
1. Service Delivery		
1.1 Strengthen preventive services than focusing on curative services.	Role out the Community Health Extension Worker (CHEW) Strategy	CHEWs strategy developed and curriculum finalised. Policy to be presented to Parliament A priority area for funding and implementation in FY 2018/19
1.2 Workable intervention developed to ensure reduction in the current very high maternal mortality	Revised RMNCAH Sharpened Plan (Investment Case) disseminated, financed and implemented	The RMNCAH sharpened plan was revised and being implemented with support from Partners. Available on the MoH website. Uganda Reproductive Maternal and Child Health Services Project to be implemented nationally from 2016 – 2020 (Funded through a WB Loan, Global Financing Facility (GFF) & SIDA Resource mapping undertaken and encourage all RMNCAH Partners to support implementation of the sharpened plan
	Post-abortion care guidelines finalized and disseminated	Consultations ongoing with the Religious and Cultural institutions.
1.3 Increasing blood collection to match the demand	Comprehensive analysis of the Blood collection and distribution system	Blood collection and distribution system in place however, likely to be scaled down due to the Human resource; Infrastructure and operational costs challenges as a result of inadequate funding. UBTS requires Ug. Shs. 3.5 bn annually, allocated Ug. Shs. 17.5 bn in 2016/17 with a funding gap of Ug. Shs. 21.9bn for collection and distribution of about 280,000 units of blood.
1.4 Operationalize the Uganda National Ambulance Services	Staffing and operationalization of the UNAS department Dissemination and implementation of the UNAS guidelines	Commissioner EMS appointed in June 2017 EMS National task force set up The structure and Job Descriptions for staff in the department developed EMS Policy development started Draft EMS guidelines and standards developed Undertook a survey on ambulance status in the country and draft report in place. Total 484 ambulances in the country, Functional are 411

Milestones	Priority Actions	Status of Implementation
		(85%). Public Functional = 181, Grounded = 56 PNFP/NGO Functional = 124, Grounded = 9 Private Functional = 106, Grounded = 8 Regional ambulance services established in Rwenzori & West Nile Region with pilot in digital applications in ambulance services. In the process of establishing Kampala Metropolitan Ambulance Services under KCCA
2. Human Resources for Health		
2.1 Health Facility in charges properly appointed as approved by MoPS	Recruitment / Appointment of Health Facility Managers (Medical Superintendents and Assistant MSs) as approved by MoPS	Appointment of health facility managers not effected by LGs. The approval of appointments for Medical Superintendants and AMSs by MoPs was not accompanied with restructuring of health sector in the LGs. LGs are not willing to trade off clinical staff (Principal Medical Officers, Senior Clinical Officers, Nursing Officers) for management positions. There should be a clear career path for health managers in LGs.
2.4 Critical staff recruited (DHT, MO, MW, AO)	Compile and submit annual recruitment plans including critical staff	Annual recruitment plan for FY 2017/18 prepared and submitted with the MPS 2017/18 In 2016/17 FY 2,129 health workers were recruited . Analysis ongoing to determine the cadres recruited.
2.5 Staffing norms at all levels reviewed in line with the current needs	Review current staff norms and propose new structures	MoPS still soliciting for funding for restructuring at Regional Refferal Hospitals and District Level MoH to review the competences required at the different health facility levels based on the recently launched service standards to guide the staff requirements.
3. Health Infrastructure		
3.1 Buildings and medical equipment well maintained	Budget allocated for maintenance and repair of buildings and medical equipment	For the 9 hospitals renovated under UHSSP @ received an additional UGX 135 m non-wage since 2016/17 FY and another UGX 30m in 2017/18 All public general hospitals (46) got an increament of UGX 30m for recurrent non-wage, PHC Development – Transitional allocated to 27

Milestones	Priority Actions	Status of Implementation
		health facilities for renovation / upgrading in FY 2017/18 UGX 2.17 billion allocated to the Regional Workshops for Equipment maintainance though inadequate to cover all facilities
	Explore & propose mechanism for leasing of medical equipment to a private provider for Regional Referral Hospitals	Guidelines on leasing medical equipments have been developed and shall be submitted to Top Management for approval this FY
3.2 New Health services improvement strategic directives operationalized	Disseminate the new directives on health services improvement. Operationalise HC III & IVs by provision of additional PHC grants	Directives disseminated on the MoH webside and communicated during the Regional Planning meetings and other fora Additional PHC grants have been allocated to HC IIIs (UGX 2.7M @) and HC IVs (UGX 7.9M @) in FY 2017/18 for non-wage recurrent costs. This translates to an average PHC Non-wage allocation of UGX 1.7m per month for HC IVs and UGX 750,000 per month for HC IIIs far below the requirement of UGX 3.5M and 1.3 for HC IVs and IIIs respectively Functionalization of HC IIIs in every subcounty and HC IVs in every County to be undertaken in a phased manner. The URMCHI Project to renovate / construct maternities and critical staff houses in 80 HC IIIs and also introduce Results Based Financing for HC IVs and IIIs that will meet the criteria.
3.4 PHC development projects in LGs completed	Re-instate the PHC development budget that was retained for procurement of furniture and equipment to LGs	The 7 bn was reallocated to other sector priorities within the LGs i.e. Uniforms UGX 3bn, Stationery UGX 1 bn, incomplete structures in LGs UGX 2 bn, and UGX 1 bn to all (46) general hospitals @30m for utilities.
4. Governance and leadership		
4.1 Efficient utilisation of the available budget	Efficient utilization of resources by initiating procurements in time.	Bottleneck analysis undertaken in 2016 and MoH to implement recommendations which include; introduction of a Procurement request tracker indicating the value and timing of all procurement requests; inclusion of procurement updates and related issues on the agenda Top

Milestones	Priority Actions	Status of Implementation
		Management on a routine rather than ad hoc basis.
4.2 Proper coordination of partner support to focus on National priorities	Quaterly review of the joint working arrangements defined in the compact implementation (HPAC, TWGs, Intersectoral committees) Develop guidelines for project identification, appraisal, commissioning & coordination in the sector	HPAC functional and meets monthly. 40% (6/14) of TWGs hold regular monthly meetings Guidelines provided by MoFPED. MOH Project Coordination Committee established in August 2017
4.3 Improved engagement & monitoring of the private sector & civil society.	Finalisation of the PPPH strategic plan Strengthen PPPH node/ LG PPPH desk capacity Improve representation of private sector and civil society in the governance structures.	PPPH strategic plan was finalised and approved, costed implementation plan finalised and is due for presentation to Top Management for approval. USAID /BTC supported training and capcity building of PPPH desk officers in LGs. All the 15 TWGs have got private sector representation
4.4 Functional Health Unit Management Structures (Staff & HUMC)	Induction Course / Mentorship for Health facility managers for HC IV & Hospitals Revise HUMC guidelines	Mentorship not carried Review process started with the guidelines for Hospital Boards of RRHs and draft in place.
4.5 Aide memoire disseminated timely	Finalization and dissemination of the JRM aide memoire early for stakeholders to act on the resolutions	Aide memoire for the 22nd JRM was finalised and disseminated
5. Health Information		
5.1 DHIS2 rolled out to the HC IVs (Public & Private)	Mobilise/allocate resources for DHIS2 roll out	DHIS2 rolled out to all LGs. Assessment of capacity of HC IVs to report through DHIS2 is being done– availability of computers, network and person.
5.2 Data from all private health facilities is captured in the DHIS-2	Provide codes for all private facilities Access rights for private hospitals	The DHIS2 has 780 private facilities that are tagged to report and 732 private facilities are actually reporting which is about 94.3% reporting rates for July 2017. Access rights provided for private hospitals that requested.
5.3 Improve completeness and quality of data entered	Quaterly data quality reviews and feedback to LGs.	Quaterly Regional data quality reviews conducted with support from Partners

Milestones	Priority Actions	Status of Implementation
into the DHIS2	Install quality checks in the DHIS 2 system	Data quality checks applied in the DHIS2
6. Supervision, Monitoring and Evaluation		
6.1 Enforcement of quality standards in LGs and private sector	Strengthen regulatory bodies for inspection and monitoring of adherence to standards in LGs and private sector.	Self-Regulatory Quality Improvement System (SQIS) was rolled in the private sector in August 2015 and since then 300 private facilities have conducted self assessments under the support of UHF. More information on SQIS and progress on its adoption is available from info@uhfug.com The laws of the three councils have been reviewed and harmonized. Engagement and buy-in from key stakeholders namely: MOH, Cabinet, Parliament and the public to pave way for enactment.
6.2 Regular support supervision at all levels	Finalise and implement the supervision and mentoring strategy	Service Delivery Standards finalised and launched in August 2017. To guide revision of the support supervision guidelines. Situation analysis of the supervison system undertaken and recruitment of Consultancy firm for develoment of supervision strategy ongoing with support from WHO. To be finalised by March.
6.3 Regional JRMs scaled up	Regional JRM concept discussed and impact assessed	RJRM guidelines were developed and disseminated. The second Regional JRMs were held in Rwenzori and West Nile in August and September 2017 supported by the BTC. Issues raised will be presented at this JRM. To roll out to other regions when funds are avaialble
6.4 Improved efficiency, effectiveness and safety of health services	Dissemination and Implementation of the Quality Improvement framework Conduct an evaluation of salary enhancement for Doctors recruited and serving in HC IVs	QI Framework was disseminated to all districts with support from partners _METS, ASSIST and all districts implementing QI interventions in line with the framework. Rolled out the Health Facility Quality of Care Program to 56 districts. Baseline report for 38 districts is available. Evaluation not done, however there is an increase in HC IVs providing CoEMOC services over the last 3 years.

3.4 Annex Four: Statistical Details of Performance at all levels

3.4.1 Disaggregation of Key Performance Indicators

Indicator	Performance 2016/17			
	Achievement	Disaggregation	Numerator	Denominator
ART Coverage	73%		1,028,909	1,402,628
HIV+ pregnant women not on HAART receiving ARVs for eMTCT during pregnancy, labour, delivery and postpartum	90%		38,243	42,467
TB case detection Rate (all forms)	46%			
IPT[2] doses coverage for pregnant women	54%		995,390	1,830,295
IPT3 doses coverage for pregnant women				
In Patient malaria deaths per 100,000 persons per year	20.2	M (21.6)	3,864	17,907,000
		F (18.8)	3,521	18,698,900
		Total	7,385	36,605,900
Malaria cases per 1,000 persons per year	433	M (516.3)	9,245,873	17,907,000
		F (353.6)	6,611,780	18,698,900
		Total	15,857,653	36,605,900
Under five vitamin A second dose coverage	25.3	M (24.7%)	862,553	3,148,912
		F (25.8%)	941,807	3,330,332
		Total	1,804,360	6,479,244
DPT[3]HibHeb[3] Coverage	99.2	M (103.0%)	793,324	764,990
		F (95.5%)	768,215	809,064
		Total	1,561,539	1,574,054
Measles coverage under 1 year	86.7	M (88.8%)	683,680	764,990
		F (84.7%)	681,402	809,064
		Total	1,365,082	1,574,054
Bed occupancy rate (Hospitals & HC IVs)	71.9	NRH	1,361	1,893
	115	RRH	5,124	4,436
	60.1	GH	9,289	15,477
	54	HC IV	3,781	6,973
Average length of Stay (Hospitals & HC IVs)	7.7	NRH	496,725	64,209
	6.9	RRH	1,870,206	269,473
	5.1	GH	3,390,528	663,580
	3.2	HC IV	434,284	1,379,975
Contraceptive prevalence Rate	39%			
Couple year of protection	2,156,240			
ANC 4 Coverage	37%		677,472	1,830,295
Health Facility deliveries	58%		1,033,531	1,775,386
HC IVs offering CEmOC services	44.6%		83	186
HC IVs conducting C/S	70.4%		131	186
HC IVs conducting blood transfusion	47.3%		83	186
New OPD Utilization rate	1.1	M (0.9)	16,751,534	17,907,000
		F (1.3)	24,580,509	18,698,900
		Total	41,332,043	36,605,900
Hospital (Inpatient) Admissions per 100 population	7.8		2,839,950	36,605,900
Population living within 5km of a Health Facility	100%			
Availability of a basket of commodities in the previous quarter	83%			

Indicator	Performance 2016/17			
	Achievement	Disaggregation	Numerator	Denominator
(% of facilities that had over 95%)				
Facility based fresh still births (per 1000 deliveries)	10.1		10,445	1,032,020
Maternal deaths among 100,000 health facility deliveries	384	NRH		
	379	RRH		
	290	GH		
	170	HC IVs		
	154	Total	1,543	1,004,333
Maternal death reviews	23.9%		267	1,118
Under Five deaths among 1,000 under 5 admissions	20.2 / 1,000	M (17.1)	7,540	440,352
		F (23.6)	9,367	396,700
		Total	16,907	837,052
ART Retention rate	82%		na	na
TB treatment success rate	80.4%			
Client satisfaction index	na			
Timeliness of reporting (HMIS 105)	88.1%			
Latrine coverage	76.7%			

3.5 Annex 5: District League Table FY 2016/17

District	PCV3		ANC4		IPT2		Deliveries		HIV+ pregnant women initiated on ART		Latrine Coverage		Fresh Still Births per 1,000 Deliveries		Maternal Deaths Audited		TB Treatment Success Rate		Patients diagnosed with Malaria that are lab confirmed		Approved posts filled with qualified personnel in public health facilities		Monthly reports sent on time		Completeness monthly reports		Timeliness of Quarterly DBT reporting		% score (Total score /90)*100	National Ranking
	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score		
		10		5		5		10		5		10		5		5		5		5		10		5		5		5		
ADJUMANI	111.5	10.0	65.8	3.3	84.5	4.2	83.0	8.3	89.6	4.5	84	8.4	7.3	3.9	9.1	0.5	80.8	4.0	79.1	4.0	84.2	8.4	94.6	4.7	96.5	4.8	75	3.8	80.9	1
GULU	101.1	10.0	40.4	2.0	79.7	4.0	98.0	9.8	89.0	4.4	77	7.7	7.5	3.9	32.3	1.6	81.3	4.1	77.8	3.9	98.4	9.8	88.8	4.4	99.6	5.0	0	0.0	78.5	2
MBALE	140.4	10.0	42.7	2.1	68.1	3.4	75.5	7.5	91.2	4.6	78	7.8	19.7	2.1	57.1	2.9	60.0	3.0	78.3	3.9	94.1	9.4	93.2	4.7	100	5.0	50	2.5	76.6	3
KAMWENGE	97.9	9.8	49.9	2.5	60.7	3.0	58.3	5.8	94.9	4.7	82	8.2	10.7	3.4	200.0	5.0	90.9	4.5	85.8	4.3	80.7	8.1	93.2	4.7	96.5	4.8	0	0.0	76.6	4
KIBOGA	99.3	9.9	50.3	2.5	77.5	3.9	91.0	9.1	81.9	4.1	60	6.0	12.1	3.2	75.0	3.8	86.7	4.3	107.5	5.0	63.6	6.4	93.4	4.7	93.9	4.7	25	1.3	76.5	5
KAMPALA	101.0	10.0	54.9	2.7	44.8	2.2	119.1	10.0	109.9	5.0	98	9.8	11.8	3.3	32.1	1.6	85.1	4.3	43.4	2.2	88.5	8.9	71.9	3.6	80.9	4.0	0	0.0	75.1	6
KABALE	83.3	8.3	48.1	2.4	89.4	4.5	69.6	7.0	99.6	5.0	96	9.6	8.0	3.8	37.5	1.9	85.1	4.3	77.1	3.9	69.6	7.0	93.5	4.7	98.1	4.9	0	0.0	74.6	7
OYAM	111.1	10.0	48.3	2.4	66.8	3.3	76.7	7.7	68.1	3.4	80	8.0	6.8	4.0	0.0	0.0	90.0	4.5	79.0	3.9	100.3	10.0	94.1	4.7	98	4.9	0	0.0	74.3	8
KABAROLE	101.9	10.0	63.1	3.2	65.8	3.3	82.9	8.3	93.7	4.7	85	8.5	12.1	3.2	27.7	1.4	75.6	3.8	49.5	2.5	87.4	8.7	85.2	4.3	99.1	5.0	0	0.0	74.2	9
KOBOKO	88.8	8.9	42.6	2.1	61.2	3.1	54.8	5.5	82.7	4.1	78	7.8	10.0	3.5	100.0	5.0	55.2	2.8	91.2	4.6	80.2	8.0	100	5.0	100	5.0	25	1.3	74.0	10
NAKASEKE	90.9	9.1	42.9	2.1	70.4	3.5	82.8	8.3	137.6	5.0	84	8.4	12.8	3.1	0.0	0.0	78.1	3.9	65.1	3.3	85.7	8.6	99.3	5.0	99.7	5.0	25	1.3	73.9	11
BUSHENYI	84.7	8.5	59.6	3.0	62.1	3.1	83.3	8.3	81.9	4.1	95	9.5	5.7	4.2	0.0	0.0	86.9	4.3	81.2	4.1	77.8	7.8	95.1	4.8	99.4	5.0	0	0.0	73.9	12
MOYO	68.6	6.9	43.8	2.2	61.5	3.1	59.6	6.0	84.8	4.2	92	9.2	6.0	4.1	133.3	5.0	78.6	3.9	72.7	3.6	82.1	8.2	98	4.9	99.6	5.0	0	0.0	73.7	13
NGORA	101.1	10.0	34.8	1.7	67.6	3.4	64.6	6.5	102.0	5.0	86	8.6	13.5	3.0	100.0	5.0	90.9	4.5	58.9	2.9	60.4	6.0	90.3	4.5	100	5.0	0	0.0	73.6	14
RUKUNGIRI	83.8	8.4	47.9	2.4	53.6	2.7	79.1	7.9	101.1	5.0	99	9.9	3.4	4.5	0.0	0.0	80.7	4.0	67.2	3.4	69.5	7.0	89.7	4.5	98.1	4.9	25	1.3	73.1	15
SERERE	130.6	10.0	29.9	1.5	88.3	4.4	79.2	7.9	60.9	3.0	88	8.8	9.0	3.7	50.0	2.5	95.3	4.8	26.4	1.3	66.4	6.6	89.5	4.5	100	5.0	25	1.3	72.5	16
LYANTONDE	96.9	9.7	50.2	2.5	73.4	3.7	77.0	7.7	72.5	3.6	89	8.9	10.9	3.4	0.0	0.0	86.2	4.3	73.5	3.7	82.3	8.2	92.3	4.6	98.8	4.9	0	0.0	72.5	17
MARACHA	93.3	9.3	44.5	2.2	65.8	3.3	60.0	6.0	124.2	5.0	88	8.8	15.4	2.8	0.0	0.0	81.8	4.1	85.5	4.3	107.1	10.0	90.6	4.5	97.8	4.9	0	0.0	72.4	18
KAMULI	110.0	10.0	57.5	2.9	74.0	3.7	95.4	9.5	75.1	3.8	70	7.0	8.5	3.8	0.0	0.0	88.1	4.4	71.3	3.6	70.4	7.0	89	4.5	100	5.0	0	0.0	72.4	19
KISORO	96.8	9.7	32.9	1.6	68.1	3.4	66.2	6.6	97.2	4.9	78	7.8	10.3	3.5	42.9	2.1	79.7	4.0	82.8	4.1	75.7	7.6	97.2	4.9	97.4	4.9	0	0.0	72.4	20

District	PCV3		ANC4		IPT2		Deliveries		HIV+ pregnant women initiated on ART		Latrine Coverage		Fresh Still Births per 1,000 Deliveries		Maternal Deaths Audited		TB Treatment Success Rate		Patients diagnosed with Malaria that are lab confirmed		Approved posts filled with qualified personnel in public health facilities		Monthly reports sent on time		Completeness monthly reports		Timeliness of Quarterly DBT reporting		% score (Total score /90)*100	National Ranking
	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score		
		10		5		5		10		5		10		5		5		5		5		10		5		5		5		
KASESE	94.0	9.4	47.5	2.4	68.9	3.4	55.9	5.6	101.5	5.0	85	8.5	11.5	3.3	54.2	2.7	94.9	4.7	54.7	2.7	63.5	6.4	84.4	4.2	99.1	5.0	25	1.3	71.8	21
MITOOMA	77.1	7.7	34.5	1.7	51.2	2.6	38.5	3.8	99.2	5.0	94	9.4	2.6	4.6	-	5	92.6	4.6	58.9	2.9	71.4	7.1	79.2	4.0	97.9	4.9	25	1.3	71.8	22
KYENJOJO	89.9	9.0	53.7	2.7	57.8	2.9	58.8	5.9	97.2	4.9	86	8.6	9.8	3.6	33.3	1.7	79.1	4.0	78.0	3.9	78.4	7.8	95.4	4.8	99.1	5.0	0	0.0	71.7	23
KYEGEGWA	85.5	8.5	49.0	2.4	66.5	3.3	44.3	4.4	95.9	4.8	79	7.9	11.3	3.4	33.3	1.7	76.1	3.8	76.8	3.8	94.3	9.4	93.9	4.7	100	5.0	25	1.3	71.7	24
KATAKWI	114.1	10.0	30.1	1.5	56.7	2.8	54.9	5.5	110.2	5.0	76	7.6	5.6	4.2	100.0	5.0	91.9	4.6	49.8	2.5	59.8	6.0	94.8	4.7	98.5	4.9	0	0.0	71.5	25
KABERAMAIDO	84.5	8.5	25.3	1.3	66.2	3.3	57.8	5.8	94.9	4.7	90	9.0	11.7	3.3	400.0	5.0	70.2	3.5	34.0	1.7	84.6	8.5	96.9	4.8	96.9	4.8	0	0.0	71.3	26
LUWERO	106.5	10.0	44.6	2.2	70.3	3.5	62.7	6.3	90.3	4.5	77	7.7	9.9	3.6	0.0	0.0	75.0	3.8	110.9	5.0	83.6	8.4	69.2	3.5	89.2	4.5	25	1.3	71.2	27
AMURIA	108.1	10.0	34.2	1.7	77.1	3.9	64.1	6.4	102.5	5.0	86	8.6	6.5	4.1	0.0	0.0	88.4	4.4	50.1	2.5	75.8	7.6	98.2	4.9	98.5	4.9	0	0.0	71.1	28
OTUKE	114.2	10.0	30.0	1.5	77.2	3.9	39.9	4.0	56.5	2.8	71	7.1	11.5	3.3	-	5	90.4	4.5	78.9	3.9	81.3	8.1	95.1	4.8	100	5.0	0	0.0	71.1	29
NAMUTUMBA	107.0	10.0	34.3	1.7	59.4	3.0	38.2	3.8	87.8	4.4	84	8.4	3.8	4.4	-	5	95.9	4.8	48.6	2.4	58.5	5.8	97.5	4.9	99.5	5.0	0	0.0	70.8	30
LIRA	102.8	10.0	34.2	1.7	48.9	2.4	58.9	5.9	78.7	3.9	80	8.0	14.0	3.0	15.4	0.8	86.6	4.3	51.9	2.6	100.3	10.0	90.2	4.5	99.8	5.0	25	1.3	70.4	31
KANUNGU	92.4	9.2	49.2	2.5	56.4	2.8	57.8	5.8	89.0	4.5	94	9.4	7.4	3.9	50.0	2.5	86.0	4.3	66.8	3.3	63.7	6.4	82.5	4.1	90.6	4.5	0	0.0	70.3	32
KIBUKU	90.3	9.0	36.3	1.8	57.5	2.9	62.6	6.3	103.4	5.0	82	8.2	4.9	4.3	0.0	0.0	87.8	4.4	53.1	2.7	87.8	8.8	97.4	4.9	100	5.0	0	0.0	70.2	33
RUBIRIZI	83.8	8.4	48.0	2.4	60.8	3.0	48.5	4.9	64.8	3.2	89	8.9	8.3	3.8	-	5	41.2	2.1	97.2	4.9	57.8	5.8	91.1	4.6	100	5.0	25	1.3	70.1	34
JINJA	108.9	10.0	43.8	2.2	70.9	3.5	81.2	8.1	87.5	4.4	70	7.0	10.4	3.5	6.7	0.3	74.3	3.7	49.5	2.5	84.9	8.5	86.4	4.3	98.4	4.9	0	0.0	70.0	35
KAPCHORWA	87.3	8.7	33.6	1.7	68.4	3.4	64.8	6.5	88.9	4.4	73	7.3	17.6	2.5	75.0	3.8	90.3	4.5	39.9	2.0	87.0	8.7	92.1	4.6	98.4	4.9	0	0.0	70.0	36
AMURU	81.6	8.2	34.6	1.7	55.7	2.8	46.5	4.6	56.8	2.8	73	7.3	4.8	4.3	---	5	91.5	4.6	76.9	3.8	82.8	8.3	91.4	4.6	97.3	4.9	0	0.0	69.9	37
DOKOLO	81.3	8.1	46.1	2.3	82.5	4.1	52.1	5.2	47.9	2.4	90	9.0	6.0	4.1	0.0	0.0	91.1	4.6	68.1	3.4	88.1	8.8	93.4	4.7	96.1	4.8	25	1.3	69.8	38
BUHWEJU	96.5	9.6	43.0	2.1	64.5	3.2	36.2	3.6	94.8	4.7	88	8.8	1.8	4.7	0.0	0.0	91.7	4.6	98.9	4.9	55.7	5.6	90.2	4.5	100	5.0	25	1.3	69.8	39
KAYUNGA	97.3	9.7	28.3	1.4	40.4	2.0	55.8	5.6	93.7	4.7	72	7.2	8.0	3.8	77.8	3.9	74.6	3.7	89.4	4.5	74.0	7.4	86.1	4.3	86.4	4.3	0	0.0	69.6	40
TORORO	89.9	9.0	40.6	2.0	51.9	2.6	69.1	6.9	83.0	4.2	83	8.3	7.6	3.9	42.9	2.1	62.9	3.1	78.0	3.9	55.3	5.5	95.1	4.8	99.5	5.0	25	1.3	69.5	41

District	PCV3		ANC4		IPT2		Deliveries		HIV+ pregnant women initiated on ART		Latrine Coverage		Fresh Still Births per 1,000 Deliveries		Maternal Deaths Audited		TB Treatment Success Rate		Patients diagnosed with Malaria that are lab confirmed		Approved posts filled with qualified personnel in public health facilities		Monthly reports sent on time		Completeness monthly reports		Timeliness of Quarterly DBT reporting		% score (Total score /90)*100	National Ranking
	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score		
		10		5		5		10		5		10		5		5		5		5		10		5		5		5		
MASAKA	88.9	8.9	34.6	1.7	50.9	2.5	91.5	9.1	71.5	3.6	85	8.5	13.5	3.0	0.0	0.0	73.2	3.7	84.0	4.2	72.9	7.3	99.8	5.0	100	5.0	0	0.0	69.5	42
KUMI	89.9	9.0	43.6	2.2	66.4	3.3	69.6	7.0	133.3	5.0	88	8.8	9.0	3.7	66.7	3.3	66.7	3.3	49.4	2.5	54.2	5.4	78.3	3.9	95.6	4.8	0	0.0	69.1	43
KOLE	83.6	8.4	20.9	1.0	26.5	1.3	34.3	3.4	72.9	3.6	78	7.8	6.7	4.0	-	5	93.5	4.7	81.0	4.1	90.7	9.1	95.5	4.8	96.2	4.8	0	0.0	68.9	44
SHEEMA	59.4	5.9	39.9	2.0	50.8	2.5	59.7	6.0	95.4	4.8	92	9.2	6.2	4.1	83.3	4.2	70.6	3.5	87.9	4.4	55.9	5.6	95	4.8	100	5.0	0	0.0	68.9	45
SOROTI	108.5	10.0	35.8	1.8	69.0	3.5	82.0	8.2	91.5	4.6	87	8.7	11.9	3.3	0.0	0.0	70.0	3.5	46.4	2.3	64.9	6.5	93.4	4.7	98.7	4.9	0	0.0	68.8	46
MITYANA	93.5	9.4	36.6	1.8	63.7	3.2	67.4	6.7	87.5	4.4	89	8.9	11.1	3.4	0.0	0.0	80.4	4.0	79.5	4.0	62.3	6.2	99	5.0	99.4	5.0	0	0.0	68.8	47
BUYENDE	88.7	8.9	36.6	1.8	49.2	2.5	38.4	3.8	75.3	3.8	85	8.5	5.5	4.2	50.0	2.5	91.0	4.6	49.9	2.5	64.1	6.4	96.6	4.8	100	5.0	50	2.5	68.6	48
ISINGIRO	103.4	10.0	39.9	2.0	67.3	3.4	56.5	5.7	95.4	4.8	94	9.4	8.0	3.8	0.0	0.0	85.0	4.2	74.1	3.7	54.5	5.5	93	4.7	94.2	4.7	0	0.0	68.6	49
KIBAALE	121.2	10.0	29.2	1.5	45.4	2.3	41.8	4.2	81.0	4.0	86	8.6	10.1	3.5	0.0	0.0	85.4	4.3	77.5	3.9	85.8	8.6	92.7	4.6	100	5.0	25	1.3	68.6	50
YUMBE	88.2	8.8	33.1	1.7	36.3	1.8	45.9	4.6	68.5	3.4	82	8.2	8.4	3.8	133.3	5.0	79.8	4.0	77.2	3.9	71.1	7.1	95	4.8	95	4.8	0	0.0	68.6	51
MPIGI	99.2	9.9	37.3	1.9	62.6	3.1	73.1	7.3	112.4	5.0	68	6.8	8.1	3.8	0.0	0.0	73.0	3.7	91.8	4.6	58.3	5.8	96	4.8	99.4	5.0	0	0.0	68.6	52
MUKONO	91.8	9.2	30.3	1.5	40.1	2.0	53.5	5.4	98.3	4.9	92	9.2	10.3	3.5	0.0	0.0	72.6	3.6	79.1	4.0	84.8	8.5	98.1	4.9	100	5.0	0	0.0	68.5	53
AGAGO	111.6	10.0	49.6	2.5	66.8	3.3	72.2	7.2	71.5	3.6	67	6.7	3.8	4.5	0.0	0.0	60.6	3.0	76.3	3.8	75.1	7.5	94.6	4.7	96.3	4.8	0	0.0	68.5	54
BUTALEJA	95.3	9.5	63.8	3.2	66.5	3.3	72.8	7.3	82.5	4.1	81	8.1	7.9	3.8	0.0	0.0	91.1	4.6	34.2	1.7	61.1	6.1	95.3	4.8	98.7	4.9	0	0.0	68.3	55
ZOMBO	80.4	8.0	45.0	2.2	40.9	2.0	46.2	4.6	100.0	5.0	87	8.7	10.2	3.5	0.0	0.0	85.4	4.3	70.8	3.5	94.7	9.5	99.1	5.0	100	5.0	0	0.0	68.2	56
IBANDA	93.5	9.3	40.5	2.0	58.7	2.9	53.0	5.3	86.0	4.3	84	8.4	11.6	3.3	0.0	0.0	71.7	3.6	87.8	4.4	53.1	5.3	98.8	4.9	100	5.0	50	2.5	68.2	57
BUSIA	81.6	8.2	31.2	1.6	57.3	2.9	73.0	7.3	77.3	3.9	89	8.9	12.8	3.1	14.8	0.7	91.3	4.6	73.7	3.7	52.5	5.2	99.3	5.0	99.8	5.0	25	1.3	68.0	58
MBARARA	80.6	8.1	44.8	2.2	51.8	2.6	79.7	8.0	91.5	4.6	99	9.9	12.5	3.2	0.0	0.0	92.7	4.6	75.3	3.8	47.8	4.8	92.6	4.6	97.5	4.9	0	0.0	68.0	59
NWOYA	84.6	8.5	27.6	1.4	51.2	2.6	40.2	4.0	87.9	4.4	75	7.5	4.2	4.4	100.0	5.0	88.5	4.4	85.8	4.3	52.3	5.2	89.8	4.5	100	5.0	0	0.0	67.9	60
ARUA	83.7	8.4	34.3	1.7	57.5	2.9	61.4	6.1	92.3	4.6	73	7.3	12.7	3.2	27.6	1.4	78.0	3.9	80.3	4.0	67.4	6.7	93.2	4.7	99.1	5.0	25	1.3	67.9	61
RUBANDA	93.1	9.3	35.4	1.8	70.0	3.5	41.3	4.1	96.2	4.8	92	9.2	5.2	4.2		0.0	85.1	4.3	75.2	3.8	62.1	6.2	97.6	4.9	98.5	4.9	0	0.0	67.8	62

District	PCV3		ANC4		IPT2		Deliveries		HIV+ pregnant women initiated on ART		Latrine Coverage		Fresh Still Births per 1,000 Deliveries		Maternal Deaths Audited		TB Treatment Success Rate		Patients diagnosed with Malaria that are lab confirmed		Approved posts filled with qualified personnel in public health facilities		Monthly reports sent on time		Completeness monthly reports		Timeliness of Quarterly DBT reporting		% score (Total score /90)*100	National Ranking
	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score		
		10		5		5		10		5		10		5		5		5		5		10		5		5		5		
BUNDIBUGYO	103.9	10.0	35.7	1.8	58.9	2.9	50.1	5.0	91.2	4.6	73	7.3	9.8	3.6	0.0	0.0	73.9	3.7	57.2	2.9	92.7	9.3	98.6	4.9	99.7	5.0	0	0.0	67.6	63
ABIM	122.6	10.0	34.5	1.7	52.0	2.6	53.7	5.4	104.3	5.0	61	6.1	7.6	3.9	---	5	46.2	2.3	64.1	3.2	68.2	6.8	80	4.0	96.7	4.8	0	0.0	67.6	64
PALLISA	96.3	9.6	28.0	1.4	61.5	3.1	58.2	5.8	83.0	4.2	81	8.1	7.7	3.9	0.0	0.0	100.0	5.0	40.1	2.0	77.4	7.7	92.6	4.6	100	5.0	0	0.0	67.2	65
KWEEN	100.3	10.0	24.0	1.2	53.2	2.7	25.3	2.5	80.5	4.0	85	8.5	11.6	3.3	-	5	96.2	4.8	24.5	1.2	74.9	7.5	94.4	4.7	100	5.0	0	0.0	67.2	66
NEBBI	81.6	8.2	46.8	2.3	58.4	2.9	73.8	7.4	87.8	4.4	80	8.0	8.8	3.7	0.0	0.0	84.5	4.2	69.6	3.5	60.9	6.1	95	4.8	99.6	5.0	0	0.0	67.2	67
HOIMA	93.1	9.3	37.2	1.9	68.1	3.4	64.2	6.4	87.6	4.4	91	9.1	18.4	2.3	0.0	0.0	68.9	3.4	79.4	4.0	62.6	6.3	79.9	4.0	93.9	4.7	25	1.3	67.1	68
BUTAMBALA	74.4	7.4	27.7	1.4	55.8	2.8	96.2	9.6	92.8	4.6	68	6.8	12.3	3.2	14.3	0.7	78.9	3.9	74.8	3.7	60.8	6.1	99.6	5.0	100	5.0	0	0.0	67.1	69
BUKOMANSIMBI	64.7	6.5	25.6	1.3	41.6	2.1	31.4	3.1	93.3	4.7	69	6.9	9.0	3.7	---	5	90.5	4.5	92.1	4.6	67.6	6.8	100	5.0	100	5.0	25	1.3	67.0	70
KIRYANDONGO	121.2	10.0	35.8	1.8	69.0	3.4	65.6	6.6	81.8	4.1	74	7.4	12.9	3.1	0.0	0.0	84.9	4.2	76.0	3.8	61.4	6.1	96.8	4.8	97.1	4.9	0	0.0	67.0	71
NTOROKO	104.2	10.0	37.5	1.9	56.0	2.8	62.7	6.3	85.2	4.3	68	6.8	7.6	3.9	0.0	0.0	76.1	3.8	46.6	2.3	81.7	8.2	99.1	5.0	100	5.0	0	0.0	66.8	72
BUKWO	93.6	9.4	32.3	1.6	53.1	2.7	35.2	3.5	48.9	2.4	82	8.2	16.2	2.7	---	5	93.6	4.7	30.0	1.5	57.7	5.8	100	5.0	100	5.0	50	2.5	66.6	73
MASINDI	89.0	8.9	42.7	2.1	66.0	3.3	53.9	5.4	82.1	4.1	79	7.9	11.6	3.3	0.0	0.0	61.4	3.1	65.2	3.3	84.7	8.5	96.3	4.8	100	5.0	0	0.0	66.3	74
SIRONKO	86.7	8.7	27.3	1.4	57.0	2.9	36.2	3.6	71.1	3.6	72	7.2	9.7	3.6	100.0	5.0	95.6	4.8	44.5	2.2	73.1	7.3	89.4	4.5	100	5.0	0	0.0	66.3	75
KALUNGU	70.4	7.0	34.7	1.7	55.3	2.8	60.1	6.0	90.7	4.5	93	9.3	15.6	2.7	0.0	0.0	86.1	4.3	82.2	4.1	72.3	7.2	98.7	4.9	100	5.0	0	0.0	66.3	76
SEMBABULE	88.5	8.9	22.3	1.1	41.2	2.1	22.8	2.3	107.4	5.0	70	7.0	9.1	3.7	-	5	98.7	4.9	66.3	3.3	52.7	5.3	93.8	4.7	99.7	5.0	25	1.3	66.0	77
GOMBA	87.2	8.7	32.3	1.6	47.2	2.4	36.9	3.7	102.2	5.0	55	5.5	5.5	4.2	---	5	77.6	3.9	78.3	3.9	55.7	5.6	98.2	4.9	100	5.0	0	0.0	66.0	78
OMORO	81.5	8.2	34.1	1.7	68.5	3.4	47.3	4.7	73.1	3.7	73	7.3	2.8	4.6		0.0	81.3	4.1	83.2	4.2	82.0	8.2	85.8	4.3	100	5.0	0	0.0	65.9	79
BUGIRI	107.0	10.0	39.1	2.0	61.3	3.1	50.1	5.0	80.6	4.0	81	8.1	11.0	3.4	11.1	0.6	87.6	4.4	73.5	3.7	54.9	5.5	92.1	4.6	96.2	4.8	0	0.0	65.6	80
KALIRO	90.1	9.0	36.0	1.8	46.9	2.3	43.2	4.3	69.7	3.5	74	7.4	6.3	4.1	0.0	0.0	85.7	4.3	66.8	3.3	90.0	9.0	98.3	4.9	100	5.0	0	0.0	65.6	81
LAMWO	104.1	10.0	44.8	2.2	56.6	2.8	64.0	6.4	89.6	4.5	59	5.9	5.4	4.2	0.0	0.0	77.2	3.9	73.7	3.7	54.9	5.5	97.6	4.9	97.6	4.9	0	0.0	65.4	82
KIRUHURA	81.7	8.2	47.5	2.4	69.3	3.5	46.1	4.6	68.6	3.4	92	9.2	3.8	4.4	0.0	0.0	88.4	4.4	85.2	4.3	51.0	5.1	87.3	4.4	98	4.9	0	0.0	65.3	83

District	PCV3		ANC4		IPT2		Deliveries		HIV+ pregnant women initiated on ART		Latrine Coverage		Fresh Still Births per 1,000 Deliveries		Maternal Deaths Audited		TB Treatment Success Rate		Patients diagnosed with Malaria that are lab confirmed		Approved posts filled with qualified personnel in public health facilities		Monthly reports sent on time		Completeness monthly reports		Timeliness of Quarterly DBT reporting		% score (Total score /90)*100	National Ranking
	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score		
		10		5		5		10		5		10		5		5		5		5		10		5		5		5		
MUBENDE	109.9	10.0	27.9	1.4	44.4	2.2	43.7	4.4	89.1	4.5	84	8.4	20.0	2.1	58.8	2.9	54.6	2.7	88.3	4.4	49.2	4.9	94.9	4.7	96.6	4.8	25	1.3	65.2	84
KOTIDO	108.6	10.0	37.4	1.9	66.2	3.3	56.2	5.6	73.2	3.7	21	2.1	7.8	3.9	-	5	66.1	3.3	38.9	1.9	72.9	7.3	89	4.5	100	5.0	25	1.3	65.2	85
BUKEDEA	86.0	8.6	23.5	1.2	36.8	1.8	50.0	5.0	103.4	5.0	86	8.6	4.3	4.4	0.0	0.0	82.4	4.1	47.2	2.4	78.2	7.8	97.9	4.9	97.9	4.9	0	0.0	65.2	86
NTUNGAMO	79.2	7.9	34.1	1.7	44.6	2.2	47.5	4.7	82.8	4.1	96	9.6	5.1	4.3	0.0	0.0	77.1	3.9	73.3	3.7	74.0	7.4	87.6	4.4	93.6	4.7	0	0.0	65.0	87
LUUKA	99.5	9.9	20.9	1.0	37.3	1.9	26.2	2.6	84.7	4.2	66	6.6	6.1	4.1	-	5	86.3	4.3	63.0	3.2	58.0	5.8	97	4.9	100	5.0	0	0.0	65.0	88
APAC	73.9	7.4	28.0	1.4	36.1	1.8	43.4	4.3	86.0	4.3	80	8.0	8.5	3.8	28.6	1.4	91.3	4.6	73.0	3.6	84.3	8.4	87.7	4.4	96.8	4.8	0	0.0	64.8	89
KALANGALA	101.4	10.0	34.2	1.7	51.5	2.6	41.3	4.1	91.8	4.6	69	6.9	34.5	0.0	0.0	0.0	98.1	4.9	36.7	1.8	82.2	8.2	93.1	4.7	99.5	5.0	75	3.8	64.7	90
NAKASONGOLA	73.0	7.3	35.6	1.8	43.6	2.2	51.1	5.1	87.4	4.4	87	8.7	7.2	4.0	0.0	0.0	89.5	4.5	60.9	3.0	82.5	8.3	80.7	4.0	96	4.8	0	0.0	64.4	91
KITGUM	76.0	7.6	37.9	1.9	53.5	2.7	68.9	6.9	81.8	4.1	60	6.0	7.1	4.0	0.0	0.0	76.0	3.8	73.9	3.7	79.7	8.0	87.1	4.4	96.2	4.8	0	0.0	64.2	92
ALEBTONG	93.5	9.4	28.7	1.4	53.5	2.7	40.2	4.0	69.4	3.5	81	8.1	8.8	3.7	0.0	0.0	90.6	4.5	69.5	3.5	65.6	6.6	87.7	4.4	96.1	4.8	25	1.3	64.1	93
RAKAI	77.7	7.8	32.5	1.6	43.1	2.2	53.9	5.4	84.0	4.2	84	8.4	11.7	3.3	0.0	0.0	82.0	4.1	77.2	3.9	72.5	7.3	88.6	4.4	99.6	5.0	0	0.0	63.9	94
MAYUGE	80.5	8.0	31.7	1.6	57.8	2.9	42.1	4.2	81.3	4.1	68	6.8	11.2	3.4	0.0	0.0	77.3	3.9	80.1	4.0	74.5	7.4	98.3	4.9	98.6	4.9	25	1.3	63.8	95
KYANKWANZI	85.8	8.6	28.9	1.4	48.9	2.4	25.5	2.5	79.4	4.0	59	5.9	14.9	2.8	-	5	66.7	3.3	87.5	4.4	58.6	5.9	94.9	4.7	100	5.0	25	1.3	63.7	96
LWENGO	91.8	9.2	32.6	1.6	55.9	2.8	34.6	3.5	83.9	4.2	76	7.6	7.2	3.9	0.0	0.0	89.9	4.5	82.9	4.1	58.2	5.8	99.8	5.0	100	5.0	0	0.0	63.6	97
PADER	164.4	10.0	33.9	1.7	57.8	2.9	46.9	4.7	94.4	4.7	51	5.1	4.8	4.3	0.0	0.0	69.2	3.5	74.9	3.7	74.3	7.4	86.8	4.3	94.8	4.7	0	0.0	63.5	98
IGANGA	79.0	7.9	27.4	1.4	33.9	1.7	58.5	5.8	82.5	4.1	69	6.9	14.0	3.0	18.8	0.9	90.3	4.5	67.9	3.4	79.3	7.9	82.9	4.1	100	5.0	0	0.0	63.0	99
AMOLATAR	100.8	10.0	22.9	1.1	58.1	2.9	41.4	4.1	62.0	3.1	85	8.5	10.5	3.5	0.0	0.0	74.7	3.7	40.4	2.0	81.8	8.2	90.4	4.5	100	5.0	0	0.0	63.0	100
BUIKWE	78.2	7.8	31.6	1.6	52.9	2.6	49.7	5.0	85.2	4.3	75	7.5	13.1	3.1	33.3	1.7	66.9	3.3	72.8	3.6	69.9	7.0	89	4.5	93.9	4.7	0	0.0	63.0	101
MANAFWA	114.9	10.0	18.4	0.9	30.9	1.5	38.5	3.8	70.5	3.5	82	8.2	13.3	3.1	0.0	0.0	97.5	4.9	66.6	3.3	78.8	7.9	88.5	4.4	95.5	4.8	0	0.0	62.6	102
NAMAYINGO	123.5	10.0	33.0	1.7	68.3	3.4	40.5	4.0	100.7	5.0	62	6.2	8.0	3.8	0.0	0.0	85.3	4.3	65.2	3.3	52.6	5.3	93.9	4.7	94.1	4.7	0	0.0	62.5	103
KAGADI	80.8	8.1	28.0	1.4	48.0	2.4	51.1	5.1	91.7	4.6	69	6.9	15.3	2.8	0.0	0.0	85.4	4.3	64.2	3.2	66.2	6.6	96.5	4.8	97	4.9	25	1.3	62.5	104

District	PCV3		ANC4		IPT2		Deliveries		HIV+ pregnant women initiated on ART		Latrine Coverage		Fresh Still Births per 1,000 Deliveries		Maternal Deaths Audited		TB Treatment Success Rate		Patients diagnosed with Malaria that are lab confirmed		Approved posts filled with qualified personnel in public health facilities		Monthly reports sent on time		Completeness monthly reports		Timeliness of Quarterly OBT reporting		% score (Total score /90)*100	National Ranking
	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score	%	Score		
		10		5		5		10		5		10		5		5		5		5		10		5		5		5		
WAKISO	77.7	7.8	17.0	0.8	22.3	1.1	29.4	2.9	100.4	5.0	90	9.0	5.5	4.2	0.0	0.0	75.2	3.8	54.0	2.7	70.6	7.1	89.7	4.5	97.3	4.9	25	1.3	61.1	105
BUDUDA	79.9	8.0	16.8	0.8	28.7	1.4	30.9	3.1	49.6	2.5	76	7.6	6.5	4.1	66.7	3.3	83.3	4.2	75.5	3.8	62.9	6.3	98	4.9	99.5	5.0	0	0.0	61.0	106
BUDAKA	70.5	7.1	28.8	1.4	43.4	2.2	54.6	5.5	83.1	4.2	73	7.3	10.1	3.5	0.0	0.0	96.7	4.8	37.1	1.9	75.5	7.6	91.2	4.6	100	5.0	0	0.0	61.0	107
NAKAPIRIPIRIT	98.2	9.8	47.0	2.3	47.8	2.4	44.7	4.5	86.1	4.3	34	3.4	11.7	3.3	0.0	0.0	78.3	3.9	44.0	2.2	74.7	7.5	93.6	4.7	99.5	5.0	25	1.3	60.6	108
NAPAK	128.9	10.0	50.2	2.5	61.6	3.1	63.9	6.4	78.9	3.9	25	2.5	8.8	3.7	0.0	0.0	57.2	2.9	44.3	2.2	81.6	8.2	81	4.1	100	5.0	0	0.0	60.5	109
KAKUMIRO	86.1	8.6	32.9	1.6	46.8	2.3	39.2	3.9	80.8	4.0	78	7.8	13.1	3.1	0.0	0.0	85.4	4.3	79.3	4.0	50.2	5.0	95.6	4.8	97.5	4.9	0	0.0	60.4	110
BULIISA	74.4	7.4	26.3	1.3	56.5	2.8	45.3	4.5	86.1	4.3	68	6.8	7.7	3.9	0.0	0.0	78.3	3.9	75.0	3.8	49.6	5.0	91	4.6	96.5	4.8	0	0.0	59.0	111
MOROTO	86.3	8.6	44.1	2.2	110.3	5.0	45.3	4.5	77.1	3.9	15	1.5	8.4	3.8	0.0	0.0	82.3	4.1	43.9	2.2	53.8	5.4	86.8	4.3	96.5	4.8	0	0.0	56.0	112
BULAMBULI	59.7	6.0	21.4	1.1	40.1	2.0	29.4	2.9	66.4	3.3	81	8.1	12.2	3.2	0.0	0.0	53.9	2.7	54.5	2.7	86.6	8.7	92.1	4.6	96.7	4.8	0	0.0	55.7	113
KAABONG	96.2	9.6	42.4	2.1	47.1	2.4	58.4	5.8	39.5	2.0	30	3.0	6.4	4.1	0.0	0.0	49.1	2.5	52.5	2.6	60.7	6.1	89.4	4.5	90	4.5	0	0.0	54.6	114
BUVUMA	65.3	6.5	10.0	0.5	24.9	1.2	17.1	1.7	92.5	4.6	38	3.8	13.2	3.1	0.0	0.0	86.1	4.3	89.2	4.5	77.3	7.7	95.5	4.8	98.5	4.9	0	0.0	53.0	115
AMUDAT	75.5	7.6	19.5	1.0	39.6	2.0	39.8	4.0	79.3	4.0	21	2.1	26.8	1.1	0.0	0.0	49.2	2.5	91.6	4.6	38.5	3.9	91.7	4.6	100	5.0	0	0.0	46.8	116
NATIONAL	92.9	**9.3**	37.0	**1.9**	54.4	**2.7**	58.2	**5.8**	90.1	4.5	**76.7**	**7.7**	**10.2**	**3.5**	**23.9**	**1.2**	**80.7**	**4.0**	**68.9**	**3.4**	**71.7**	**7.2**	**88.0**	**4.4**	**94.3**	**4.7**	**9.1**	**0.5**	**59.6**	**66.2**

3.6 Annex 6: SUO for General Hospitals

No	Hospital	Admissions	OPD	Deliveries	Total ANC	Postnatal	Total family planning	Immunization	SUO
1.	Iganga	23,560	178,146	6,928	12,942	8,326	2,139	12,799	**580,406**
2.	Kitgum	19,809	73,004	2,701	4,998	5,899	716	5,856	**390,879**
3.	Mityana	16,984	87,112	6,486	11,749	3,725	3,310	9,992	**385,165**
4.	Kalongo Ambrosoli Memorial	20,446	32,373	3,453	5,883	3,330	1,609	5,479	**362,714**
5.	Apac	12,875	117,540	2,144	8,220	1,823	452	6,839	**327,586**
6.	Tororo	13,910	70,462	7,002	8,790	8,545	480	9,177	**324,981**
7.	Kamuli	15,152	74,654	2,294	7,890	7,458	3,424	8,976	**324,911**
8.	Kagando	17,980	26,941	2,428	6,377	2,776	2,240	6,825	**315,977**
9.	Kawolo	13,229	82,146	4,117	10,797	9,197	3,144	9,114	**314,053**
10.	KIU Teaching	16,997	31,139	2,499	6,196	7,588	1,038	3,929	**306,106**
11.	Kagadi	15,430	18,790	4,652	10,038	6,077	960	10,379	**284,216**
12.	Bwera	13,209	49,984	3,918	13,671	2,199	1,771	14,656	**279,756**
13.	Atutur	12,532	66,629	2,001	6,549	3,672	1,644	6,635	**271,899**
14.	Bududa	12,701	66,379	1,295	3,481	2,131	1,797	4,922	**268,490**
15.	Kayunga	12,611	56,105	3,215	4,798	1,656	1,339	8,330	**267,967**
16.	Kiryandongo	13,052	42,518	2,507	7,375	1,263	1,638	14,411	**260,964**
17.	Angal St. Luke	13,636	30,876	2,453	6,762	5,287	2,907	5,800	**256,030**
18.	Busolwe	10,834	76,110	2,077	3,615	2,733	338	2,521	**252,524**
19.	Kitagata	11,128	64,970	2,657	4,957	6,781	1,646	3,895	**252,327**
20.	Adjumani	10,611	78,703	1,938	3,836	1,805	1,118	4,425	**251,999**
21.	Yumbe	12,239	39,888	3,023	4,046	2,256	1,463	15,900	**249,207**
22.	Entebbe	10,011	51,152	6,136	16,336	7,324	1,646	17,333	**248,416**
23.	Nebbi	12,176	41,031	2,518	6,657	2,694	677	8,229	**243,392**
24.	Aber	12,252	40,618	2,253	5,818	1,158	287	7,348	**241,223**
25.	Pallisa	11,221	43,579	3,076	6,782	7,096	299	8,329	**236,492**
26.	Kalisizo	10,244	62,587	2,787	5,814	838	1,024	6,330	**235,441**
27.	Itojo	11,313	48,021	1,753	2,926	4,364	1,009	3,566	**231,536**
28.	Gombe	10,721	49,005	3,477	5,582	1,007	913	4,471	**231,517**
29.	Masafu	10,432	54,967	1,786	4,055	4,310	2,523	6,766	**227,988**
30.	Masindi	10,411	35,466	4,154	10,456	3,319	2,078	12,458	**223,420**
31.	Kiboga	10,543	38,237	3,495	7,812	6,062	211	5,323	**221,217**
32.	Kisiizi	9,099	64,580	2,245	6,891	3,157	908	7,732	**219,567**
33.	Ibanda	12,263	20,610	2,142	4,259	1,980	3	4,332	**219,274**

No	Hospital	Admissions	OPD	Deliveries	Total ANC	Postnatal	Total family planning	Immunization	SUO
34.	Kyenjojo	9,737	35,880	2,454	4,997	5,178	1,272	13,597	**205,228**
35.	Kilembe	10,953	26,183	1,853	3,426	3,159		5,408	**204,712**
36.	Nakaseke	8,349	53,931	3,229	5,474	3,528	387	12,127	**204,427**
37.	Rakai	9,618	43,660	1,659	2,447	1,254	999	3,345	**199,513**
38.	Kisoro	9,000	43,625	2,589	7,347	2,194	2,854	5,767	**198,447**
39.	Katakwi	10,588	27,768	1,165	1,693	2,577	954	4,657	**196,846**
40.	Matany	9,903	24,026	1,161	3,526	1,645	537	10,640	**185,492**
41.	Kaabong	9,214	36,651	764	2,444	2,634	442	7,300	**184,358**
42.	International Kampala (IHK)	4,403	100,895	1,436	6,050	3,244	110	2,373	**178,194**
43.	Bundibugyo	8,631	31,070	2,021	4,763	1,577	1,552	7,544	**176,929**
44.	Mutolere (St. Francis)	9,278	19,187	2,259	7,079	5,038	1,181	4,989	**176,672**
45.	Lyantonde	6,709	59,071	1,857	6,440	1,810	815	5,068	**174,126**
46.	Kamuli Mission	6,951	47,943	2,080	6,449	9,662	1,288	4,728	**171,737**
47.	Kiwoko	7,928	27,825	2,667	6,616	2,550	916	7,766	**167,019**
48.	Bombo Military	8,026	27,893	2,661	6,388	232	1,606	4,570	**166,070**
49.	St. Joseph's Kitgum	8,888	20,313	1,320	3,327	2,102	-	5,010	**164,454**
50.	Koboko	7,735	23,992	2,596	9,263	1,360	806	11,125	**161,495**
51.	Kumi	6,768	46,738	1,806	3,517	1,325	310	5,003	**161,310**
52.	Kapchorwa	7,823	26,053	1,858	4,994	82	1,456	4,798	**156,855**
53.	St. Joseph Kitovu	7,838	26,298	1,755	2,401	1,077		3,717	**155,520**
54.	Bugiri	5,396	44,696	2,787	9,546	5,096	2,327	8,332	**149,358**
55.	Anaka	7,313	28,111	1,085	3,078	2,357	691	5,367	**148,054**
56.	Kuluva	6,845	32,031	1,139	4,161	757	921	6,535	**145,340**
57.	Kibuli	4,747	54,341	2,154	6,271	2,452	378	9,578	**143,774**
58.	Moyo	5,672	49,260	1,124	1,636	1,255	339	2,241	**142,205**
59.	St. Karolii Lwanga Nyakibale	7,408	10,907	1,663	4,152	2,808	1,459	4,956	**135,784**
60.	Murchison Bay	2,460	82,921	2,002	2,078	299	330	532	**130,827**
61.	St. Francis Naggalama	5,207	35,349	1,611	4,674	3,856		5,733	**127,238**
62.	Bwindi Community	5,520	28,634	1,804	4,472	3,506	2,022	3,405	**125,815**
63.	Kisubi	4,258	40,878	1,585	4,592	2,087	29	15,035	**122,167**
64.	Ishaka Adventist	5,314	8,314	1,446	5,816	4,790	38,408	5,489	**120,761**
65.	Rugarama	5,751	21,429	1,531	2,681	2,850	751	3,472	**119,422**
66.	Virika	5,653	20,784	973	1,630	2,392	2,222	6,180	**116,167**
67.	Nyapea	5,750	17,920	1,292	3,435	2,599	24	4,205	**114,731**

No	Hospital	Admissions	OPD	Deliveries	Total ANC	Postnatal	Total family planning	Immunization	SUO
68.	Kambuga	5,358	25,991	925	2,892	1,952	900	2,434	**114,207**
69.	Abim	5,298	28,313	797	1,528	948	430	2,454	**113,990**
70.	Nkozi	4,794	27,540	1,688	3,730	4,977	802	4,787	**113,919**
71.	Comboni	5,312	23,219	1,280	2,967	3,283		2,981	**113,024**
72.	Maracha	5,507	16,873	1,085	2,104	1,299		4,536	**108,241**
73.	Bukwo	3,885	39,004	544	2,576	920	376	2,983	**102,654**
74.	Ruharo Mission	4,583	27,195	736	1,358	895	109	1,772	**101,280**
75.	Buikwe St. Charles Lwanga	5,190	11,737	1,374	2,990	1,273		3,391	**99,387**
76.	Kakira Worker's	3,229	40,468	432	1,681	1,266	1,980	2,065	**94,055**
77.	Buluba	3,988	20,907	1,264	2,323	1,731	286	3,267	**90,154**
78.	Kabarole	4,110	12,209	704	1,697	2,533	69	13,003	**85,521**
79.	Nakasero	3,720	19,479	1,465			20	4,974	**85,101**
80.	Ngora	4,450	10,421	405	813	606	1,096	7,287	**83,853**
81.	Lwala	4,229	8,657	1,093	2,465	3,608	-	4,049	**81,879**
82.	Villa Maria	4,197	11,201	1,070	1,271	385	10	2,702	**81,309**
83.	Lugazi Scoul	2,827	32,650	306	1,750	1,567	1,331	1,691	**79,230**
84.	Mayanja Memorial	2,992	12,828	1,809	1,167	6,046	1,034	3,665	**72,359**
85.	Dabani	3,757	7,406	624	1,681	625	20	3,506	**69,293**
86.	Mildmay Uganda	466	54,253	81	1,578	736	1,006	1,082	**63,376**
87.	Rubongi Military	2,020	26,707	133	1,518	332	764	1,448	**59,248**
88.	Kanginima	3,113	2,312	315	1,482	1,453	1,733	7,033	**55,988**
89.	Amudat	2,927	4,973	520	1,775	3,598	628	2,988	**55,440**
90.	Mount Elgon	1,201	33,128	196	406	621	109	688	**52,913**
91.	Rushere Community	2,407	8,625	514	1,716	626	205	3,315	**49,716**
92.	Mukwaya	557	38,376	225	959	558	106	1,029	**48,894**
93.	St. Anthony's Tororo	2,436	8,606	297	1,151	549	16	2,249	**48,268**
94.	Nkokonjeru	1,835	13,818	620	2,117	905	18	2,189	**46,422**
95.	St. Francis Nyenga	1,754	14,148	304	2,018	1,219	6	3,197	**44,593**
96.	Buwenge NGO	1,718	4,104	1,016	2,425	3,860	1,574	6,272	**41,292**
97.	Buliisa	1,607	11,440	414	1,940	336	181	1,365	**38,944**
98.	St. Catherine		36,298	168	82	347	-	805	**37,730**
99.	Nakasongola Military	1,488	13,142	157	436	705	270	635	**37,139**
100.	Gulu Military	1,332	14,249	55	738	76	237	669	**35,143**
101.	Bamu	1,392	7,276	389	185		205	-	**30,241**

No	Hospital	Admissions	OPD	Deliveries	Total ANC	Postnatal	Total family planning	Immunization	SUO
102.	Amai Community	1,427	4,873	229	1,652	878	615	2,385	**29,692**
103.	Paragon Kampala	682	8,968	1,271	913	1,192	90	1,954	**27,354**
104.	Ruth Gaylord	708	13,626	257	833	678		2,141	**27,107**
105.	Oriajini	1,256	2,907	473	1,557	1,096	81	2,139	**26,081**
106.	UPDF 2nd Div.	666	14,039	38	1,024	109	997	1,313	**25,633**
107.	Saidina Abubakar Islamic	452	8,711	248	804	276	69	4,053	**19,091**
108.	Gulu Independent	597	5,160	21	78	55	5	7,757	**18,144**
109.	Mbarara Community	785	2,082	366	185	701	185	983	**16,659**
110.	Kabasa Memorial	589	1,195	383	2,908	2,296	426	3,022	**15,399**
111.	Senta Medicare	378	7,027	208	567	609	7	1,841	**15,079**
112.	Bethany Women and Family	486	2,717	185	1,299	426	12	363	**11,592**
113.	Novik		3,627	310	864	991	201	1,279	**6,585**
114.	Tumu	266	1,227	121	216	384	149	526	**6,395**
115.	**Total**	**797,216**	**3,882,611**	**194,111**	**461,640**	**286,694**	**132,495**	**609,936**	**17,418,297**

3.7 Annex 7: Quality Parameters for General Hospitals

No.	Hospital	Beds	Admissions	Patient Days	Deliveries	Caesarean Sections	Immunization	Major Operation	Fresh Still births	Maternal deaths	Macerated still births	BOR	ALOS	Maternal Mortality Risk	FSB Risk
1.	Aber	178	12,252	52,303	2,253	495	7,348	975	42	17	74	81	4	755	19
2.	Abim	129	5,298	21,871	797	111	2,454	506	14	-	10	46	4	0	18
3.	Adjumani	148	10,611	41,206	1,938	585	4,425	1,070	23	9	28	76	4	464	12
4.	Amai Community	84	1,427	7,963	229	95	2,385	370	14	1	9	26	6	437	61
5.	Amudat	105	2,927	10,626	520	66	2,988	66	16	1	11	28	4	192	31
6.	Anaka	100	7,313	27,401	1,085	53	5,367	100	5	1	15	75	4	92	5
7.	Angal St. Luke	260	13,636	70,340	2,453	778	5,800	1,473	56	17	49	74	5	693	23
8.	Apac	100	12,875	65,127	2,144	192	6,839	925	17	5	27	178	5	233	8
9.	Atutur	400	12,532	37,110	2,001	27	6,635	156	11	1	23	25	3	50	5
10.	Bamu	60	1,392	4,282	389	111	-	176	18	-	8	20	3	0	46
11.	Bethany Women and Family	68	486	3	185	0	363	215	4	-	-	0	0	0	22
12.	Bombo Military	166	8,026	32,995	2,661	102	4,570	1,295	44	2	21	54	4	75	17
13.	Bududa	168	12,701	28,497	1,295	727	4,922	114	19	3	34	46	2	232	15
14.	Bugiri	107	5,396	29,732	2,787	106	8,332	1,877	54	8	47	76	6	287	19
15.	Buikwe St. Charles Lwanga	104	5,190	9,992	1,374	566	3,391	651	18	7	16	26	2	509	13
16.	Bukwo	35	3,885	10,314	544	343	2,983	131	12		7	81	3	0	22
17.	Buliisa	66	1,607	3,414	414	101	1,365	118	9	1	9	14	2	242	22
18.	Buluba	120	3,988	15,353	1,264	66	3,267	859	69	3	12	35	4	237	55
19.	Bundibugyo	104	8,631	36,890	2,021	603	7,544	1,004	25	4	15	97	4	198	12
20.	Busolwe	100	10,834	16,751	2,077	606	2,521	994	34	5	30	46	2	241	16
21.	Buwenge NGO	41	1,718	3,552	1,016	493	6,272	64	-	1	9	24	2	98	0
22.	Bwera	135	13,209	50,291	3,918	1244	14,656	2,267	32	4	36	102	4	102	8
23.	Bwindi Community	120	5,520	24,988	1,804	557	3,405	875	23	2	19	57	5	111	13
24.	Comboni	100	5,312	12,398	1,280	532	2,981	759	5	1	44	34	2	78	4
25.	Dabani	69	3,757	8,580	624	237	3,506	403	30	9	9	34	2	1442	48
26.	Entebbe	167	10,011	37,136	6,136	1435	17,333	1,857	36	2	50	61	4	33	6
27.	Gombe	100	10,721	30,838	3,477	906	4,471	1,176	45	12	50	84	3	345	13
28.	Gulu Independent	60	597	2,838	21	16	7,757	72	1	-	-	13	5	0	48
29.	Gulu Military	62	1,332	5,273	55		669	-				23	4	0	0
30.	Ibanda	178	12,263	41,083	2,142	886	4,332	1,336	35	13	73	63	3	607	16
31.	Iganga	104	23,560	65,030	6,928	1823	12,799	3,091	171	12	162	171	3	173	25
32.	International Kampala	100	4,403	18,128	1,436	534	2,373	1,078	2	-	6	50	4	0	1
33.	Ishaka Adventist	87	5,314	11,713	1,446	591	5,489	757	21	2	25	37	2	138	15
34.	Itojo	165	11,313	41,960	1,753	526	3,566	797	34	4	32	70	4	228	19
35.	Kaabong	100	9,214	56,554	764	137	7,300	295	10	1	7	155	6	131	13
36.	Kabarole	61	4,110	8,444	704	270	13,003	495	11	5	12	38	2	710	16
37.	Kabasa Memorial	45	589	1,703	383	0	3,022	163	4		1	10	3	0	10
38.	Kagadi	104	15,430	43,259	4,652	1022	10,379	1,294	82	6	103	114	3	129	18
39.	Kagando	208	17,980	124,857	2,428	1129	6,825	2,224	44	10	31	164	7	412	18
40.	Kakira Worker's	78	3,229	6,457	432	0	2,065	90	6		1	23	2	0	14
41.	Kalisizo	112	10,244	22,372	2,787	970	6,330	1,120	51	5	52	55	2	179	18
42.	Kalongo Ambrosoli Memorial	267	20,446	101,197	3,453	416	5,479	996	20	6	22	104	5	174	6
43.	Kambuga	100	5,358	20,416	925	176	2,434	290	9	1	14	56	4	108	10
44.	Kamuli	100	15,152	29,477	2,294	302	8,976	758	43	1	35	81	2	44	19

45.	Kamuli Mission	160	6,951	17,882	2,080	732	4,728	1,185	105	4	47	31	3	192	50
46.	Kanginima	45	3,113	8,772	315	1	7,033	26	1	1	1	53	3	317	3
47.	Kapchorwa	115	7,823	46,937	1,858	382	4,798	800	51	4	28	112	6	215	27
48.	Katakwi	100	10,588	31,036	1,165	201	4,657	646	10	1	9	85	3	86	9
49.	Kawolo	109	13,229	33,394	4,117	853	9,114	1,483	48	9	79	84	3	219	12
50.	Kayunga	104	12,611	34,576	3,215	802	8,330	1,788	52	8	51	91	3	249	16
51.	Kiboga	100	10,543	29,197	3,495	571	5,323	769	60	3	47	80	3	86	17
52.	Kibuli	121	4,747	14,891	2,154	702	9,578	1,083	12	3	20	34	3	139	6
53.	Kilembe	205	10,953	39,181	1,853	592	5,408	1,529	33	3	44	52	4	162	18
54.	Kiryandongo	104	13,052	43,592	2,507	553	14,411	874	65	3	56	115	3	120	26
55.	Kisiizi	305	9,099	56,721	2,245	626	7,732	1,442	14	1	28	51	6	45	6
56.	Kisoro	142	9,000	45,432	2,589	477	5,767	766	16	1	21	88	5	39	6
57.	Kisubi	80	4,258	13,948	1,585	644	15,035	1,229	17	5	22	48	3	315	11
58.	Kitagata	178	11,128	30,707	2,657	724	3,895	1,410	28	5	37	47	3	188	11
59.	Kitgum	220	19,809	97,237	2,701	257	5,856	816	24	2	31	121	5	74	9
60.	KIU Teaching	290	16,997	55,541	2,499	788	3,929	1,499	23	5	36	52	3	200	9
61.	Kiwoko	242	7,928	38,670	2,667	804	7,766	1,297	44	1	52	44	5	37	16
62.	Koboko	100	7,735	28,732	2,596	180	11,125	312	41	3	34	79	4	116	16
63.	Kuluva	297	6,845	47,504	1,139	524	6,535	872	37	6	16	44	7	527	32
64.	Kumi	210	6,768	30,909	1,806	717	5,003	1,762	42	2	26	40	5	111	23
65.	Kyenjojo	90	9,737	19,809	2,454	431	13,597	540	36	5	54	60	2	204	15
66.	Lugazi Scoul	43	2,827	7,353	306	0	1,691	-	3	-	3	47	3	0	10
67.	Lwala	100	4,229	24,155	1,093	336	4,049	474	33	1	13	66	6	91	30
68.	Lyantonde	100	6,709	15,786	1,857	359	5,068	417	30	6	41	43	2	323	16
69.	Maracha	214	5,507	28,759	1,085	398	4,536	772	42	8	29	37	5	737	39
70.	Masafu	82	10,432	30,915	1,786	284	6,766	636	35	15	23	103	3	840	20
71.	Masindi	160	10,411	31,968	4,154	633	12,458	1,016	52	5	59	55	3	120	13
72.	Matany	250	9,903	83,703	1,161	324	10,640	685	26	3	17	92	8	258	22
73.	Mayanja Memorial	100	2,992	7,761	1,809	1027	3,665	1,197	15	-	34	21	3	0	8
74.	Mbarara Community	120	785	1,816	366	227	983	249	3	-	4	4	2	0	8
75.	Mildmay Uganda	42	466	2,644	81	28	1,082	37			1	17	6	0	0
76.	Mityana	146	16,984	61,236	6,486	1290	9,992	2,248	96	6	84	115	4	93	15
77.	Mount Elgon	37	1,201	3,243	196	83	688	311	3		7	24	3	0	15
78.	Moyo	162	5,672	21,735	1,124	401	2,241	600	7	5	18	37	4	445	6
79.	Mukwaya	50	557	1,440	225	45	1,029	69	2		27	8	3	0	9
80.	Murchison Bay	177	2,460	17,053	2,002	0	532	48	-	-	2	26	7	0	0
81.	Mutolere (St. Francis)	200	9,278	49,721	2,259	785	4,989	1,582	48	6	25	68	5	266	21
82.	Nakaseke	90	8,349	43,636	3,229	1212	12,127	2,081	47	4	62	133	5	124	15
83.	Nakasero	77	3,720	15,300	1,465	868	4,974	1,578	4	1	126	54	4	68	3
84.	Nakasongola Military	98	1,488	9,023	157	0	635	27	2	-	3	25	6	0	13
85.	Nebbi	169	12,176	36,636	2,518	457	8,229	800	29	12	43	59	3	477	12
86.	Ngora	99	4,450	14,673	405	180	7,287	251	12	1	4	41	3	247	30
87.	Nkokonjeru	61	1,835	5,020	620	162	2,189	276	12	2	9	23	3	323	19
88.	Nkozi	100	4,794	16,122	1,688	548	4,787	780	30	3	34	44	3	178	18
89.	Novik				310		1,279	-	3		3	-		0	10
90.	Nyapea	139	5,750	28,352	1,292	591	4,205	845	28	8	35	56	5	619	22
91.	Oriajini	48	1,256	3,056	473		2,139	6	9		3	17	2	0	19
92.	Pallisa	161	11,221	42,051	3,076	248	8,329	737	46	5	46	72	4	163	15
93.	Paragon Kampala	22	682	1,740	1,271	273	1,954	310			3	22	3	0	0
94.	Rakai	76	9,618	26,377	1,659	446	3,345	797	38	12	43	95	3	723	23
95.	Rubongi Military	56	2,020	4,315	133	0	1,448	9	1			21	2	0	8
96.	Rugarama	167	5,751	26,181	1,531	437	3,472	656	30	4	18	43	5	261	20
97.	Ruharo Mission	107	4,583	14,620	736	379	1,772	594	11	2	15	37	3	272	15
98.	Rushere Community	86	2,407	6,964	514	248	3,315	335	10	1	15	22	3	195	19

99.	Ruth Gaylord	32	708	1,392	257	48	2,141	89	6		2	12	2	0	23
100.	Saidina Abubakar Islamic	20	452	915	248	37	4,053	73				13	2	0	0
101.	Senta Medicare	23	378	139	208	68	1,841	80	2		3	2	0	0	10
102.	St. Anthony's Tororo	150	2,436	10,548	297	107	2,249	280	2	-	5	19	4	0	7
103.	St. Catherine				168		805	-	2	-	2	-		0	12
104.	St. Francis Naggalama	97	5,207	12,780	1,611	592	5,733	1,089	34	8	43	36	2	497	21
105.	St. Francis Nyenga	81	1,754	4,311	304	112	3,197	163	9	-	6	15	2	0	30
106.	St. Joseph Kitovu	200	7,838	33,100	1,755	794	3,717	1,478	66	12	41	45	4	684	38
107.	St. Joseph's Kitgum	280	8,888	64,091	1,320	301	5,010	1,069	13	3	39	63	7	227	10
108.	St. Karoli Lwanga Nyakibale	146	7,408	25,557	1,663	781	4,956	1,208	5	4	32	48	3	241	3
109.	Tororo	224	13,910	55,336	7,002	499	9,177	969	74	6	56	68	4	86	11
110.	Tumu	26	266	208	121	3	526	20	1			2	1	0	8
111.	UPDF 2nd Div.	45	666	2,262	38		1,313	4	1			14	3	0	26
112.	Villa Maria	126	4,197	17,141	1,070	479	2,702	739	34	6	23	37	4	561	32
113.	Virika	202	5,653	15,120	973	503	6,180	1,115	30	4	18	21	3	411	31
114.	Yumbe	206	12,239	51,104	3,023	606	15,900	1,015	63	9	35	68	4	298	21
	Total	**13,979**	**797,216**	**3,032,740**	**194,111**	**48,695**	**609,936**	**87,274**	**3,027**	**419**	**3,131**	**59**	**4**	**216**	**16**

3.8 Annex 8: HC IV Functionality

No.	District	Health Facility	HMIS 108 Reporting rate	Caesarian Sections	Offers blood transfusion	CS and Blood Transfusion
1.	Mukono	Mukono T.C.	100	1414	Yes	Yes
2.	Isingiro	Rwekubo	100	795	Yes	Yes
3.	Kamwenge	Rukunyu	100	715	Yes	Yes
4.	Kasese	St. Paul	100	553	Yes	Yes
5.	Mukono	Mukono CoU	100	502	Yes	Yes
6.	Mpigi	Mpigi	100	489	Yes	Yes
7.	Luwero	Bishop Asili Ceaser	100	355	Yes	Yes
8.	Kakumiro	Kakindo	100	322	No	No
9.	Serere	Serere	100	297	Yes	Yes
10.	Kyegegwa	Kyegegwa	100	274	No	No
11.	Kagadi	St. Ambrose Charity	100	272	Yes	Yes
12.	Amuria	Amuria	100	267	Yes	Yes
13.	Rubirizi	Rugazi	100	255	Yes	Yes
14.	Kabarole	Kibiito	91.7	246	Yes	Yes
15.	Isingiro	Kabuyanda	100	235	Yes	Yes
16.	Bushenyi	Kyabugimbi	100	235	Yes	Yes
17.	Kasese	Rwesande	100	219	Yes	Yes
18.	Lira	PAG Mission	100	214	Yes	Yes
19.	Bundibugyo	Busaru	100	212	Yes	Yes
20.	Mubende	Kassanda	91.7	202	No	No
21.	Kakumiro	Kakumiro	100	198	Yes	Yes
22.	Sheema	Kabwohe	100	194	Yes	Yes
23.	Mubende	Kiganda	100	183	No	No
24.	Luwero	Luwero	83.3	183	Yes	Yes
25.	Kasese	Bishop Masereka Christian Foundation	100	180	Yes	Yes
26.	Kibaale	Kibaale	91.7	169	Yes	Yes
27.	Kampala	Benedict Medical centre	75	166	Yes	Yes
28.	Hoima	Azur	100	162	No	No
29.	Kamuli	Namwendwa	100	159	Yes	Yes
30.	Manafwa	Magale	83.3	157	Yes	Yes
31.	Jinja	Buwenge	91.7	155	No	No
32.	Oyam	Anyeke	100	147	Yes	Yes
33.	Sironko	Budadiri	100	143	Yes	Yes
34.	Kyotera	Kakuuto	100	134	Yes	Yes
35.	Bundibugyo	Nyahuka	100	133	Yes	Yes
36.	Budaka	Budaka	100	132	Yes	Yes

No.	District	Health Facility	HMIS 108 Reporting rate	Caesarian Sections	Offers blood transfusion	CS and Blood Transfusion
37.	Wakiso	Namayumba	83.3	129	No	No
38.	Adjumani	Mungula	100	114	Yes	Yes
39.	Kamwenge	Ntara	100	114	Yes	Yes
40.	Ibanda	Ishongororo	100	112	Yes	Yes
41.	Wakiso	Kasangati	100	112	No	No
42.	Sembabule	Ssembabule	100	112	No	No
43.	Mitooma	Mitooma	100	110	Yes	Yes
44.	Apac	Aduku	100	108	Yes	Yes
45.	Kole	Aboke	100	106	No	No
46.	Kabarole	Bukuku	100	106	Yes	Yes
47.	Bulambuli	Muyembe	100	105	Yes	Yes
48.	Masindi	Bwijanga	100	104	Yes	Yes
49.	Busia	Busia	100	102	Yes	Yes
50.	Mbale	Bufumbo	100	101	Yes	Yes
51.	Jinja	Budondo	100	92	No	No
52.	Nakapiripirit	Tokora	91.7	92	Yes	Yes
53.	Kalungu	St. Joseph of the Good Shephard Kyamulibwa	91.7	90	Yes	Yes
54.	Kaliro	Bumanya	100	87	Yes	Yes
55.	Ntungamo	Rubaare	100	87	Yes	Yes
56.	Kaberamaido	Kaberamaido	100	84	Yes	Yes
57.	Ntungamo	Rwashamaire	91.7	83	Yes	Yes
58.	Kyankwanzi	Ntwetwe	100	80	No	No
59.	Arua	Adumi	100	77	No	No
60.	Wakiso	Wagagai	100	74	Yes	Yes
61.	Kyenjojo	Kyarusozi	100	73	Yes	Yes
62.	Iganga	Busesa	100	72	Yes	Yes
63.	Kalangala	Kalangala	100	71	Yes	Yes
64.	Kotido	Kotido	100	71	No	No
65.	Rukungiri	North Kigezi	100	70	Yes	Yes
66.	Mbarara	Bwizibwera	100	68	No	No
67.	Nakasongola	St. Franciscan	100	68	Yes	Yes
68.	Sheema	Shuuku	100	66	No	No
69.	Kalungu	Bukulula	100	58	Yes	Yes
70.	Dokolo	Dokolo	100	56	Yes	Yes
71.	Mbale	Busiu	100	52	Yes	Yes
72.	Buhweju	Nsiika	100	52	No	No
73.	Namayingo	Buyinja	100	51	No	No

No.	District	Health Facility	HMIS 108 Reporting rate	Caesarian Sections	Offers blood transfusion	CS and Blood Transfusion
74.	Wakiso	Wakiso	100	50	No	No
75.	Pallisa	Butebo	100	46	Yes	Yes
76.	Kayunga	Kangulumira	100	46	No	No
77.	Mayuge	Kigandalo	100	45	No	No
78.	Serere	Apapai	100	44	Yes	Yes
79.	Rukungiri	Bugangari	91.7	42	No	No
80.	Kanungu	Kihiihi	100	41	Yes	Yes
81.	Nakasongola	Nakasongola	100	41	Yes	Yes
82.	Ibanda	Ruhoko	100	41	No	No
83.	Sironko	Buwasa	83.3	40	No	No
84.	Kiruhura	Kiruhura	100	40	No	No
85.	Nakapiripirit	Nabilatuk	100	37	Yes	Yes
86.	Amuria	Kapelebyong	100	34	Yes	Yes
87.	Amolatar	Amolatar	100	33	No	No
88.	Kiruhura	Kazo	100	32	No	No
89.	Rukungiri	Kebisoni	83.3	30	No	No
90.	Bukomansimbi	Butenga	91.7	28	Yes	Yes
91.	Wakiso	Buwambo	100	28	Yes	Yes
92.	Mbale	Namatala	100	25	No	No
93.	Mbarara	Kinoni	100	24	Yes	Yes
94.	Manafwa	Bugobero	91.7	22	No	No
95.	Kibuku	Kibuku	100	22	Yes	Yes
96.	Nebbi	Pakwach	100	21	Yes	Yes
97.	Mukono	Kojja	100	20	No	No
98.	Kiboga	Bukomero	100	16	Yes	Yes
99.	Bukwo	Bukwa	100	16	Yes	Yes
100.	Lwengo	Kiwangala	100	16	Yes	Yes
101.	Moyo	Obongi	100	16	Yes	Yes
102.	Masaka	Kiyumba	100	15	Yes	Yes
103.	Lamwo	Padibe	100	15	Yes	Yes
104.	Luwero	Kalagala	91.7	14	No	No
105.	Kisoro	Chahafi	100	13	No	No
106.	Kaabong	Karenga	100	13	No	No
107.	Lira	Ogur	100	13	No	No
108.	Pader	Pajule	100	13	Yes	Yes
109.	Ntoroko	Karugutu	100	12	Yes	Yes
110.	Kisoro	Rubuguri	100	12	No	No
111.	Buyende	Kidera	100	10	Yes	Yes

No.	District	Health Facility	HMIS 108 Reporting rate	Caesarian Sections	Offers blood transfusion	CS and Blood Transfusion
112.	Rukungiri	Buhunga	91.7	9	No	No
113.	Masaka	Kyannamukaaka	100	9	No	No
114.	Omoro	Lalogi	100	9	Yes	Yes
115.	Wakiso	Ndejje	100	8	No	No
116.	Nakaseke	Semuto	100	8	No	No
117.	Ngora	Ngora Gvt	91.7	6	No	No
118.	Luwero	Nyimbwa	100	6	No	No
119.	Arua	Omugo	100	6	No	No
120.	Soroti	Atitrir	100	5	No	No
121.	Soroti	Princes Diana	91.7	5	Yes	Yes
122.	Alebtong	Alebtong	100	4	Yes	Yes
123.	Lira	Ayira Health Services	100	4	No	No
124.	Bugiri	Nankoma	100	3	No	No
125.	Mityana	Kyantungo	100	2	No	No
126.	Yumbe	Midigo	100	2	Yes	Yes
127.	Mbarara	Bugamba	100	1	No	No
128.	Bundibugyo	Kikyo	100	1	No	No
129.	Ntungamo	Kitwe	100	1	No	No
130.	Luuka	Kiyunga	75	1	No	No
131.	Kabale	Rubaya	100	1	No	No
132.	Amuru	Atiak	100	0	No	No
133.	Kayunga	Bbaale	91.7	0	No	No
134.	Kalangala	Bukasa	100	0	No	No
135.	Kabale	Kamwezi	100	0	No	No
136.	Hoima	Kyangwali	100	0	Yes	Yes
137.	Kabale	Maziba Gvt	100	0	No	No
138.	Kabale	Mparo	100	0	No	No
139.	Jinja	Mpumudde	75	0	No	No
140.	Kitgum	Namokora	100	0	Yes	Yes
141.	Nakaseke	Ngoma	100	0	No	No
142.	Namutumba	Nsinze	100	0	No	No
143.	Sembabule	Ntuusi	91.7	0	No	No
144.	Kasese	Nyamirami	100	0	No	No
145.	Lira	Amach	100	0	No	No
146.	Gulu	Awach	100	0	No	No
147.	Manafwa	Bubulo	83.3	0	No	No
148.	Jinja	Bugembe	100	0	No	No
149.	Iganga	Bugono	100	0	No	No

No.	District	Health Facility	HMIS 108 Reporting rate	Caesarian Sections	Offers blood transfusion	CS and Blood Transfusion
150.	Bukedea	Bukedea	100	0	No	No
151.	Buliisa	Buliisa	100	0	No	No
152.	Kisoro	Busanza	100	0	No	No
153.	Bushenyi	Bushenyi	91.7	0	No	No
154.	Buvuma	Buvuma	91.7	0	No	No
155.	Rubanda	Hamurwa	100	0	No	No
156.	Kasese	Hiima	100	0	No	No
157.	Kabale	Kamukira	0	0	No	No
158.	Kanungu	Kanungu	100	0	No	No
159.	Kween	Kaproron	100	0	No	No
160.	Kabarole	Kataraka	100	0	No	No
161.	Hoima	Kigorobya	100	0	No	No
162.	Hoima	Kikuube	0	0	No	No
163.	Mayuge	Kityerera	91.7	0	Yes	No
164.	Kumi	Kumi	100	0	No	No
165.	Lwengo	Kyazanga	91.7	0	No	No
166.	Lwengo	Lwengo	100	0	Yes	No
167.	Gomba	Maddu	100	0	No	No
168.	Lamwo	Madi-Opei	100	0	Yes	No
169.	Mbarara	Mbarara Municipal Council	0	0	No	No
170.	Rubanda	Muko	100	0	No	No
171.	Tororo	Mukuju	100	0	No	No
172.	Tororo	Mulanda	100	0	No	No
173.	Mityana	Mwera	100	0	No	No
174.	Tororo	Nagongera	100	0	No	No
175.	Kamuli	Nankandulo	100	0	Yes	No
176.	Isingiro	Nyamuyanja	100	0	No	No
177.	Otuke	Orum	100	0	Yes	No
178.	Arua	Rhino Camp	100	0	No	No
179.	Arua	River Oli	100	0	No	No
180.	Isingiro	Rugaaga	100	0	No	No
181.	Mityana	Ssekanyonyi	100	0	No	No
182.	Jinja	Walukuba	91.7	0	No	No
183.	Yumbe	Yumbe	100	0	No	No

3.9 Annex 9: SUO for HC IVs

No.	HC IV	Admissions	Patient Days	OPD	Deliveries	Total ANC	Postnatal	Total family planning	Immunization	SUO
1.	Kisenyi	9,431	12,268	130,836	10,585	36,376	16,296	4,946	14,895	350,570
2.	Mukono T.C.	9,842	19,650	37,917	7,245	18,362	2,113	2,118	39,591	247,355
3.	Kumi	7,631	14,562	58,965	898	3,449	3,893	5,440	7,683	187,118
4.	Busia	7,867	13,171	45,208	2,410	10,715	1,437	2,829	10,848	184,963
5.	Anyeke	7,803	21,176	51,680	1,058	2,857	559	1,496	2,883	177,055
6.	Luwero	6,908	12,412	45,035	2,578	11,551	376	998	9,247	169,166
7.	Serere	7,915	24,553	28,869	1,784	4,584	4,256	870	4,927	162,457
8.	Amuria	7,661	25,014	29,350	1,899	2,755	2,793	696	3,914	158,013
9.	Rukunyu	7,525	19,821	22,043	2,025	2,997	4,108	1,134	5,554	151,040
10.	Mpigi	6,348	10,857	34,643	2,566	8,365	1,696	1,322	9,049	150,400
11.	Budaka	7,089	10,584	29,057	2,070	6,542	335	265	5,245	149,973
12.	Kibuku	6,165	10,485	27,439	1,285	4,688	1,155	1,158	5,232	131,049
13.	Kasangati	4,581	9,108	31,498	3,233	12,104	1,991	1,592	14,631	127,906
14.	Bukedea	5,916	17,153	25,602	1,437	5,651	1,364	1,338	5,946	126,981
15.	Budadiri	5,555	15,492	26,786	1,249	5,169	2,680	7,653	8,595	126,854
16.	Kyangwali	5,474	18,039	27,069	1,057	4,981	371	594	6,164	119,025
17.	Wakiso	3,520	6,104	29,959	2,571	11,297	319	732	39,387	118,092
18.	Kitwe	5,727	16,390	18,332	1,349	6,817	1,622	1,212	7,404	117,464
19.	Butebo	5,446	13,659	25,035	1,341	6,236	417	451	4,019	117,121
20.	Nankandulo	5,197	10,254	27,537	1,418	2,475	3,518	819	3,590	117,041
21.	PAG Mission	6,451	46,102	11,486	722	2,799	1,277	349	5,237	115,852
22.	Pakwach	5,289	13,412	22,931	1,238	4,587	3,556	1,316	6,438	115,028
23.	Ruhoko	6,365	5,309	11,676	958	3,331	1,300	533	1,796	114,422
24.	Busiu	5,945	9,919	15,330	1,010	3,045	1,987	1,730	4,035	114,040
25.	Kidera	5,098	11,725	26,277	765	3,472	2,157	930	9,818	113,719
26.	Kaberamaido	4,273	10,853	38,141	1,098	3,198	2,508	1,435	4,114	112,394
27.	Pajule	5,222	11,540	24,936	1,041	3,465	1,717	645	3,658	112,174
28.	Kabuyanda	5,159	13,596	20,238	1,747	5,224	3,715	1,474	3,587	111,791
29.	Princes Diana	5,037	25,334	25,704	916	3,401	2,614	773	4,942	110,684
30.	Kangulumira	3,310	4,780	42,859	1,554	6,037	5,168	3,102	8,447	109,845
31.	Kyegegwa	4,612	10,369	27,221	1,504	4,524	2,261	693	6,713	109,659
32.	Nyahuka	4,825	14,142	24,996	1,505	7,101	568	538	4,486	109,112
33.	Kibaale	5,418	7,483	15,063	1,597	5,181	72	595	5,638	108,507

No.	HC IV	Admissions	Patient Days	OPD	Deliveries	Total ANC	Postnatal	Total family planning	Immunization	SUO
34.	Buwenge	5,153	13,948	19,167	1,256	3,235	2,511	1,258	3,911	107,229
35.	Bumanya	5,277	13,990	18,182	663	2,806	1,106	105	4,499	104,068
36.	Kakuuto	4,814	16,257	24,490	823	2,335	223	282	2,889	102,979
37.	Mungula	3,850	13,573	37,255	914	3,588	1,656	301	3,106	102,824
38.	Lalogi	4,222	10,420	31,814	550	2,457	713	1,008	3,159	100,825
39.	Bugobero	3,951	7,595	27,628	817	4,063	890	486	16,512	100,735
40.	Rugazi	4,178	11,284	23,795	1,699	3,414	4,091	958	4,933	100,634
41.	Ngora Gvt	3,849	774	38,029	414	2,885	633	608	2,147	100,105
42.	Kabwohe	4,169	9,001	22,778	1,782	5,049	3,508	1,135	4,731	99,920
43.	Karugutu	4,439	11,724	21,785	1,206	2,875	2,777	271	6,530	99,764
44.	Mulanda	3,904	16,538	27,819	1,282	4,405	2,279	3,930	4,611	99,080
45.	Muyembe	4,611	10,000	18,795	1,166	4,819	990	1,374	3,822	97,847
46.	Bufumbo	4,525	12,607	19,231	1,043	2,898	1,789	2,357	3,680	96,814
47.	Buyinja	4,338	7,556	22,125	974	3,650	1,735	811	3,352	95,744
48.	Namokora	4,376	17,733	24,817	549	1,907	828	780	2,426	95,600
49.	Mitooma	2,705	11,386	46,735	821	3,224	1,131	980	4,527	95,379
50.	Dokolo	3,959	19,357	26,326	890	3,013	3,017	946	5,097	95,294
51.	River Oli	3,837	8,734	23,160	1,126	6,477	2,337	1,057	9,375	94,025
52.	Kapelebyong	4,229	12,822	21,494	917	2,527	699	200	3,902	92,420
53.	Semuto	3,872	6,358	25,386	915	5,120		728	5,018	91,938
54.	Awach	3,590	9,873	32,104	528	1,927	1,215	839	3,453	91,733
55.	Mukono CoU	3,724	9,872	23,693	1,275	2,932	1,607	140	8,218	91,497
56.	Kotido	4,174	11,297	23,925	552	1,117	1,773	29	1,745	91,292
57.	Kakindo	4,217	9,994	12,966	1,375	8,695	2,027	794	8,861	90,676
58.	Nagongera	3,550	6,812	23,281	1,387	6,769	546	903	7,708	89,398
59.	Bukomero	3,378	5,268	23,690	1,676	7,236	1,509	790	7,316	88,995
60.	Namwendwa	3,774	7,330	18,413	1,715	3,262	3,377	1,031	4,501	88,705
61.	Midigo	4,364	18,556	14,310	825	2,610	858	1,231	5,762	88,343
62.	Ntwetwe	4,087	9,506	13,753	1,292	5,950	3,201	1,236	6,540	88,197
63.	Atirir	3,884	8,079	24,312	569	1,174	1,359	770	2,894	88,163
64.	Magale	4,331	11,688	9,698	1,347	4,132	3,657	353	7,575	88,017
65.	Apapai	3,817	6,931	24,724	604	1,855	1,069	205	3,857	87,936
66.	Kyabugimbi	3,593	8,964	22,215	1,284	4,027	3,294	734	4,724	87,711
67.	Bubulo	3,610	3,166	23,392	982	4,013	2,830	1,566	3,916	87,411

No.	HC IV	Admissions	Patient Days	OPD	Deliveries	Total ANC	Postnatal	Total family planning	Immunization	SUO
68.	Omugo	3,259	8,081	30,488	880	4,158	1,070	517	2,936	86,866
69.	Amolatar	3,931	9,277	19,371	1,008	3,032	1,446	386	3,671	86,734
70.	Rubaare	2,013	13,770	19,586	1,201	3,204	1,869	52,534	6,131	86,694
71.	Busesa	3,536	7,013	24,184	1,035	3,734	2,513	314	2,731	85,925
72.	Kibiito	4,006	5,279	11,018	1,697	4,856	3,095	665	3,790	84,339
73.	Kiyunga	3,070	2,905	28,240	1,038	5,072	2,693	381	4,422	84,242
74.	Nankoma	3,092	3,731	23,231	899	5,078	4,148	1,387	10,892	83,335
75.	Rwekubo	3,645	9,249	15,073	1,991	1,784	2,640	924	2,813	83,248
76.	Kiganda	3,097	6,995	19,694	2,000	7,211	2,995	1,821	6,298	83,148
77.	Aduku	3,260	9,406	24,444	1,043	4,144	1,264	1,336	4,849	83,112
78.	Mukuju	3,051	10,847	26,162	1,055	4,198	2,156	2,086	3,788	82,057
79.	Obongi	3,685	10,984	22,895	456	1,594	742	204	1,354	81,919
80.	Rwesande	4,091	13,482	12,222	778	3,410	1,235	1,293	3,093	80,970
81.	Rwashamaire	3,361	7,193	18,309	1,469	3,718	2,513	705	3,052	79,948
82.	Kyarusozi	3,031	7,176	25,112	877	3,446	2,975	288	2,821	78,693
83.	Atiak	3,033	8,533	29,480	256	1,416	433	486	3,249	78,622
84.	Nakasongola	3,195	5,952	22,862	936	3,723	579	615	2,812	78,215
85.	Yumbe	3,562	6,545	18,015	416	4,534	665	823	5,904	78,128
86.	Tokora	3,900	8,651	13,291	471	2,444	1,742	458	3,363	77,416
87.	Kigandalo	2,059	2,803	36,435	1,103	4,934	1,919	455	4,038	77,028
88.	Kihiihi	3,069	9,900	22,677	747	3,942	2,571	1,123	2,514	76,339
89.	Buliisa	3,579	8,934	15,263	669	2,362	2,089	564	3,875	76,029
90.	Ogur	3,184	9,676	16,712	1,024	3,084	186	2,046	8,158	75,404
91.	Alebtong	2,904	4,440	21,448	787	3,715	1,660	1,443	7,297	74,886
92.	Bugembe	1,163	1,287	41,482	1,375	6,905	2,996	3,991	8,384	74,869
93.	Bwizibwera	3,143	8,611	16,350	841	3,429	2,982	5,781	3,975	74,755
94.	Lwengo	2,661	125	28,778	596	2,682	1,127	594	2,641	74,390
95.	Ndejje	1,907	3,281	28,849	1,463	7,841	925	1,033	12,916	73,774
96.	Karenga	3,347	8,223	19,925	390	1,501	665		1,876	73,651
97.	Bukululа	2,620	4,818	25,651	989	2,877	2,285	778	3,118	73,562
98.	Nabilatuk	3,661	8,908	14,403	391	1,870	698	5	2,560	73,279
99.	Kakumiro	2,484	5,887	22,018	1,617	7,112	337	614	6,001	72,261
100.	Kassanda	2,654	4,146	12,561	1,876	6,722	3,050	3,179	11,211	71,815
101.	Kityerera	1,975	2,771	29,955	1,126	5,828	1,814	1,189	6,341	71,048

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102.	Bugono	2,390	2,470	29,094	595	4,087	2,032	462	1,398	70,682
103.	Bbaale	2,613	7,566	24,606	533	2,942	1,368	1,165	4,093	70,367
104.	Ntara	2,959	6,953	15,002	897	3,158	2,270	1,020	8,068	70,183
105.	Walukuba	1,916	2,236	33,544	734	4,417	1,089	1,180	3,657	69,800
106.	Ishongororo	2,742	6,969	17,634	936	4,118	2,136	1,465	5,803	68,970
107.	Padibe	2,209	6,626	30,359	489	1,248	1,279	484	1,988	68,064
108.	Namayumba	1,911	2,629	30,074	1,164	5,429	716	1,257	2,224	67,743
109.	Kigorobya	2,349	4,795	23,906	993	4,558	1,456	1,144	2,773	67,704
110.	Madi-Opei	2,171	6,326	30,887	292	1,265	760	819	2,519	67,214
111.	Kyannamukaaka	2,806	6,824	21,122	370	1,391	886	251	2,004	66,911
112.	St. Paul	3,452	10,742	5,178	1,324	2,156	830	950	2,849	66,324
113.	Busaru	3,569	11,996	6,853	482	2,625	1,283	36	4,459	66,212
114.	Kyazanga	2,411	3,222	23,927	649	3,964	1,431	1,020	802	65,756
115.	Amach	2,545	4,246	18,634	845	3,643	675	1,015	6,200	65,708
116.	Orum	2,864	6,284	16,329	396	2,189	1,344	1,152	2,751	64,330
117.	Mpumudde	1,515	2,937	32,214	958	4,345	2,700	1,233	3,007	64,068
118.	Kiwangala	1,455	6,614	31,784	547	2,262	337	1,185	7,915	61,515
119.	Aboke	2,371	6,618	16,828	921	2,699	1,733	1,298	4,539	61,323
120.	Buwambo	1,538	4,137	29,628	656	3,357	1,324	618	7,304	61,272
121.	Bishop Asili Ceaser	2,940	7,377	10,539	861	1,296	938	-	1,472	60,408
122.	Kanungu	2,457	6,703	17,811	288	1,601	637	1,173	1,628	58,145
123.	Bukuku	1,707	4,211	18,374	1,308	5,097	5,512	3,099	4,225	57,956
124.	Kazo	1,609	4,177	25,566	849	4,561	1,349	691	3,811	57,784
125.	Ssembabule	1,873	108	20,235	1,019	5,753	242	1,368	4,784	57,773
126.	Budondo	2,096	5,947	19,378	741	3,490	1,574	678	2,830	57,762
127.	Bugangari	1,690	5,130	24,668	766	2,682	2,128	875	2,690	57,231
128.	Chahafi	2,023	5,904	20,687	627	3,211	1,473	958	2,203	57,126
129.	Benedict Medical centre	1,287	3,448	31,170	415	1,903	1,248		1,655	54,382
130.	Namatala	1,707	4,048	22,958	291	5,225	961	562	4,306	53,978
131.	Kalagala	2,240	2,267	14,716	528	3,937	377	1,347	2,721	53,966
132.	Kinoni	2,157	4,031	14,942	738	2,505	1,579	385	2,542	53,741
133.	Adumi	1,849	5,106	18,667	640	3,150	990	310	5,178	53,471
134.	Kiruhura	2,020	4,148	17,101	558	2,334	1,031	578	3,843	53,384

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135.	Kaproron	1,910	1,758	20,129	327	1,789	588	975	2,147	52,627
136.	Bwijanga	2,227	4,222	11,689	814	4,026	709	1,097	3,311	52,528
137.	Rugaaga	1,196	3,095	23,456	499	3,509	1,948	7,959	3,808	51,450
138.	Nyimbwa	1,794	2,019	17,862	554	3,916	671	382	2,774	50,239
139.	Ssekanyonyi	1,508	3,302	20,469	689	3,551	1,061	1,611	2,868	50,014
140.	Shuuku	1,815	6,230	16,226	503	2,277	1,195	1,149	1,987	48,587
141.	Muko	1,618	5,254	19,316	399	2,095	820	1,077	1,719	47,808
142.	Rhino Camp	1,846	3,163	15,129	431	1,569	1,059	943	2,394	47,486
143.	St. Ambrose Charity	2,538	3,832	3,479	420	877	539	815	3,358	46,180
144.	Nsinze	1,216	598	20,917	809	2,508	1,628	1,302	1,499	45,918
145.	Buwasa	1,300	3,113	21,388	551	3,028	141	387	2,373	45,699
146.	Wagagai	663	1,216	32,065	290	1,227	964	1,055	1,791	45,610
147.	Maddu	1,444	1,374	16,141	775	3,492	1,687	660	3,088	45,092
148.	Nyamuyanja	1,416	3,377	19,216	402	2,262	994	780	2,566	45,088
149.	Kebisoni	1,319	2,381	15,780	1,039	2,934	2,377	1,070	2,854	44,497
150.	Kojja	925	76	19,587	883	3,628	1,433	2,069	6,772	43,740
151.	Rubuguri	1,307	3,831	18,159	521	2,050	1,229	949	2,065	42,901
152.	Hamurwa	848	2,878	23,444	619	3,373	1,645	787	3,476	42,888
153.	Butenga	1,371	4,362	16,316	719	2,934	700	784	1,577	42,593
154.	Kikyo	1,943	3,140	9,683	229	1,607	482	105	2,059	41,617
155.	Buvuma	1,029	1,660	20,211	416	2,356	965	708	4,156	41,112
156.	Kamwezi	1,263	3,065	14,720	470	1,923	1,398	728	2,305	38,615
157.	Kalangala	1,066	2,904	17,953	419	1,669	769	1,410	2,286	38,604
158.	Buhunga	1,139	2,707	14,761	726	1,688	1,672	992	2,285	38,288
159.	Rubaya	1,181	2,502	15,064	487	2,789	1,511	1,317	1,962	38,167
160.	Mparo	1,404	2,793	13,477	313	1,420	1,089	942	777	37,790
161.	Toroma	1,273	3,569	13,594	441	1,386	465	638	2,068	36,757
162.	Kiyumba	1,001	2,411	17,893	381	1,593	639	349	1,783	36,517
163.	Kyantungo	1,273	3,798	14,166	204	819	420	1,009	2,128	36,223
164.	St. Joseph Kyamulibwa	1,625	3,703	7,213	360	336	912	15	896	34,367
165.	Kikuube			23,833	1,088	4,911	555	430	5,654	33,575
166.	Busanza	799	1,607	18,342	276	1,407	826	303	950	33,028

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167.	Bishop Masereka Christian Foundation	1,555	3,408	5,413	260	2,010	327	273	3,488	32,484
168.	Nsiika	1,041	847	11,362	632	1,427	1,173	992	1,526	32,268
169.	Mwera	1,023	2,713	13,223	333	1,538	784	446	1,895	32,103
170.	Masindi Military	1,007	3,567	15,664	65	420	169	457	687	31,835
171.	Maziba Gvt	889	2,428	13,958	299	2,122	1,019	743	1,027	30,607
172.	Ngoma	430	1,046	19,758	185	2,751	449	911	2,970	29,848
173.	Bugamba	827	2,117	10,995	483	2,646	874	613	2,516	28,346
174.	North Kigezi	1,257	3,296	4,959	403	691	1,009	891	1,001	27,418
175.	Bushenyi	257	423	20,383	203	2,048	672	741	1,611	27,175
176.	Bukasa	383	765	18,191	157	1,091	511	428	2,106	26,462
177.	Kamukira			22,947	172	1,655	934	2,060	1,433	26,352
178.	Mbarara Mun. Council			14,492	525	6,714	7,866	897	5,500	25,591
179.	Bukwa	1,035	2,666	4,783	144	883	1,270	315	2,400	23,197
180.	Nyamirami	643	458	10,004	222	1,117	358	481	1,902	22,353
181.	St. Franciscan	866	1,657	4,936	179	339	532	-	950	19,630
182.	Kataraka	104	46	15,171	112	1,370	411	855	1,356	18,876
183.	Ntuusi	339	417	10,171	243	2,650	384	731	1,934	18,526
184.	Hiima	115	222	6,255	2	65	7	217	73	8,152
	Total	**571,653**	**1,371,999**	**4,115,947**	**180,514**	**698,426**	**301,039**	**248,616**	**850,236**	**14,432,943**