MIDTERM REVIEW REPORT

Of the
Health Sector Strategic and Investment Plan
(HSSIP)
2010/11 - 2014/15
(VOLUME: 1)

In Collaboration with the
WORLD HEALTH ORGANIZATION

September, 2013
FOREWORD:
The Ministry of Health in Collaboration with the World Health Organization (WHO) has conducted a Midterm Review (MTR) of the progress of implementation of the Health Sector Strategic and Investment Plan (HSSIP). The HSSIP was developed and approved for implementation for a period of five (5) years from the Financial Year (FY) 2010/11 to 2014/15 (HSSIP 2010/11-2014/15). The HSSIP provides the overall strategic and implementation framework for the health sector priorities and is aimed at contributing towards the overall development goal of the Country in regard to accelerating economic growth and reducing poverty as stated in the National Development plan (NDP) 2011/11-2019/20 and the National Health Policy II.

The overall goal of the Health Sector during the HSSIP was to attain a good standard of health for all people in Uganda in order to promote a healthy and productive life. This was designed to be achieved by focusing on achieving universal coverage with quality health and health related services through addressing the following 5 major Strategic Objectives: 1) Scale up critical interventions 2) Improve access and demand 3) Accelerate quality and safety improvements 4) Improve efficiency and budget effectiveness and 5) Deepen Health Stewardship. Under each of the strategic objectives were key interventions to be implemented and targets to be met during the 5 year period.

As the life of the plan approached its midterm, it was necessary to review progress made under each of the intervention areas. The extent to which the plan is being implemented is reflected in the various chapters of the report. The MTR report assessed the progress so far made in the attainment of the HSSIP objectives through an in-depth analysis of relevant data from existing sources such as administrative, health facility and population surveys, as well as research publications. This was done from objective one to five and also the investment focus area. The report identifies key achievements, bottlenecks/challenges faced, and areas of deficiency and proposes areas for modification for the remaining two (2) years of the HSSIP life.

I am glad to note that the midterm review of the HSSIP was conducted through a participatory process by all key stakeholders and has successfully been concluded. May I appeal to all Health Sector Stakeholders and readers of this report, to not only use it to guide the implementation of the remaining period of the HSSIP but also use it to guide future planning for the health sector.

In conclusion I wish to thank all the Ministry of Health staff and other stakeholders who participated in the review process.

FOR GOD AND MY COUNTRY

Hon. Dr. Ruhakana Rugunda
MINISTER OF HEALTH
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ACKNOWLEDGEMENTS:
Special thanks go to the Ministry of Health Technical Working Groups for their tireless efforts in putting together their respective reports. In yet another special way, the Core Analytical Team composed of Ministry of Health, World Health Organization (WHO), and Uganda Bureau of Statistics (UBOS) staffs are highly appreciated for coordinating the whole MTR process; and to Quality Assurance Department for being the Secretariat.

Furthermore thanks to the World Health Organization Headquarters and Country office for supporting the MTR process from inception to the end through Technical and Financial Assistance.
SUMMARY ASSESSMENT OF HSSIP CORE INDICATORS:

During the mid-term review of the Health Health Sector Strategic and Investment Plan (HSSIP) 2010/11-2014/15, an assessment of performance of the twenty six (26) core indicators which were selected to monitor the implementation of the HSSIP was done and the overall progress is summarized in the table below:

<table>
<thead>
<tr>
<th>HEALTH STATUS</th>
<th>OVERALL PROGRESS</th>
<th>BASELINE 2009/10</th>
<th>ACHIEVEMENT 2012/13</th>
<th>TARGET 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality ratio</td>
<td>435/100,000 (1999-2006)</td>
<td>438/100,000 (2004-11)</td>
<td>131</td>
<td></td>
</tr>
<tr>
<td>Under-5 mortality rate</td>
<td>137/1,000 (2001-05)</td>
<td>90/1,000 (2007-11)</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>76/1,000 (2001-05)</td>
<td>54/1,000 (2007-11)</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>Neonatal mortality rate</td>
<td>29/1,000 (2001-05)</td>
<td>27/1,000 (2007-11)</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Child stunting rate</td>
<td>38% (2006)</td>
<td>33% (2011)</td>
<td>28%</td>
<td></td>
</tr>
<tr>
<td>Child wasting rate</td>
<td>16% (2006)</td>
<td>14% (2011)</td>
<td>10%</td>
<td></td>
</tr>
</tbody>
</table>

COVERAGE OF INTERVENTIONS

<table>
<thead>
<tr>
<th>INTERVENTIONS</th>
<th>OVERALL PROGRESS</th>
<th>BASELINE 2009/10</th>
<th>ACHIEVEMENT 2012/13</th>
<th>TARGET 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC at least 4 visits</td>
<td>47% (2001-2006)</td>
<td>31% (HMIS)</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>IPT2 coverage</td>
<td>47%</td>
<td>47% (HMIS)</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Deliveries in health facilities</td>
<td>33% (2004-06)</td>
<td>41% (HMIS)</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Contraceptive prevalence rate</td>
<td>24% (2006)</td>
<td>30% (2011)</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>Penta 3 immunization coverage</td>
<td>76%</td>
<td>87% (HMIS)</td>
<td>85%</td>
<td></td>
</tr>
<tr>
<td>Measles immunization coverage</td>
<td>72%</td>
<td>91% (HMIS)</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Malaria treatment &lt;24h for U5s with fever</td>
<td>70%</td>
<td>No data</td>
<td>85%</td>
<td></td>
</tr>
<tr>
<td>TB case detection rate</td>
<td>56% (2008/09)</td>
<td>67%</td>
<td>70%</td>
<td></td>
</tr>
<tr>
<td>HIV testing of HIV-exposed infants</td>
<td>29%</td>
<td>46%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>ART coverage among those in need</td>
<td>53%</td>
<td>73%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Households with pit latrine</td>
<td>70%</td>
<td>70%</td>
<td>72%</td>
<td></td>
</tr>
</tbody>
</table>

HEALTH SYSTEMS

<table>
<thead>
<tr>
<th>SYSTEMS</th>
<th>OVERALL PROGRESS</th>
<th>BASELINE 2009/10</th>
<th>ACHIEVEMENT 2012/13</th>
<th>TARGET 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government allocation for health (%)</td>
<td>8.3%</td>
<td>7.9%</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Catastrophic payments (% households)</td>
<td>43%</td>
<td>No data</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>Annual reduction in absenteeism</td>
<td>Absenteeism 46%</td>
<td>No data</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Villages/wards with VHTs</td>
<td>75%</td>
<td>55%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approved posts filled (%)</td>
<td>56%</td>
<td>63%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>No stockouts of tracer meds</td>
<td>21%</td>
<td>53%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Outpatient visits per capita</td>
<td>0.9</td>
<td>1.1</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>HC IVs providing EmOC</td>
<td>23%</td>
<td>36%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Client satisfaction</td>
<td>46%</td>
<td>No data</td>
<td>70%</td>
<td></td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY:

The Health Sector Strategic and Investment plan (HSSIP) 2010/11-14/15 provides the overall strategic and implementation framework for the health sector priorities. It was intended to be implemented under five (5) major Strategic Objectives: 1) Scale up critical interventions 2) Improve access and demand 3) Accelerate quality and safety improvements 4) Improve efficiency and budget effectiveness and 5) Deepen Health Stewardship. A Mid Term Review of its implementation was carried out in line with the M&E Framework.

The findings under objective 1; Scale up of critical interventions: showed mixed progress, some indicators have been achieved, others are on track to be achieved by 2015, while others are off track.

Under this objective; review of the Health Promotion, Environmental Health, Nutrition and Community Initiatives cluster reported good progress has been made on pit latrine coverage, under-weight in the under-five children and reduction in stunting for children above 5 years. The remaining indicators under this cluster seem to be off track and will require more effort to attain the 2015 targets.

Besides the core indicators, significant progress has been made in various areas, such as reduction of anaemia where the 2015 target has been surpassed and vitamin A supplementation and water quality surveillance indicators which are on track. Slow progress has been registered in access to safe water and percentage of districts with trained VHTs. However, 2015 targets could be attained with more effort. Stagnation and / or decline were observed in safe water chain, hand-washing facilities with soap and exclusive breast-feeding in the first 6 months.

Concerning Epidemic Preparedness and Disaster Response cluster, a lot of progress was made in containing disease outbreaks during the review period. Through coordinated efforts of a multisectoral National Task Force (NTF), major outbreaks of Yellow Fever in Northern Uganda in 2010, Nodding Syndrome in the Acholi sub-region, Ebola and Marburg in Central and Western Uganda were effectively contained. Consequently, significant progress has been made investigating and responding to the Nodding disease epidemic in the Acholi sub-region. Similarly, following containment of the Yellow Fever epidemics in Northern Uganda in 2010, a national Yellow Fever risk assessment was conducted and policy dialogue for Yellow Fever control is ongoing. The NTF has also been applauded by the international community for controlling the viral hemorrhagic fever outbreaks of 2012 in record time.

In the cluster of HIV/AIDS prevention, care and support, there was an increase in the prevalence of HIV among adults from 6.4% in 2004/05 to 7.3% in 2011, according to the Sero-Survey study. This trend was attributed to both new infections and improved survival as more People Living with HIV (PLHIV) access Anti Retro-viral Therapy (ART). Women were disproportionately more affected than men (a prevalence of 8.3% versus 6.1%), and this trend was evident in all regions of the country.

Access to HIV Counseling and Testing (HCT) services by the general population has increased; estimated at 25% of women and 23% of men in 2006; increased to 38% in 2008 and currently estimated at 66% among women and 45% among men. The higher coverage among females is attributed to HCT opportunities during MCH and PMTCT services contact.
The number of individuals accessing ART increased from 329,060 (57% coverage) by end of September 2011 to 566,046 (76.5% coverage) by end of June 2013. Children comprise 8% of all ART recipients; coverage among eligible children is only 41%. The number of facilities providing ART increased from 398 by March 2011 to 1,073 at the end of June 2013.

Among 53,451 pregnant women who received ARVs between October 2012 and March 31st 2013 at 2,087 sites, 33% received PMTCT option A, 38% received option B+ and 29% were already on ART before their first Antenatal Care (ANC).

Coverage of Early Infant Diagnosis (EID) testing in 2012 was 53,981 (56%) of exposed infants (53,944 of the estimated 96,328 exposed infants) for first PCR, a steady increase from 7% in 2007. Prevalence of HIV among those tested was 9%, a significant decline from 19% in 2007.

For the case of TB & Leprosy, Case detection rate has stagnated between (54 -57) % over the past four years, Cure rate has improved but general performance is still low, CPT Uptake has remained high over time, and ART uptake among those co infected with HIV is still low. While some improvement has been realized with DOT coverage, its quality is questionable.

In the field of malaria, among the core indicators, it is only the Proportion of Children Under 5 years Receiving Treatment for Malaria currently at 53% (HMIS) which appear to be on track to reach the HSSIP target of 85%. The other core indicator (IPTp2) has had very slow progress and 2015 target is unlikely to be met. Besides the core indicators, other indicators for Net Coverage and Net Use are improving steadily and with the ongoing universal coverage Long Lasting Insecticide Treated Net (LLIN) campaign, the HSSIP set targets are likely to be met.

The MTR of Neglected Tropical Diseases (NTDs) section, found that there was timely reporting and investigation of suspected guinea worm cases, Ochocerciasis transmission has been eliminated in all isolated foci, all NTD endemic districts have undergone mass treatment, Schistosomiasis prevalence of heavy intensity has reduced and ddagnostic procedures and treatment for sleeping sickness is gradually improving. However, therapeutic coverage for most NTDs were still below the target of >75%.

Assessment of Non Communicable diseases performance was rather problematic because most of the NCD program indicators lacked baseline data and some key indicators were difficult to track and measure due to their composite nature. However, two scientific conferences on Diabetes were held in Kampala, all Regional Referral Hospitals and Faith based Hospitals had been supported in terms of training and equipments to diagnose and manage Diabetes. Partnerships have been established with International Diabetes Federation and World Diabetes federation in prevention and management of Diabetes. Data collection has been strengthened in routine HMIS and Diabetes information captured by HMIS tools. The NCD Survey which was planned in the first year of the HSSIP hadnot been carried out due to lack of funds. It is however, a priority for the remaining period of the HSSIP.

The Reproductive health, maternal, newborn care and child health assessment found that virtually all pregnant women attend antenatal care at least once (95%) however; only 48% make the recommended 4 or more ANC visits. It is unlikely that the HSSIP target of 60% for 4 or more ANC visits will be met. In addition, while there has been an upward trend in Institutional deliveries, the
HSSIP target of 90% in 2015 may be difficult to achieve. The situation is similar for the proportion of deliveries by skilled birth attendants.

As regards Child Health; Child mortality in Uganda continued to decline rapidly to 90 per 1,000 live births in 2011, from 137/1,000 in 2006, although the pace of mortality needs to be accelerated if the HSSIP target of 56 per 1000 is to be met. Uganda continues to improve its child immunization coverage with overall increase in the trend from 52% in 2006 to 66% in 2011.

All HC IIIs and 30% of HC IIs were able to offer basic obstetric and newborn care services, with improved availability of essential life-saving commodities including contraceptives. However, postnatal care for babies within 2 days of birth is very low and the equipment for newborn care is available in only half of the facilities offering delivery services. And the inequalities between urban and rural women and between the poorest and best off women for ANC and institutional deliveries are large and persisting with little progress in closing the gaps.

The findings under objective 2 (Improve Levels and Equity in Access and Demand for services) also showed a mixed picture: Regarding Health Infrastructure and Service Delivery, the functionality of Health Centre (HC) IVs increased from 5% in 2009/10 to 36%. The proportion of the population of Uganda living within 5 km of a health facility remains at 72% until work on population projections by UBOS is completed for proper assessment. The proportion of HC IVs and hospitals with functional ambulances for referral increased to 100% and Percent of medical equipment in good condition and maintained currently at 51%. The Percentage of mobile population that physically access health facilities has stagnated with the pilots in Moroto and Kotido districts closed due to lack of logistics.

On Essential Medicines and Health Supplies (EMHS): Availability of the six tracer medicines (ACT, Cotrimoxazole, measles vaccine, Oral Rehydration salt, Depo-Provera and Sulphadoxine pyramethamine has been increasing steadily with 53% of health facilities without monthly stock outs in 2012/13. Further analysis by level of care shows availability of all the six tracer medicines increasing from 30% and 42% in 2010/11 to 53% and 48% in 2012/13 for HC2 and HC3 respectively compared to 20% and 18% in 2010/11 to 47% and 40% in 2012/13 for HC4 and Hospitals. However, stock outs are still experienced in half of the health facilities.

Financing for EMHS points out that there has been significant increase in per capita expenditure from $0.5, 2010/11 to $0.9, 2012/13, with budget out turn of 79%, 2010/11 to 96% 2011/12. Further analysis on the proportion of government funding for EMHS increased from 52 billion of shillings to 86 billion of shillings with NMS utilizing 95% of this budget. 38% of the vote spent mostly at district level. Despite these increases, EMHS funding is still insufficient and equitable distribution needs to be realized.

On Health Workforce: Health workers are the most important component of any Health System: they design it, manage it, and deliver preventive and curative services. However, there is shortage of health workers and the available health workers perform below expectation. The health workforce crisis is characterized by inadequate number and skill mix to effectively respond to the health needs, low retention and motivation, poor performance and high rate of absenteeism. The total estimated health workforce is about 45,598, serving a total projected population in Uganda of about 31.8 million. This means that there is one health worker for over 697 people, taking the entire health workforce together. According to WHO, a country with less than 2.28 health workers (doctors, nurses and midwives only) per 1000 population is regarded to be in severe shortage of
health workers to meet its health needs. For Uganda this ratio is about 1.55. About 7,000 HWs recruited in 2013 increasing staffing levels from 58% to 63%. A hard to reach/stay strategy and the motivation and retention strategy developed and operationalized. Despite the achievements and progress made so far, the HRH systems are still generally weak and the achievements need to be scaled up, consolidated and sustained.

Findings on Objective 3(Accelerate Quality and Safety Improvements of Services) are as follows indicates that a National Quality Improvement Framework and Strategic Plan 2011/12 to 2014/15 FY was developed, launched and is being implemented, and this has created a more focused involvement of the different stakeholders implementing Quality Improvement (QI) initiatives in the country. As a foundation for Quality Improvement, 5S has been introduced in 8 Regional Referral Hospitals and selected health facilities within these regions and will be extended to the remaining health facilities in the sector by 2015.

To ensure safety improvements, the National Infection Prevention and Control guidelines and the Standards for Diagnostic Imaging and Therapeutic Radiology were developed and launched for use throughout the country. The Patients Charter was disseminated to all districts and translated in Ateso and Luganda to stimulate demand for better services by users. The Ministry of Health Client Charter was reviewed and the Regional Referral Hospitals supported to develop their own charters. This is expected to improve responsiveness and build a more client focused service delivery system for the health sector where feedback can be used to improve the quality of health services.

There was slow progress in developing the Comprehensive Support supervision Strategy for the sector, mainly because of procurement delays and inadequate funding. This is expected to be completed in the course of the remaining period of HSSIP.

The 14 Area Teams (AT) carried out regular quarterly supervision to Local Governments and Hospitals during the first two years of the HSSIP however, this momentum was not maintained in the third year of the HSSIP implementation because of budget constraints.

Client satisfaction with the services based on waiting time in 2009/10 and 2010/11 indicated that 71% and 72% of clients respectively were satisfied with the services, according to the panel surveys. This was an improvement from the baseline of 46% at the end of HSSP II. Another study under the 5S CQI TQM project done in 2013 in all RRHs and selected HFIs showed that in general, 67% of clients were satisfied with the services while client satisfaction based on waiting time was 54%. A country wide Client Satisfaction survey will be conducted during FY 2013/14.

Findings on objective 4 (improve efficiency and budget effectiveness): A Health Financing Strategy is being developed and will be completed by end of this year. Government per capita expenditure on health shows it is on track given the US$ 9 in 2012/2013 against US$ 12 in 2015. The share of government allocation to health currently at 7.8% declined from 9.6% in 2009/2010; hence the HSSIP target of 15% may not be met. External funding for health as a % of total health expenditure has reduced from 41% in 2009/10 to 26% in 2012/2013. Per capita out of pocket expenditure on health is still high at US$22 in 2009 and Target of US$10 may not achievable for the HSSIP period. A percentage of quarterly internal audit reports (district, hospitals, central level) prepared and submitted timely is an important indicator but data is not available to measure progress towards the HSSIP target of 100%.
Findings on Objective 5 (Deepen Health Stewardship): There was continued advocacy for increasing the health workforce through stakeholder meetings e.g. Joint Reviews, Social Services (Health) Committee of Parliament and this resulted in a lift on the ban on recruitment in the health sector. The revised VHT Strategy was launched and VHT established fully in 75% of districts. Only 55% of villages/wards have trained VHTs which is below the target of 75% for 2012/13 FY.

The UNMHCP is delivered in an integrated manner. The major programmes such as Malaria, TB, HIV/AIDS and EPI have maintained the role of technical supervision and programming however, at district level the integrated approach is applied. Management structures were clearly defined and Governance and Management Structures guidelines for the MoH were developed. The Planning guidelines were revised and disseminated to all Local Governments.

With the support of the GFTAM a regional structure to support planning, monitoring and supervision of health services delivery was proposed and the MoH is in the process of establishing and functionalizing this structure. The Resource functions of information management and dissemination was strengthened by adopting the DHIS-2 as the official MoH web-based aggregate reporting tool for health facility data. The DHIS-2 can be accessed by all levels as and when access is given.

A comprehensive M&E Plan for Implementation of the HSSIP with clear indicators, taking onto consideration disaggregation by sex and age was developed. E-health innovations e.g. mTRAC, U-reporting and revision of HMIS tools e.g. Mother-Child health Passport and registers were done.

UNHRO developed the National Health Research Policy and Strategic Plan. The research agenda is still under development. Mapping, capacity assessment and inventory of institutions that conduct health science research was done.

Established a District Supervisory Authority to support the inspection and monitoring function of the Professional Councils. Preliminary stages in development of the Joint Professional Council Bill. Reviewed guidelines for establishing and operating private guidelines and made recommendations to the health training institutions for improving quality of training.

The PPPH policy was approved by the Cabinet and disseminated. The Implementation guidelines are being revised, and also PHC Grant funding transfer to PNFP facilities were streamlined.

To strengthen intersectoral collaboration, other GoU Ministries (e.g. MoES, MoFPED, MoPS, MoGLSD, MoW&H, MoAAIF, MoLG, MoW&E, MoL&UD) and departments (e.g. UBOS) are invited to participate during the NHAs and JRMs or relevant planning meetings. Adhoc inter-departmental consultations initiated for specific tasks or problems.

The key over arching recommendations are that where there is good progress, sustained investment in such critical interventions may be necessary in order to maintain the momentum; and where there is stagnation or decline in performance, it may be necessary to revise the targets to realistic levels, identify and address reasons behind the current status. Finally where services/interventions are available but there is low update, further in-depth research studies to identify barriers would be appropriate.
CHAPTER ONE

Introduction:

The Health Sector Strategic and Investment Plan (HSSIP) was developed and approved for implementation for a period of five (5) years from the Financial Year (FY) 2010/11 to 2014/15 (HSSIP 2010/11-2014/15). The HSSIP provides the overall strategic and implementation framework for the health sector priorities. The plan aimed at contributing towards the overall development goal of the Government of Uganda in regard to accelerating economic growth, reducing poverty as stated in the National Development plan (NDP) 201/11-2019/20, and guided the sector focus towards attainment of the policy objectives as outlined in the National Health Policy II.

The guiding principles of the plan were equality and non-discrimination, participation and accountability and the rights to health elements of availability, accessibility, acceptability and quality.

The overall goal of the Health Sector during the HSSIP was to attain a good standard of health for all people in Uganda in order to promote a healthy and productive life. The goal when achieved would lead to acceleration in the improvements in the level and distribution of health in the country as reflected in by the health impact indicators. This was designed to be achieved by focusing on achieving universal coverage with quality health and health related services through addressing the following 5 major Strategic Objectives: 1) Scale up critical interventions 2) Improve access and demand 3) Accelerate quality and safety improvements 4) Improve efficiency and budget effectiveness and 5) Deepen Health Stewardship. Under each of the strategic objectives were key interventions to be implemented and targets to be met during the 5 year period.

A Monitoring and Evaluation (M&E) Framework was developed for monitoring implementation of the HSSIP, which included a midterm review to be carried out in the second half of Financial Year 2012/2013. As the life of the plan approached its midterm, it was necessary to review progress made under each of the intervention areas. The extent to which the plan is being implemented is reflected in the various chapters of the report.

About the report:

The midterm review report of implementation of the HSSIP is in has two parts: Volume I is the main report having policy recommendations and Volume II is the MTR Analytical Report. The analytical report provided the evidence for policy recommendations in Volume I.

The HSSIP was operationalized in the last three years through development and implementation of Annual Health Sector Work-plans which are assessed through Output Budget Tool (OBT) reporting to Ministry of Finance, Planning and Economic Development (MoFPED) and Office of the Prime Minister (OPM), Quarterly Performance Review reports, Annual Health Sector Performance reports (AHSPR), and the annual Joint Review Missions (JRM). Every 2 years a National Health Assembly (NHA) is also held to assess overall sector performance.

This Midterm Review Report (MTR) will be presented to the 19th JRM and the 9th NHA for consideration. The recommendations therein will be used to re-align the HSSIP for the remaining period.
Goal and objectives of the Midterm review (MTR):
The MTR is one of the key activities under the HSSIP monitoring and review processes to be conducted after two and a half years of implementation of the sector strategic plan. More important for the health sector, the MTR of the HSSIP is being undertaken at the same time as the MTR of the National Development Plan (NDP) to be finalised in April 2013. The MTR of the NDP will guide revision of the government wide development framework. This offers the health sector an opportunity to effectively inform revision of the health component of the NDP.

The overall goal of the MTR was to assess, through an in-depth analysis, the attainment of the HSSIP objectives and, propose areas for modification for the remaining duration using relevant existing data from administrative, health facility and population surveys, as well as research publications.

The specific objectives were:

1) Assess progress of implementation of the HSSIP 2010/11 – 2014/15 against the key targets (as set out in the M&E Plan for implementation of the HSSIP) during the 1st Year (2010/11), 2nd Year (2011/12) and the 3rd Year (2012/13).

2) Identify the challenges experienced, lessons learnt and best practices during the implementation of the HSSIP 2010/11 – 2014/15 strategic interventions in the first two and half years.

3) Detection of deficiency and identification of areas for change or modification in planned intervention strategies.

4) Propose recommendations and adjustment to the HSSIP strategies, implementation modalities and Government policies for the remaining years of the plan and subsequent alignment to the National Development Plan.

5) Review the costing and financing of the HSSIP and resources available from Government of Uganda and Development Partners.

Methodology and process of development:
The MTR was conducted through a participatory approach rather than an expert driven approach. This was aimed at building the capacity of the sector to conduct evaluations and at the same time minimize costs bearing in mind the fact that a good evaluation should be impartial, credible, useful, participatory, cost-beneficial and supportive. There was also limited time to engage in procurements for an expert driven approach. The whole process was therefore MOH led.

The MOH Technical Working Groups (TWGs) and key Programs actively participated in the MTR process by compiling, analysing, synthesizing and reviewing data and drafted relevant sections of the report. The TWGs would report to the Core Analytical Team for the MTR process.

The Core Analytical Team’s role was to review and validate the reports submitted by the TWGs, and further carry out in-depth analysis of data. The whole process was backed up by external facilitation of WHO team, a Lead Consultant and two other consultants for data analysis.
Approach to summary presentation of performance of assessment findings:
The HSSIP 2010/11-14/15 under review had five (5) strategic objectives, namely scale up critical interventions, improve levels and equity in access and demand for services, accelerate quality and safety improvements of services, improve efficiency and budget effectiveness, and deepen health stewardship. Under some of the HSSIP Strategic Objectives were elements/clusters with indicators to assess their performance overtime. The review assessed the performance so far made for the past 3 years of implementation of the HSSIP under each of the strategic objectives. Performance ranking of the core and programmatic indicators were done by colour coding whereby Green means achieved, yellow fair progress and red not achieved or off track.
CHAPTER TWO

Overview of the Overall Health Status:

Uganda has made considerable progress towards improving the overall health status of the population, based on the results of the impact indicators as a proxy. The Uganda Bureau of Statistics conducted and concluded the Health and Demographic Survey (UDHS) during the first year of the HSSIP in 2011. This survey provided us with an insight into the performance of key impact indicators that are used to track progress towards the attainment of health related MDGs, namely Maternal Mortality Ratio, Infant Mortality Rate, Under Five Mortality Rate and Neonatal Mortality Rate.

Regarding Child Health, the Infant Mortality Rate declined from 76/1,000 Live Births in 2006 to 54/1,000 Live Births in 2011, Under Five mortality rate improved from 137/1,000 to 90/1,000, and Neonatal mortality rate declined from 29/1,000 to 27/1,000.

From the above data, with the exception of neonatal mortality rate, there has been a downward trend in infant and child mortality. If the impetus and decline of child mortality are sustained, the country is likely to achieve the HSSIP target of 56 per 1,000 which is aligned to MDG target by 2015.

HSSIP Indicators and Targets

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline (year)</th>
<th>Achievement</th>
<th>Target 2015</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under-five mortality</td>
<td>137 (UDHS2006 for period 2001-05)</td>
<td>90 (UDHS 2011 for period 2004-11)</td>
<td>56</td>
<td>Major progress in the past decade</td>
</tr>
<tr>
<td>rate (per 1000)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>76 (UDHS2006 for period 2001-05)</td>
<td>54 (UDHS 2011 for period 2004-11)</td>
<td>41</td>
<td>Major progress in last decade</td>
</tr>
<tr>
<td>(per 1000)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neonatal mortality rate</td>
<td>29 (UDHS2006 for period 2001-05)</td>
<td>27 (UDHS 2011 for period 2004-11)</td>
<td>23</td>
<td>Slow progress</td>
</tr>
<tr>
<td>rate (per 1000)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal Mortality rate</td>
<td>435 (UDHS 2006 for period 2001-06)</td>
<td>438 (UDHS 2011 for period 2006-11)</td>
<td>131</td>
<td>Slow progress</td>
</tr>
<tr>
<td>rate (per 100,000)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

On the other hand, the Maternal Mortality rate has remained more or less stagnant. According to the UDHS results, the MMR increased slightly from 435/100,000 Live Births in 2006 to 438/100,000 in 2011. There was however, improvement of women who are delivered by skilled birth attendants from 38% in 2006 to 59% in 2011. In order to address the poor maternal health outcome, the Health Sector is implementing an accelerated roadmap to maternal health.
Health Financing Status:

As regards health financing fairness, it is important to note that equitable financing is based on financial protection, progressive financing and cross-subsidies. Uganda's health sector remains significantly under-funded, mainly relying on private sources of financing, especially out of pocket payments. At 7.9% total government expenditure a decline from 9.6% in 2006, public spending on health is far below the HSSIP and Abuja target of 15% that Government committed to. Prepayment methods form a small portion of funding Uganda's health sector. Per capita out of pocket expenditure on health is still high at US$22 in 2009 and the HSSIP target of US $10 may not be achieved. There is limited cross subsidization and high fragmentation within and between health financing mechanisms, mainly due to high reliance on out-of-pocket payments and limited pooling of resources. Although tax revenue is equitable, the remaining financing mechanisms are inequitable due to their retrogressive nature.
CHAPTER THREE

Assessment of Objective 1: Scale up Critical Interventions

a) Health Promotion, Environmental Health, Nutrition and Community Initiatives:

Main findings:
Of the twelve (12) programmatic indicators under this cluster which were selected to monitor progress of implementation of the HSSIP, only five (5) are on track to achieve the 2015 target, which translates into a performance of 42%. This performance is illustrated by the traffic light colour coding in the table below. The colour red means off track, yellow means off track but can be achieved with more effort, and green means on track to be achieved or has been achieved or even exceeded.

The percentage of villages with trained VHTs improved from 31% to 55% during the review period. The Ministry of Health has not yet been in position to adequately support printing and distribution of IEC materials country-wide.

The implementation of the KDA has registered an increase in latrine coverage of up 70% (69.2%) and 81% (77%) of HH both for rural and urban respectively. However the ratio of pupil per latrine stance moved from 66:1 to 50:1 which is below the target of 40:1 of 2015. Out of 1991 villages triggered for community led sanitation 556 were declared open defecation-free.

Access to safe water was reported to have changed from 65% to 64% (Rural) and from 67% to 69% (urban) however the Households maintaining a safe water chain increase from 20% to 26.7%, and the percentage of districts carrying out water quality surveillance increased from 57% to 93%.

Hand washing was scaled up from 5 to 30 districts. This has led to an increase of Households with hand washing facilities with soap from 21% to 28%.

HSSIP 2010-14-15 Indicators and targets

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline (Year)</th>
<th>Achievement</th>
<th>Target 2015</th>
<th>Progress</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>The % of Villages with trained VHTs</td>
<td>31%</td>
<td>55%</td>
<td>100%</td>
<td>Slow progress, target not likely to be achieved</td>
<td></td>
</tr>
<tr>
<td>The % of households in Uganda with access to latrine.</td>
<td>69.7%</td>
<td>70%</td>
<td>72%</td>
<td>Slow progress but with more effort target could be achieved</td>
<td></td>
</tr>
<tr>
<td>The % of households access to safe water</td>
<td>65%</td>
<td>64%</td>
<td>77%</td>
<td>Decline in coverage; achieving target would require enhanced effort</td>
<td></td>
</tr>
<tr>
<td>The % of households maintaining a safe water chain (safe drinking water)</td>
<td>20%</td>
<td>26.7%</td>
<td>50%</td>
<td>Slow progress; target not likely to be achieved</td>
<td></td>
</tr>
<tr>
<td>The % of districts implementing water quality surveillance</td>
<td>57%</td>
<td>93%</td>
<td>95%</td>
<td>On track; Good progress made; at this rate, target will be achieved</td>
<td></td>
</tr>
<tr>
<td>The % of households with hand washing facilities with soap</td>
<td>21%</td>
<td>28%</td>
<td>50%</td>
<td>Slow progress; target not likely to be achieved</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Pupil per latrine stance ratio</td>
<td>54:1</td>
<td>50:1</td>
<td>40:1</td>
<td>Some progress made; with more effort, target could be achieved</td>
<td></td>
</tr>
<tr>
<td>The percentage of underweight among Under Five Year children.</td>
<td>16%</td>
<td>14%</td>
<td>10%</td>
<td>On track; with increased effort, target could be achieved</td>
<td></td>
</tr>
<tr>
<td>Vitamin A supplementation for children aged 6-59 months</td>
<td>60%</td>
<td>64%</td>
<td>80%</td>
<td>On track</td>
<td></td>
</tr>
<tr>
<td>The percentage of stunted children below 5 years</td>
<td>38%</td>
<td>32%</td>
<td>28%</td>
<td>On track</td>
<td></td>
</tr>
<tr>
<td>The prevalence of anaemia among children Under 5</td>
<td>73%</td>
<td>49%</td>
<td>60%</td>
<td>Performance exceeded 2015 target</td>
<td></td>
</tr>
<tr>
<td>Exclusive breastfeeding in the first 6 months</td>
<td>60%</td>
<td>63%</td>
<td>80%</td>
<td>Stagnation</td>
<td></td>
</tr>
</tbody>
</table>

**Key Achievements /Progress of activities:**

- The Public Health Act is under review to strengthen sanitation and public health
- The percentage of district carrying out water quality surveillance improved from 57% to 93%
- Prevalence of anaemia among children decreased from 73% to 49% in children Under 5 years; in women from 49% to 23%; and men from 28% to 15%. The target of 60% for children, 30% for women and 15% for men set out in the HSSIP has been surpassed
- Vit. A supplementation has increased from 60% to 64% in children under 5 yrs

**Main Challenges/Best Practices:**

- Funding: inadequate, delayed release, inability to access released funds
- Limited transport
- Nutritionists that would also help in implementing the interventions are also still lacking. The human resource problem is at all levels, starting with the national to the community.
- Inadequate supply for nutrition commodities; RUTF, Formula milk, CSB and equipment has made it difficult to achieve the goals.
- Weak coordination and monitoring of nutrition programs and activities at all levels.
- Slow Scale up of high impact nutrition interventions.
- Few community based nutrition interventions and poor Weak growth monitoring of children at health facility and community levels due lack of equipment and skills.
- MOH does not produce and distribute adequate IEC materials to meet the national needs
Best practices for Nutrition:

- The creation of the Nutrition Cluster technical working group has been a good initiative. This has helped to coordinate the different interventions.

- Use of a multi-sectoral approach to address nutrition problems has also achieved results as all partners embrace the same interventions to holistically support. Multisectoral nutrition committees have been set up at national and district level.

- Strong Government commitment to support the implementation of nutrition interventions through the Scale up Nutrition (SUN) initiative and the UNAP framework with special focus on the first 1000 days “Window of Opportunity”.

- Active involvement of the Private Sector through Public Private Partnership’s initiatives has seen the implementation of fortification of vegetable oil, wheat flour and maize flour.

Conclusions:

- Among the core indicators, good progress has been made on pit latrine coverage, underweight in the under-fives and stunting for children above 5 years; however, apart from stunting which is on track, the other two will require more effort to attain the 2015 targets.

- Besides the core indicators, significant progress has been made in various areas, such as reduction of anaemia where the 2015 target has been surpassed and vitamin A supplementation and water quality surveillance indicators which are on track.

- Slow progress has been registered in access to safe water and percentage of districts with trained VHTs. However, 2015 targets could be attained with more effort.

- Stagnation and/or decline were observed in safe water chain, hand-washing facilities with soap and exclusive breast-feeding in the first 6 months.

Implications for policy adjustments and challenges:

- To enhance the contribution of health promotion, nutrition and environmental health to the overall health status of the population, there is need for increased and sustained investment in the area of health promotion and disease prevention.

- Where there has been stagnation or decline in performance, it may be necessary to revise the targets to realistic levels, identify reasons behind the current status and address them.

- More effort should be put in cross-sectoral collaboration and harness the potential synergies for attaining substantial progress towards the targets.

- Expedite the operationalization of the MOH print unit in order to produce adequate IEC materials at an affordable cost.
b) Epidemic and disaster preparedness and response

Main Findings:

In 2000, Uganda adopted the World Health Organization, Regional Office for Africa (WHO/AFRO) strategy of integrated disease surveillance and response (IDSR) in which epidemic prone and other diseases of public health importance are reported using an integrated system. In this strategy, health personnel at district, health sub-district, and health facility levels, join with communities to monitor report, investigate, and respond to all diseases on the national priority list.

IDSR uses the HMIS reporting platform to receive weekly reports on all diseases, conditions, and events on the national priority list including the nineteen (19) diseases and conditions that are considered to be epidemic prone in the country and require immediate response when detected in epidemic proportions.

Following the enactment of the international health regulations of 2005 (IHR (2005), surveillance has been extended beyond infectious disease conditions to include zoonoses, foodborne diseases, as well as chemical and radio-nuclear events, and other public health events (with known or unknown aetiology) of national or international concern. The IDSR activities are coordinated by the Epidemiology and Surveillance Division with participation of various disease control programs, community Health department and Clinical Services Department.

HSSIP 2010/11-14/15 Indicators and targets

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13(Jul 2012 to Dec 2012)</th>
<th>2015 target</th>
<th>Progress &amp; Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>The proportion of suspected disease outbreaks responded to within 48 hours of notification</td>
<td>52%</td>
<td>57%</td>
<td>61%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of districts with functional epidemic preparedness and response committees</td>
<td>76%</td>
<td>81%</td>
<td>82%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of districts with epidemic preparedness plans</td>
<td>62%</td>
<td>69%</td>
<td>73%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timeliness of weekly reporting</td>
<td>82%</td>
<td>85%</td>
<td>85%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completeness of weekly reports</td>
<td>87%</td>
<td>88%</td>
<td>88%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Cases and deaths due to disease outbreaks between 2010/11 and 2012/13.

<table>
<thead>
<tr>
<th>Disease or Condition</th>
<th>Affected Districts</th>
<th>Cases and Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yellow Fever</td>
<td>Agago, Abim, Lamwo, Pader and Kitgum</td>
<td>157 cases with 41 deaths</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13 laboratory confirmed cases were reported</td>
</tr>
<tr>
<td>Acute Hemorrhagic</td>
<td>26 districts affected</td>
<td>8,272 cases</td>
</tr>
<tr>
<td>Conjunctivitis (Red</td>
<td></td>
<td>eyes)</td>
</tr>
<tr>
<td>Ebola Virus Disease</td>
<td>Kibale and Luwero,</td>
<td>Kibaale-24 cases, 17 deaths</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Luwero-7 cases 4 deaths</td>
</tr>
<tr>
<td>Marburg Virus Disease</td>
<td>Kabale, Ibanda, Kampala</td>
<td>Kabale-14 cases, 7 deaths</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ibanda-12 cases, 8 deaths</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kampala-2 cases, 0 deaths</td>
</tr>
<tr>
<td>Plague</td>
<td>Arua and Zombo</td>
<td>19 cases, 3 deaths</td>
</tr>
<tr>
<td>Cholera</td>
<td>17 districts</td>
<td>5448 cases with 126 deaths</td>
</tr>
<tr>
<td>Measles</td>
<td>44 districts</td>
<td>At least 8734 cases with 45 deaths</td>
</tr>
</tbody>
</table>

**Cholera**

Cholera has been endemic in Uganda since 1979, when the first epidemic was reported. Sporadic cases are seen throughout the year with cases concentrated during the rainy season. Figure 1 shows the number of cholera cases and deaths from 1997 to 2012. The largest cholera epidemic occurred in 1998, when there were over 40,000 cases and 1,600 deaths. More recently, there was an outbreak in the western part of the country in 2013 with over 5000 cases and 126 deaths.

![Figure 1: Trend of Cholera cases in Uganda, 1997 to 2012](image)
Animal bites

The number of animal bite cases has decreased by approximately 30% since 2009/10. The largest proportion of animal bites are reported in Wakiso district (12% of all cases) and Kampala (7%), as there are reputed treatment centres in these districts.

Figure 2: Number of animal bite cases, 2009/10 – 2012/13

Progress of Activities/Achievement:

- Through coordinated efforts of a multisectoral National Task Force (NTF), major outbreaks of Yellow Fever in Northern Uganda in 2010, Nodding Syndrome in the Acholi sub-region, Ebola and Marburg in Central and Western Uganda were effectively contained. Consequently, significant progress has been made investigating and responding to the Nodding disease epidemic in the Acholi sub-region. Similarly, following containment of the Yellow Fever epidemics in Northern Uganda in 2010, a national Yellow Fever risk assessment was conducted and policy dialogue for Yellow Fever control is ongoing. The NTF has also been applauded by the international community for controlling the viral hemorrhagic fever outbreaks of 2012 in record time.

- The NTF has embraced the one health to holistic disease control and consequently enhanced inter-sectoral linkages and collaboration with MAAIF, UWA and Environmental authorities to enable joint investigation and response to zoonotic disease outbreaks.

- A National Multidisciplinary Rapid Response Team is in place to support the District Rapid Response teams in timely investigation of suspected outbreaks. In the same way, District Rapid Response Teams have been set up and trained in 20 new districts.

- Training of district health teams on the revised Integrated Disease Surveillance and Response (IDSR) guidelines has been completed in the three districts of Luwero, Kibaale and Kabale.

- The Ministry of Health working with the World Bank project is planning to establish a state of the art regional network of laboratories in Mbale, Gulu, and Arua with the auspices of East African community.

- Routine Surveillance has been beefed by Information Technology (IT) innovations like m-Trac which enables health facilities to submit disease surveillance reports using mobile phones in a timely manner. The Epidemiology and Surveillance Division (ESD) receives weekly reports from districts on diseases of epidemic potential for prompt analysis to allow appropriate public health response to be initiated.
Sharing of disease surveillance data with MoH programs, districts, and partners has been enhanced through publications of the weekly epidemiology bulletin in the print media and on the Ministry website.

Epidemic alerts corresponding to the established seasonal patterns of epidemics like meningitis and cholera continue to be issued to enhance epidemic preparedness and response in at-risk districts.

Deficiencies and areas for change or modification in the planned strategies:

- EPR Structures at Districts are not fully functional due to logistical and personnel problems
- Community involvement in detection and reporting of outbreaks is still low (We need to engage the VHTs)
- Uganda has not yet acquired the IHR core capacities that are needed for effective management of Public Health Emergencies (It requires participation of various stakeholders who are difficult to coordinate).

Best Practices:

- Publishing weekly districts; weekly surveillance data in the print media and posting the weekly epidemiological bulletin on the Ministry website
- Involving all relevant Government sectors and institutions in the implementation of IHR
- Notifying WHO and the international community of outbreaks in a transparent manner

Recommendations for adjustment to the HSSIP strategies and implementation modalities for the remaining years of the HSSIP:

- Put emphasis on community involvement in Epidemic Detection, Preparedness and Response activities (Community Surveillance).
- Have dedicated fund for epidemic preparedness
- Work closely with all stakeholders to ensure that the country attains the IHR core capacities.

c) Control of communicable diseases:

i) HIV/AIDS

Main findings:

In the HSSIP, Aids Control Programme (ACP) selected ten (10) programmatic indicators as shown in the table below, to monitor its performance during implementation of the HSSIP. Of these indicators, five (5) out of the ten (10) are on track or have been achieved (50% good performance), while two (2) can be achieved with concerted extra efforts and the rest are off track and can not be achieved in the remaining 2 years.

The prevalence of HIV among adults rose from 6.4% in 2004/05 to 7.3% in 2012. This trend is attributed to both new infections and improved survival as more PLHIV access ART. Women are disproportionately more affected than men (a prevalence of 8.3% versus 6.1%), and this trend is evident in all regions of the country. Urban residents were more likely to be infected (8.7%) than
their rural counterparts (7%); this picture is prominent among women with prevalence among urban women estimated at 10.7% compared to 7.7% among rural women while the rates for urban and rural men are the same (6.1%). In the younger age groups 15-24 years, HIV prevalence is estimated at 3.7%; the female HIV prevalence for the age groups 20-24 is two to three fold that of males within the same age category.

Access to HCT services by the general population has increased; estimated at 25% of women and 23% of men in 2006; increased to 38% in 2008 and currently estimated at 66% among women and 45% among men. HIV testing among men increased four-fold, from 11% in 2004-05. The higher coverage among females is attributed to HCT opportunities during MCH and PMTCT services contact.

The number of individuals accessing ART increased from 329,060 (57% coverage) by end of September 2011 to 566,046 (76.5% coverage) by end of June 2013. Children comprise 8% of all ART recipients; coverage among eligible children is only 41%. The number of facilities providing ART increased from 398 by March 2011 to 1,073 at the end of June 2013.

Among 53,451 pregnant women who received ARVs between October 2012 and March 31st 2013 at 2,087 sites, 33% received PMTCT option A, 38% received option B+ and 29% were already on ART before their first ANC18. There are several interventions related to community systems strengthening (e.g. mentor mothers, mentor fathers, family support groups, and VHT among others) to support mobilization, retention, adherence and psychosocial support.

Coverage of EID testing among infants in 2012 was 53,981 (56%) of exposed infants (53,944 of the estimated 96,328 exposed infants) for first PCR, a steady increase from 7% in 200719. Prevalence of HIV among those tested was 9%, a significant decline from 19% in 2007.
## HSSIP 2010-14-15 Indicators and targets

<table>
<thead>
<tr>
<th>Strategic Intervention 1.2.1: Prevent STI/HIV/TB transmission and mitigate the medical and personal effects of the epidemic.</th>
<th>Baseline</th>
<th>Achievement</th>
<th>Target 2014/15</th>
<th>Source</th>
<th>Progress &amp; Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HIV prevalence among pregnant women (19-24 yrs) attending antenatal clinics</td>
<td>7.0%</td>
<td>6.6%</td>
<td>7.1%</td>
<td>Results not yet available</td>
<td>4%</td>
</tr>
<tr>
<td>2. The proportion of people who know their HIV status</td>
<td>38%</td>
<td>55% Women 66% Men 45%</td>
<td>55% Women 66% Men 45%</td>
<td>55% Women 66% Men 45%</td>
<td>70% The UAS 2011</td>
</tr>
<tr>
<td>3. The proportion of people who are on ARVs</td>
<td>Adults: 214,087 (53%)</td>
<td>260,856 (60.2%)</td>
<td>372,785 (64%)</td>
<td>524,603 (76.5%)</td>
<td>Adults: 75% ART reports, ART Master list</td>
</tr>
<tr>
<td></td>
<td>Children &lt;15y: 10% (18,079)</td>
<td>26,699 (27%)</td>
<td>30,641 (30%)</td>
<td>41,520 (41.4%)</td>
<td>Children &lt;15y: 119,668 50%</td>
</tr>
<tr>
<td>4. The proportion of children exposed to HIV from their mothers access HIV testing within 12 months</td>
<td>29%</td>
<td>30%</td>
<td>32.3%</td>
<td>47,444</td>
<td>75% EID reports</td>
</tr>
<tr>
<td>5. The proportion of pregnant women accessing HCT in ANC</td>
<td>83% at 90% reporting</td>
<td>82% at 70% reporting</td>
<td>100% at 75% reporting</td>
<td>100%</td>
<td>100% ACP</td>
</tr>
<tr>
<td>6. HCT services available in all health facilities including HC IIs, and at community level (Proportion of health facilities with HCT services; Proportion of community structures with HCT services)</td>
<td>HF: 37% = 1,840 out of 4,980</td>
<td>Hospitals: 116 (100%); HC IV 167 (100%); HC III 806 (50%); HC II 500 (30%)</td>
<td>Hospitals: 116 (100%); HC IV 190 (100%); HC III 942 (80%); HC II 1215 (35%)</td>
<td>Hospitals:143 (100%); HC IV:190 (100%); HC III:902 (80%); HC II:1041 (30%) 1,849 out of 5,033 (77% SARA 2013)</td>
<td>HF: 100% Community: 100%</td>
</tr>
<tr>
<td>Baseline 2009/10</td>
<td>Achievement 2010/11</td>
<td>Achievement 2011/12</td>
<td>Achievement 2012/13</td>
<td>Target 2014/15</td>
<td>Source</td>
</tr>
<tr>
<td>------------------</td>
<td>---------------------</td>
<td>---------------------</td>
<td>---------------------</td>
<td>----------------</td>
<td>--------</td>
</tr>
<tr>
<td><strong>7. PMTCT services available in all health facilities up to HC III’s and 20% of HC IIIs (Proportion of health facilities with PMTCT services; Proportion of HC IIIs with PMTCT services).</strong></td>
<td>Total: 25.6% = 1,150 out of 4,480 HC II: No data HC II: No data</td>
<td>Total: 1257 (28.3%) Hospital: 110 (84%) HC IV: 178 (100%) HC III: 969 (87%) HC II: 339 (11.2%)</td>
<td>Total: 1551 (43.9%) Hospitals: 109 (84%) HC IV: 179 (93%) HC III: 914 (82%) HC II: 333 (11%) (PEPFAR)</td>
<td>Hospitals: 85% HC IV: 97% HC III: 93% (52% SARA 2013)</td>
<td>ACP &amp; SARA</td>
</tr>
<tr>
<td><strong>8. ART services available in all health facilities up to HC IV and 20% of HC III by 2015. (Proportion of health facilities with ART services; Proportion of HC IIIs with ART services).</strong></td>
<td>Hospitals 116 (100%); HC IV 134 (81%); HC III 54 (6%); HC II 3 (0.2%) [SPA 2007]</td>
<td>Hospitals 116 (100%); HC IV 143 (86.1%); HC III 56 (6.2%); HC II 3 (0.2%)</td>
<td>Hospitals 125 (97%) HC IVs 187 (100%) HC IIIs 90 (8%); HC II 24 (0.8%) and 35 Specialized ART clinics</td>
<td>Hospitals 125 (97%) HC IVs 187 (100%) HC IIIs 827 (73.6%); HC II 24 (0.8%) and 35 Specialized ART clinics</td>
<td>SARA: HC IV+: 96% HC III: 53%</td>
</tr>
<tr>
<td><strong>9. The proportion of males circumcised (denominator is number of all males in Uganda).</strong></td>
<td>25% No data captured</td>
<td>380,000 (38%)</td>
<td>510,000 (51%)</td>
<td>50% SMS reports</td>
<td>There are still challenges with harmonization of reporting</td>
</tr>
<tr>
<td><strong>10. HIV prevalence in the general adult population (15-49 years).</strong></td>
<td>6.4% (UAIS 2004/05)</td>
<td>6.4%</td>
<td>7.3%</td>
<td>7.3%</td>
<td>5.5% UAIS 2011</td>
</tr>
</tbody>
</table>
**Key Achievements /Progress of activities:**

- Developed the National HIV Strategic Plan (NSP) 2011/12 – 2014/15 and Monitoring and Evaluation plan (2011/12-2014/15), in line with the HSSIP, as well as implementation guidelines that guide the programming and monitoring of grant implementation.

- Completed the National AIDS Indicator Survey (2011) as well as more targeted surveys among key population. These will guide programmatic planning and implementation.

- Developed national policies and guidelines for key interventions including the Integrated National Guidelines on Antiretroviral Therapy, Safe Male Circumcision Policy, Prevention of Mother to Child Transmission of HIV and Infant & Young Child Feeding (2012), a National Condom Strategy 2013-2015, HIV Counseling and Testing Policy 2010 (HCT), and TB-HIV collaborative activities Strategic Plan 2013-2015, among others. The country has also developed a scale-up plan for e-MTCT “The Uganda National Plan for Elimination of Mother to Child Transmission of HIV 2012 – 2015, October 2012” which aims to reduce the risk of MTCT to less than 5% by 2015/16. The national policies and guidelines are developed in alignment with international policies and universal access targets.

- Development of training curricular for Paediatrics HIV, Lab, Option B+, Quality Improvement

- Trainings (TOT & Cascade) and follow up, mentorship and support supervision

- Data Quality Assessment and Reporting

- Revised reporting tools in line with new updates in care and treatment

- Conducted Regional stakeholder meetings

- There has been a steady scale up of EID from 2009/10 where the programme managed to scale up to our target was to have EID services in 800 health facilities and test 44,000 tests. By the end of that time period, we had scaled up services to 950 health facilities and had conducted 45,400 tests. In 2010/11, we had planned to 870 health facilities and conduct 57,000 tests. However by the end of the time period we had reached 1200 health facilities and conducted 65,000 tests. In 2011/12 we had planned to reach 1000 health facilities and conduct 71,000 tests. We however reached 1450 health facilities and conducted 77,940 tests. In 2012/13 we planned to reach 1100 health facilities and conduct 85,000 tests. We are already in 1680 health facilities and have so far tested 83,579

- Lab activities: Performed EID testing on 77,712 babies from 1582 facilities SMC

- Developed a policy for SMC in 2010

- Training, QA materials and M&E tools were developed

- Funding from GOU and PEPFAR

- Mixed model approach using roving teams for SMC outreaches and camps, as well as SMC at static sites

- Streamlined Supply Chain management system for SMS
CONDOM USE
- Distribution of condoms through close cooperation with social marketing groups who also assist in distributing public sector condoms; distribution is also done through implementing partners who are better resourced to reach key populations in communities.
- Conduct quarterly condom coordination meetings to check on condom status and address any issues of quality, supply chain management among other matters arising.
- Work closely with NDA to monitor the quality assurance for new imports and those in the supply chain.
- Rebranding public sector condoms.
- Training of female condom service providers.

Main Challenges/Best Practices:

CONDOM USE
- Irregular and insufficient supplies of condoms.
- Distribution to non-medical facilities and key populations such as boda boda riders.
- Storage at district level sometimes non-existent or very poor.
- Incorrect and inconsistent use; there seems to be a preference for body to body contact to condom use.
- Poor disposal causing conflicts with neighbors.
- Development partners no longer willing to pay post-shipment testing fees ($280 per batch).

EID
- Data quality and reporting.
- Reliability of supplies of commodities and medicines.
- EID: Loss along the continuum of care, LTFU, Mothers opting out, late initiation of ART, linkages to ART clinics.
- Paed HIV: Decentralization of Paed HIV.

PMTCT
- Slow progress of mentorships and accreditation & Missed opportunities for ARV (12% missed ARVs).
- Inadequate supply of HIV test kits.
- Some districts lack Web based ARV Ordering System.
- Monitoring adherence and retention for mothers still a big challenge and information has already shown that there is substantial loss to follow ups.
- Poor documentation coupled with a big number of tools needed to monitor the HIV positive mother and her baby and poorly motivated work force
- Stack with Option A medicines
- Poor infrastructure at lower HF

BEST PRACTICES

- Provider Initiated Testing and Counselling (PITC) and other community models of HCT as well as couples HIV testing
- Scaled up specimen referral and transportation network hubs from 19 to 78 and use of motorbike riders
- Adoption of Option B+ which was initiated simultaneously; regional launches involving political and cultural leader
- EID yellow stickers for initiation of ART
- Consolidation of EID testing into one laboratory (costs); Installation of GSM printers at laboratory hubs
- Rationalization of supply chain management
- Accelerated scale up of accreditation of health facilities
- Introduction of ART/PMTCT Master lists
- QPPU stock monitoring
- Regular staff meetings, regular consultations with partners, materials dissemination
- Capacity building and accreditation of health centres to provide HCT, PMTCT, and ART services
- M&E systems enhancement including rolling out DHIS2 countrywide; open Medical Records System (MRS) at high volume ART facilities;
- ARV web-based ordering and reporting on commodities;
- Establishment of the Regional Performance Monitoring Teams to enhance data integrity, support supervision, and reporting as well as quality improvement initiatives
- Human resource improvements: recruitments and training of additional health workers by GF, PEPFAR, World Bank, and GOU; and
- MoH Implementing Partner rationalisation to improve efficiency and coordination within the districts and facilities

Conclusions:

- The rising HIV prevalence is a cause for concern. Monitoring of HIV incidence is very crucial in detecting new infects and people most affected.
Implications for policy adjustments and challenges:

Prevention

- SMC

CONDOM USE:

- Make good quality condoms more regularly available to users. Govt. to have a budget for Condom procurement, distribution and quality assurance at National & district levels.
- Intensification of community education on correct use for both male & female Condoms, and support community based Condom distributors and peer groups.
- Make condoms more accessible through non-human distribution mechanisms i.e. self-dispensing facilities.
- Support social marketing initiatives for both male & female Condoms including making Condoms more appealing to users.
- Ensure appropriate storage facilities at all districts to always have a 3 to 6 months buffer stock.
- Move towards Comprehensive Condom Programming
- Ensure appropriate monitoring system
- Move towards comprehensive condom programming

EID

- Speed up decentralization of paediatric services to all HCIII's; To reduce on loss of infants due to inter-facility referral, IP’s will systematically support all accredited HCIII that are providing Option B+ and EID to start providing paediatric ART services.
- MOH should work with partners to accredit other facilities
- To achieve continuous quality improvement of paediatric HIV services, QI should be integrated into the current mentorships and MOH together with partners should train regional mentors in paediatric QI.
- Partners to plan review meetings and include paediatric issues in the meetings
- Guidelines for use of ARV's for HIV prevention and treatment have revised and from 2014 All children below 15 years of age will be treated irrespective of CD4 or WHO clinical staging. The number of children eligible for ARV by 2015 will therefore be 159,584. The target of 75% will be 119,688 children.

PMTCT

- Address data quality and timely reporting through continuous Data Quality Audits, timely mentorships and M & E training
Orient all ToTs on QI initiative
- Strengthen the supply chain management systems to match the demand
- Recruit, attract and motivate the health workers to address Human resource needs especially at the lower Health facilities
- Strengthen integration of EID & EPI and SRH and HIV & AIDS services
- Monitoring retention for mother-baby pairs as this has already been shown to be a big challenge
- Provide answers to the identified/remaining gaps
- ART

Strategic Information (M&E and Operational Research)
- Finalize M&E Framework
- Development of the ACP performance plan
- Develop district capacity to manage HIV/AIDS data
- Strengthen Sentinel surveillance
- Conduct surveys among key populations
- Strengthen HIV Surveillance TWG meetings
- Conduct biannual review meetings
- Conduct integrated support supervision for all ACP programmes.

ii) TB & Leprosy:

Main findings:
Almost all of the indicator targets used to monitor performance have not been met, as shown in the HSSIP indicator performance table below. 50% of the eight (8) TB monitoring indicators are off target while the remaining may be achieved only with extra resources, reprogramming and efforts. The 3 Leprosy indicators are performing fairly and if the trend continues the 2015 target may be met.

The Case detection rate has stagnated between (54 -57) % over the past four years, while Cure rate has improved but general performance is still low. CPT Uptake has remained high over time, while ART uptake among those co infected with HIV is low. While some improvement has been realized with DOT coverage, its quality is questionable.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline (Year)</th>
<th>Achievement 2012</th>
<th>Target 2015</th>
<th>Progress</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB case detection rate</td>
<td>56.8% (2011)</td>
<td>57% (2012)</td>
<td>65% NTLP, (SP)</td>
<td></td>
<td>Very Minimal progress over time, more effort required if the 2015 targeted is to be achieved.</td>
</tr>
<tr>
<td>2. TB cure rate /Treatment success rate</td>
<td>Cure: 34% (2011)</td>
<td>40% (CR)</td>
<td>45% NTLP, (SP)</td>
<td></td>
<td>Generally permanent is low. Promising performance and on track to achieving 2015 target.</td>
</tr>
<tr>
<td></td>
<td>TSR: 71% (2011)</td>
<td>77.5%(TSR)</td>
<td>80% NTLP, (SP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB associated death rate among the smear positive</td>
<td>4.5% (2010)</td>
<td>4.5%</td>
<td>2.5%</td>
<td></td>
<td>Mortality is declining but more effort is needed to achieve the target</td>
</tr>
<tr>
<td>The proportion of TB cases on supervised DOT</td>
<td>40% (2011)</td>
<td>55%</td>
<td>100%(WHO) (60% NTLP, SP)</td>
<td></td>
<td>While improvement is registered, there are concern about the quality of DOT services</td>
</tr>
<tr>
<td>DST uptake among smear positive Relapse cases (CAT II)</td>
<td>46%</td>
<td>59%</td>
<td>75%(WHO) (80% NTLP, SP)</td>
<td></td>
<td>Slow progress in performance improvement</td>
</tr>
<tr>
<td>Proportion of TB patients tested for HIV</td>
<td>80% (2011)</td>
<td>86%</td>
<td>100% (95% NTLP, (SP)</td>
<td></td>
<td>Good progress towards achieving 2015 target</td>
</tr>
<tr>
<td>Proportion of TB/HIV patients started on Cotrimoxazole Prophylaxis</td>
<td>90% (2011)</td>
<td>93%</td>
<td>100%(WHO) (98% NTLP, (SP)</td>
<td></td>
<td>Some progress has been made however still below 100%</td>
</tr>
<tr>
<td>Proportion of TB/HIV patients started on ART</td>
<td>34%</td>
<td>56%</td>
<td>100% (WHO) (50% NTLP, (SP)</td>
<td></td>
<td>The performance has surpassed the NLP 2015 target but not the WHO target</td>
</tr>
<tr>
<td>Proportion of MDR TB patients started on treatment</td>
<td>0.3% (2011)</td>
<td>10.1%</td>
<td>80% NTLP, (SP)</td>
<td></td>
<td>There is a challenge accessing MDR data</td>
</tr>
</tbody>
</table>
## Leprosy

<table>
<thead>
<tr>
<th>The prevalence of leprosy</th>
<th>0.13/10,000</th>
<th>0.15/10,000</th>
<th>&lt; 1/10,000</th>
<th>Elimination still sustained but this is national data; indicator not useful for district level</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. At least one &quot;Skin Clinic&quot; per Health Sub District (HSD) held on a weekly basis in all HSDs across the country.</td>
<td>missing</td>
<td>missing</td>
<td>missing</td>
<td>There is only quarterly information on the number of functional leprosy treatment units in the district.</td>
</tr>
<tr>
<td>3. The rate of grade II disability in newly diagnosed leprosy cases</td>
<td>20.5% (2011)</td>
<td>25%</td>
<td>5%</td>
<td>Increasing instead of decreasing!</td>
</tr>
</tbody>
</table>

### Key Achievements /Progress of activities:

- **Programme Documents:** National TB Strategic Plan in Place (2012/13 – 2014/15), National TB Monitoring and Evaluation Plan in place ((2012/13 – 2014/15)), TB/HIV collaboration Policy, TB unit registers and other reporting tools;

  **Progress:** The documents are being printed and dissemination will follow.

- **Capacity Building** – Officers from NTLP trained in Essential medicines supply, PMDT, Management of TB/HIV infection, Trained KCCA health workers in TB and Leprosy control activities,

  **Progress:** more health workers will be trained; International conferences will be attended

- **MDR TB Treatment**- 6 treatment centers in Regional hospitals have been opened with a National referral one in Mulago ward 5 and 6,

  **Progress:** MDR TB referral ward is in use; more patients are being diagnosed by NTRL and use of Gene xpert

- **National TB Prevalence survey** have been planned and it is starting in September 2013

  **Progress:** 5 vehicles have been procured and the actual survey exercise will commence within September 2013.

- **Coordination of Partner projects**- the Partners supporting TB and Leprosy control activities hold regular meetings i.e. quarterly:
**Progress:** several meetings have been held and more have been planned for.

- International Day Commemorations – World TB and World Leprosy Days in Masaka and Namutumba Districts respectively. Progress: These are annual events that will be commemorated next year.

- **Procurement of TB medicines** of First line and second line treatment:

**Progress:** more requisitions have been place in NMS.

- **Research** - TB HAART study completed 2012

**Progress:** there are weekly presentations on research activities.

- More Doctors recruited in the programme - 4 of them from Partners

**Conclusions:**

- More patients of MDR TB are being diagnosed. All Regional hospitals will act as initiation centres and treatment will continue in the nearest health facility to the patient

- TB/HIV integration has been planned under GF to orient health workers to implement the TB/HIV Policy

**Implications for policy adjustments and challenges:**

- The low case detection and cure rate needs to addressed in the next 2 years of the HSSIP and beyond through reinvigorated contact tracing of cases, strengthened diagnostic capacity at all levels of care including at community level by use of VHTs and ensuring readily available TB medicines.

**iii) Malaria**

**Main findings:**

Regarding the National Malaria Control Program, the percentage of children with fever decreased from 45% to 40%. Among children with fever, the proportion of children who took antimalarial drugs increased slightly from 60% at baseline year (2009) to 65% while those receiving antimalarial drugs the same day or the day after showed a small increase from 36% to 43%.

The other indicator, Intermittent preventive treatment (IPTp) with two doses of Fansidar (SP) during pregnancy made a slight increase from 18% (UDHS, 2006) to 27% (UDHS, 2011)/48.5% (HMIS, 2013) far below the 2015 target of 80%. Comparison of survey data from five neighboring countries in the last 10 years shows that Uganda is close to the median of these countries for coverage of this intervention.

The proportion of households in possession of ITNs increased significantly from 47% at baseline to 60% in 2011 getting a little closer to the target of 85% in 2015. Possession of ITNs slightly favours the rural areas. The Use of Insecticide treated nets (ITN) by children under five and pregnant women has however, only increased slightly from 33% and 43% respectively to 43% and 47% respectively.

The country coverage of IRS remains very low. The proportions of households sprayed with insecticide in the last 12 months remain low (7.2%) and far from the 2015 target of 30%. The case fatality rate among malaria in-patients under five (5) is consistently decreasing. The target has already been met.
HSSIP 2010-14-15 Indicators and targets

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Achievement 2012</th>
<th>Target 2015</th>
<th>Progress</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>U5s with fever receiving malaria treatment within 24 hours</td>
<td>29% (UDHS 2006); 70% (HMIS 2009-10)</td>
<td>43% (UDHS 2011); 53% (HMIS Jul-Dec 2012)</td>
<td>85%</td>
<td></td>
<td>There is a remarkable improvement with a positive trend</td>
</tr>
<tr>
<td>IPT: pregnant women taking at least 2 doses</td>
<td>18% (UDHS 2006 for period 2004-06); 42% (HMIS 2009-10)</td>
<td>27% (UDHS 2011) for period 2009-11)/48.5% (HMIS, 2013)</td>
<td>80%</td>
<td></td>
<td>There has been very slow progress and 2015 target is unlikely to be met</td>
</tr>
</tbody>
</table>

Key Achievements /Progress of activities:

- Procurement and distribution of Long Lasting Insecticide Treated Nets (LLINs) through mass campaigns and routine fill in methods during ANC and EPI clinics have led to increased ownership of ITNs. This has also led to an increase of net use by vulnerable groups like pregnant women and children under 5 years
- Indoor Residual spraying has been done consistently in 10 districts in Northern Uganda with impressive entomological and epidemiological results
- Training of 11,178 Health workers in Integrated Management of Malaria in 103 districts. This has partly led to the increased testing rate for malaria
- Introduction of a new policy where Quinine was replaced with a more efficacious medicine (Artesunate) for the management of severe malaria and increased availability of anti-malaria medicines through the Affordable Medicines facility Malaria programme has contributed to declining mortality due to malaria among the under 5 children

Main Challenges:

- Inadequate funds for programme running
- Inadequate staffing and office space
- Procurement delays of medicines and essential health supplies
- Vehicle fleet is very old and expensive to maintain
- Emergence of Insecticide resistance especially Pyrethroids.

Best Practices:

- Routine Data quality audits have improved the quality of data for malaria. These need to be institutionalized
- Planned MTR of the malaria strategic plan to assess through an in-depth analysis the attainment of the malaria strategic plan objectives and propose areas for modification for the remaining duration using existing evidence base
- Establishment of an innovative mobile phone based information system: mTRAC which uses real time data to monitor stock outs of ACTs and RDTs and report community concerns
- Production of Malaria bulletin to update all stakeholders on surveillance data and ongoing events to increase advocacy
Therapeutic Efficacy Studies and Insecticide Resistance Studies

Initiatives to update malaria epidemiological profile maps using current data in order to target interventions

Conclusions:

- Among the core indicators, it is only the proportion of children under 5 years receiving treatment for malaria which appear to be on track and likely to reach the target.
- Besides the core indicators, other indicators for net coverage and net use are improving steadily and with the ongoing universal coverage LLIN campaign, the set targets are likely to be met.
- The other core indicator (IPTp2) has had very slow progress and 2015 target is unlikely to be met.

Implications for policy adjustments and challenges:

- More investment is required to roll out iCCM in the country to increase prompt access to anti-malaria treatment in children
- In view of the fact that the indicator for IPTp2 has stagnated despite concerted efforts to address barriers to uptake the target should be revised downwards. Country wide exploratory in-depth studies on barriers to uptake of IPT should be undertaken.

iv) Neglected diseases:

Main findings

The NTD program has performed quite well during the first 3 years of the HSSIP in as far as meeting their indicator targets were concerned. Out of the seventeen (17) indicators, 70% have achieved the set target even before 2015, while the rest are on track to meet the target and only one (1) is off track.

The review found that there was timely reporting and investigation of suspected guinea worm cases, Onchocerciasis transmission has been eliminated in all isolated foci, and therapeutic coverage for most NTDs below the target of >75%. Al NTD endemic districts have undergone mass treatment.

In addition, Morbidity due to NTDs has reduced, Diagnostic procedures and treatment for sleeping sickness has gradually improved and Schistosomiasis prevalence of heavy intensity reduced.

However, the Proportion of General hospitals conducting proper laboratory diagnosis of brucellosis still low.
## HSSIP 2010-14-15 Indicators and targets

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline (Year)</th>
<th>Achievement</th>
<th>Target 2015</th>
<th>Progress</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Guinea worm</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Timely reporting of guinea worm from villages at risk of importation</td>
<td>100%</td>
<td>88%</td>
<td>100%</td>
<td></td>
<td>Included in IDSR</td>
</tr>
<tr>
<td>2. All rumours of suspected guinea worm cases investigated.</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td>Due to limited funding, most investigations are delegated to district focal persons (reported back to national level)</td>
</tr>
<tr>
<td>3. Case containment of imported guinea worm cases</td>
<td>100%</td>
<td>0 cases</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. A MoU signed with neighbouring countries on elimination of guinea worm</td>
<td>2003 protocol signed with East African countries for NTD control (including Guinea worm)</td>
<td>Meeting to be held in October to address inclusion of South Sudan</td>
<td>MoU including South Sudan to be signed</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Onchocerciasis:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Simulium neveai eliminated in all endemic districts in Uganda.</td>
<td>Elimination in 7 isolated foci</td>
<td>Eliminated in 7 foci</td>
<td>100%</td>
<td></td>
<td>Elimination of simulium flies in all isolated foci achieved</td>
</tr>
<tr>
<td>(% endemic districts that have eliminated Simulium neveai)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Therapeutic coverage in all affected communities / geographic coverage in endemic districts.</td>
<td>Therapeutic coverage:</td>
<td>Therapeutic coverage:</td>
<td>Therapeutic coverage:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Geographic coverage:</td>
<td>72.2%</td>
<td>Geographic coverage:</td>
<td>&gt;75%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Geographic coverage:</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. CDTI activities integrated within their district health plans in all endemic districts to sustain integration.</td>
<td>90%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td>Activities included in district work plans but no funds allocated</td>
</tr>
<tr>
<td>(% endemic districts with CDTI activities integrated within district health plans)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Positivity of fresh water crabs</td>
<td>69%</td>
<td>2.5%</td>
<td>0%</td>
<td></td>
<td>Good progress</td>
</tr>
<tr>
<td>5. Reduction of oncho worms in endemic communities</td>
<td>&gt;80%</td>
<td>25.4%</td>
<td>0%</td>
<td></td>
<td>Good progress</td>
</tr>
</tbody>
</table>
### Trachoma

<table>
<thead>
<tr>
<th>Description</th>
<th>Achieved</th>
<th>Target</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Prevention and control measures for trachoma fully integrated within the district work plans in endemic areas (% endemic districts with prevention and control measures fully integrated within district work plans)</td>
<td>3/24</td>
<td>24</td>
<td>100%</td>
</tr>
<tr>
<td>2. Endemic districts reached with mass distribution of Tetracycline and Azithromycin</td>
<td>19% = 11 out of 24 districts</td>
<td>100% = 36 out of 36 districts (district coverage varies from 50% to 85%)</td>
<td>100%</td>
</tr>
<tr>
<td>3. The provision of surgical services to patients with trichiasis</td>
<td>17,000</td>
<td>60,000 people</td>
<td></td>
</tr>
<tr>
<td>4. Number of lid rotation surgeons trained.</td>
<td>0</td>
<td>60</td>
<td>100%</td>
</tr>
</tbody>
</table>

### Lymphatic filariasis:

<table>
<thead>
<tr>
<th>Description</th>
<th>Achieved</th>
<th>Target</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Therapeutic coverage for the affected people with single annual dose of Ivermectin and Albendazole</td>
<td>93%</td>
<td>83.4%</td>
<td>100%</td>
</tr>
<tr>
<td>2. Mapping of areas with lymphatic filariasis completed in all endemic districts conducted by 2011/12.</td>
<td>75%</td>
<td>Completed</td>
<td>100% 54 known LF endemic districts</td>
</tr>
<tr>
<td>3. Morbidity and disability associated with lymphatic filariasis reduced by 25% by 2015.</td>
<td>No Data</td>
<td>No Data</td>
<td>No Data Data at Hospitals/Health units, Limited funds for collection</td>
</tr>
<tr>
<td>4. Proportion of endemic implementation units having antigeneamia prevalence &lt;2% or microfilariae prevalence &lt;1%.</td>
<td>100%</td>
<td>14.8</td>
<td>35%</td>
</tr>
<tr>
<td>5. Number of hydrocelectomies done</td>
<td>No Data</td>
<td>No Data</td>
<td>No Data</td>
</tr>
<tr>
<td>Sleeping sickness:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>1. Access to diagnostic procedures and treatment of sleeping sickness for communities</td>
<td>40%</td>
<td>&gt;50%</td>
<td>&gt;80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Inadequate support for field surveillance staff</td>
</tr>
<tr>
<td>2. Treatment success rate improved to 95% at completion of therapy</td>
<td>80%</td>
<td>90%</td>
<td>95%</td>
</tr>
<tr>
<td>Schistosomiasis/STH:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Geographical coverage with mass chemotherapy in endemic districts</td>
<td>74%</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Geographic coverage improving</td>
</tr>
<tr>
<td>2. All endemic districts integrate prevention and control measures within the district work plans (% endemic districts with prevention and control measures fully integrated within district work plans)</td>
<td>90%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Activities included in district work plans but no funds allocated</td>
</tr>
<tr>
<td>3. Prevalence of heavy intensity of infection to &lt;1%</td>
<td>&gt;70%</td>
<td>37%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Good progress</td>
</tr>
<tr>
<td>Leishmaniasis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. The magnitude and full extent of the disease in the country is established by 2010/2011</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2. Increase early case detection</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Zoonotic diseases</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Zoonotic diseases technical guidelines, developed and disseminated by 2011/2013.</td>
<td>5%</td>
<td>70%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Guidelines include IEC and Advocacy materials published by Avian &amp; Human Influenza Project (AHIP).</td>
</tr>
<tr>
<td>2. The proportion of General Hospitals and RRH conducting proper laboratory diagnosis of brucellosis increased by 20% and 50% by 2015 respectively</td>
<td>GH:2%</td>
<td>GH:6%</td>
<td>GH: 20% increase</td>
</tr>
<tr>
<td></td>
<td>RRH:15%</td>
<td>RRH:35%</td>
<td>RRH: 50% increase</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Proper diagnosis defined as use of the Titration and/or Culture method.</td>
</tr>
</tbody>
</table>
Key Achievements /Progress of activities:

- Guinea worm case surveillance and reporting contained
- Onchocerciasis transmission has been eliminated in all isolated foci i.e. no adult flies and no vector-carrying crabs
- All endemic districts treated for NTDs i.e. 100% geographical coverage
- Morbidity due to NTDs has reduced
- NTDs included in the district work plans
- Technical guidelines for zoonotic diseases developed
- Reduced proportion of people with Lymphatic filariasis in endemic implementation units having antigeneamia prevalence <2% or microfilariae prevalence <1%
- Sleeping sickness treatment success rate at completion of therapy improving

Best Practices:

- Enhanced community awareness for identification of guinea worm suspects and reporting
- Integration of NTDs in district plans which has also lead to recruitment of Vector Control Officers who manage the NTDs in the district
- Consistent mass treatment for NTDs has resulted into reduced morbidity

Challenges:

- Inadequate funds, districts plan but do not budget for NTDS. The programme depends on donor funds
- Inadequate trained Ophthalmologic Clinical Officers to conduct lid rotation surgeries
- Inadequate staff at National and District levels to implement the activities.
- An MoU for guinea worm surveillance has not been signed with South Sudan
- Therapeutic coverage for most NTDs below the target of >75%
- Due to dependence on donor support, some of the NTDs which have no external funders are not active. For example, there is no active Leishmaniasis programme and the disease distribution is not known.
- Management of morbidity due to NTDs not supported.

Conclusions:

- Publicity and advocacy for NTDs has improved and the Ministry, with assistance from partners has made good progress in control and elimination of NTDs. However, for sustainability and better integration into the health system, the central and district levels need to allocate funds to the programme.

Implications for policy adjustments and challenges:

- NTD mass treatment should be fully integrated into the health systems
The districts should manage NTD related morbidity such as podoconiosis, trachoma related surgeries.

Schistosomiasis can be eliminated in low transmission areas.

d) NCDS, Mental health and Injuries

Although there were no smart indicators for non-communicable diseases, mental disorders or injuries among the core 26 HSSIP 2010/11 – 2014/15 indicators, tracking these conditions, their risk factors and interventions is becoming increasingly important. This is because they are gradually getting more prevalent in Uganda as a cause of death and poor-health.

There is a paucity of data on NCDs. Estimates generated by WHO show that non-communicable diseases contribute about 25% of all deaths in the general Ugandan population. Of these, age standardized estimates indicate that cardiovascular diseases are the leading cause of death among NCDs followed by chronic respiratory diseases and cancers.

Percentage distribution of all causes of deaths for all ages groups.

*Source: WHO NCD Country Profile 2008*

Main findings:

- No baseline data for most of NCD indicators
- HSSIP indicators for NCDs were not smart, mostly composite and costly to measure
- Most NCD data collected is too aggregated for analysis to benefit policy and planning
- The SARA Survey report included in the MTR analytic report provides useful information for planning and policy decisions.
### HSSIP 2010-14-15 Indicators and targets

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline (Year)</th>
<th>Achievement</th>
<th>Target 2015</th>
<th>Progress</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Public awareness on diabetes and risk factors increased by 5% by 2015.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No baseline</td>
</tr>
<tr>
<td>2. Percentage of HCIVs and hospitals equipped with equipment to diagnose diabetes increased by 5% by 2015.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No baseline</td>
</tr>
<tr>
<td>3. Standard diabetes files utilized in 30% of health facilities HCIVs and hospitals by 2015.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No baseline</td>
</tr>
<tr>
<td>1. Standards and guidelines for CVD prevention and management developed by 2014/15.</td>
<td></td>
<td>Draft guidelines awaiting presentation to TWG</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Public awareness on CVDs and their risk factors increased by 10% by 2014/15.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No baseline</td>
</tr>
<tr>
<td>3. The percentage of health facilities from HC IV and above equipped to diagnose CVDs increased by 5% by 2014/15.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No baseline</td>
</tr>
<tr>
<td>1. Cancer policy and National Cancer Control Program in place by 2013</td>
<td></td>
<td>Draft Policy presented to TWG</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Increase in cancer awareness activities by 50% by 2013</td>
<td></td>
<td></td>
<td></td>
<td>Indicator needs revision</td>
<td></td>
</tr>
<tr>
<td>3. Availability of cervical cancer screening in all Health centre IV country wide by 2015</td>
<td></td>
<td></td>
<td></td>
<td>Indicator is not easily measurable</td>
<td></td>
</tr>
<tr>
<td>4. Establishment of two population based cancer registry and a national cancer data base by 2015</td>
<td></td>
<td></td>
<td></td>
<td>Indicator needs revision</td>
<td></td>
</tr>
<tr>
<td>5. Cancer guidelines and SOP for lower level training in place by 2013</td>
<td></td>
<td>Draft awaiting presentation to TWG</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Increased awareness on COPD and asthma disease and risk factors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No baseline</td>
</tr>
<tr>
<td>2. Improved diagnostic capacity and treatment at all levels of care</td>
<td></td>
<td>No baseline</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Improved quality of data on COPD and asthma</td>
<td></td>
<td>Indicator difficult to measure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Increased quality operational research targeted to improve the prevention and management of COPD and asthma</td>
<td></td>
<td>Indicator needs revision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Policy and guidelines on Sickle cell disease developed by 2014/15.</td>
<td></td>
<td>Indicator needs to be revised. Policy will be part of the NCD policy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Sickle cell clinics established in 30% of Regional Referral Hospitals by 2015.</td>
<td></td>
<td>Services available but not specialized clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Hearing impairment reduced from 8% to 6% by 2014/2015.</td>
<td>2011 5.4 (UDHS 2011)</td>
<td>Baseline used was not national Indicator needs revision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Visual impairment reduced from an estimated 0.8% to 0.7% by 2014/2015.</td>
<td>2010</td>
<td>Indicator needs revision. Baseline was for blindness and not visual impairment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Assistive devices provided to 80% of PWDs who need them by 2015.</td>
<td></td>
<td>Indicator was very ambitious, Had no baseline and there are Very many categories of assistive devices.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. The proportion of the population reached with messages on disability prevention and rehabilitation increased to 80% by 2015.</td>
<td></td>
<td>No Baseline, Indicator costly to measure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The proportion of HC IVs with well equipped and functional dental units increased from 25% to 80% by 2015</td>
<td>2010</td>
<td>80%</td>
<td>Funding for equipment was not realized, Indicator needs revision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. The proportion of the population with access to primary oral health care increased from 20% to 80%</td>
<td>2010</td>
<td>80%</td>
<td>Indicator costly to measure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Guidelines and standards for palliative care developed.</td>
<td>Guidelines developed in 2013</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. All hospitals and HC IVs providing palliative care.</td>
<td>50% of the districts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Adequate stocks of appropriate medication and supplies at palliative care centers are available.</td>
<td></td>
<td></td>
<td>Indicator needs to be revised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health law enacted by 2011/12</td>
<td>Presented to Cabinet in 2013</td>
<td>Awaits Cabinet approval</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health policy finalized 2010/11</td>
<td>Presented to Senior Management in 2012</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health policy operationalized 2010/11</td>
<td></td>
<td>Still being reviewed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operationalize mental health units in all RRHs by 2010/11.</td>
<td>2010/2011</td>
<td>100% in 2012</td>
<td>Achieved through SSHP support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community access to mental health increased from 60%-80%</td>
<td></td>
<td>80%</td>
<td>There was no baseline. Indicator is costly to measure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services for alcohol and drug abuse mgt are available at HCIV.</td>
<td></td>
<td></td>
<td>Indicator to be revised to become measurable</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Key Achievements /Progress of activities:

- Several awareness campaigns including media and community engagements held on NCDs.
- Regional Referral Hospitals were supported in terms of equipment and training to manage NCDs.
- Built partnerships with development partners and stakeholders to support planned activities.
- HMIS strengthened to capture data on NCDs.
- Parliamentary fora for NCDs and Road safety formed and sensitized.
- NCDs related policies, Standards, guidelines drafted and are at different levels of approval.
- Patient organizations have been formed and strengthened.
- Workshops for assistive devices established/strengthened.
- Local surveys (RAABs) conducted.
- Improved provision of specialized medicines, raw materials for assistive devices by NMS.
- Research on Helmet use among Boda boda.

Best Practices:

1. Partnerships with Stakeholders including SCO, Universities and international organizations.
2. Regular stakeholder meetings.
3. Training of middle level health workers to provide specialized care like mental health and eye care.
4. Advocacy with the Parliamentary fora on NCDs and Road safety to put the NCD on the national agenda.
5. Camps enable increased access to specialized care for NCDs.
6. Integration of specialized services into PHC.

Main Challenges:

- Lack of baseline data.
- Failure to conduct surveys to inform our progress.
- NCDs not given the priority they deserve in funding and human resource allocation.
- Aggregated data on HMIS.
- Lack of technologically appropriate equipment by level.
- Lack of maintenance of available equipment.
- Stigma towards PWDs & the mentally ill.
Implications for policy adjustments and challenges:

- Develop new indicators that are SMART for Non communicable diseases/conditions
- The NCD risk factor and prevalence survey should be done and results disseminated by 2015.
- The NCD program should in the meantime use available data sources Hospitals, Cancer/Heart Institutes, UBOS, WHO web based data for planning and programming.

e) Reproductive health, maternal, newborn care and child health (RMNCH)

Main findings:

A comprehensive analysis was done in the area of RMNCH. Virtually all pregnant women attend antenatal care at least once 95%, however only 48% make the recommended 4 or more ANC visits. It is unlikely that the target of 60% for 4 or more ANC visits will be met.

Institutional deliveries have been gradually increasing, but while there has been an upward trend, the HSSIP target of 90% in 2015 may be difficult to achieve. The situation is similar for the proportion of deliveries with skilled birth attendance. The SARA Survey also found out that all HC IIIs and 30% of HC IIs are able offer basic obstetric and newborn care services, with improved availability of essential life-saving commodities including contraceptives. The inequalities between urban and rural women and between the poorest and best off women for ANC and institutional deliveries are large and persisting with little progress in closing the gaps.

In conclusion, there is slow progress in achievement of MDG 5 targets IF 131/100,000 by 2015.

Regarding Child Health, Postnatal care for babies within 2 days of birth is very low, and the availability of equipment for newborn care is available in only half of the facilities offering delivery services. However, Child mortality in Uganda continued to decline rapidly from 137/1,000 in 2006 to 90 per 1,000 live births in 2011. Although the pace of mortality needs to be accelerated if the HSSIP target of 56 per 1000 by 2015 is to be met.
## HSSIP 2010-14-15 Indicators and targets

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline (Year)</th>
<th>Achievement</th>
<th>Target 2015</th>
<th>Progress</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality ratio (deaths per 100,000 live births)</td>
<td>435 (UDHS 2006 for period 1999-2006)</td>
<td>438 (UDHS 2011 for period 2004-2011)</td>
<td>131</td>
<td></td>
<td>There appears to be no progress and the indicator is well off the target for 2015</td>
</tr>
<tr>
<td>ANC: pregnant women attending at least 4 times</td>
<td>47% (UDHS 2006 for period 2001-06)</td>
<td>48% (UDHS 2011 for period 2006-11)</td>
<td>60%</td>
<td></td>
<td>There has been no progress, and 2015 target may not be achieved</td>
</tr>
<tr>
<td>IPT: pregnant women taking at least 2 doses</td>
<td>18% (UDHS 2006 for 2004-06)</td>
<td>27% (UDHS 2011 for period 2009-11)</td>
<td>80%</td>
<td></td>
<td>There has been slow progress and 2015 target is unlikely to be met</td>
</tr>
<tr>
<td>Institutional delivery rate</td>
<td>41% (UDHS 2006 for 2004-06)</td>
<td>57% (UDHS 2011 for 2006-2011)</td>
<td>90%</td>
<td></td>
<td>There has been some progress, and but the 2015 target is unlikely to be met</td>
</tr>
<tr>
<td>Emergency Obstetrics Services: HC IV (%) providing EMOC</td>
<td>23% (HMIS 2008-09)</td>
<td>36% (HMIS 2012-13)</td>
<td>50%</td>
<td></td>
<td>Positive trends</td>
</tr>
<tr>
<td>Contraceptive prevalence rate</td>
<td>24% (UDHS 2006)</td>
<td>30% (UDHS 2011)</td>
<td>40%</td>
<td></td>
<td>The use of modern contraceptives has increased.</td>
</tr>
</tbody>
</table>

## Child Immunization

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline (Year)</th>
<th>Achievement</th>
<th>Progress</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPT3/pentavalent coverage in children under 1 (%)</td>
<td>76% (HMIS 2009/10)</td>
<td>66.0% (UDHS 2011)</td>
<td>Overall increase in trend data from both data sources</td>
<td></td>
</tr>
<tr>
<td></td>
<td>85% (HMIS 11/12)</td>
<td>93.3% (HMIS 2012/13)</td>
<td>Data quality assessment suggests some over-reporting from HMIS, but positive trends.</td>
<td></td>
</tr>
<tr>
<td>Measles vaccination in children under 1 (%)</td>
<td>52% (UDHS 2006)</td>
<td>60.3% (UDHS 2011)</td>
<td>Both data sources show increases in coverage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>72% (HMIS 2009/10)</td>
<td>93.32% (HMIS 2012-13)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>85% (HMIS 11/12)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Key Achievements /Progress of activities:

- There was a significant increase in budgetary allocation to reproductive health commodities by the Government of Uganda by increasing from 750,000 USD in 2009/10 to 3.3 USD by 2011.

- Government procured Reproductive Health (RH) commodities including contraceptives worth USD12.2 million (including USD 8.6 million from the World Bank) in 2012/2013. UNFPA procured RH commodities worth USD 7.4 million while USAID procured RH commodities worth USD 8 million. This has greatly improved the availability of these commodities at National and facility levels.

- Emergency Obstetric and Neonatal Care equipment worth US$3.9 million was procured and delivered in the country and will be distributed to 230 Government health facilities (65 Hospitals and 165 HCIVs). UNFPA also procured equipment for 8 UNFPA supported districts up to HCIIIs worth USD700,000.

- A total of 41 ambulances and 3 tricycles were procured using funds from UNFPA, SHSSP, BTC and SMGL partners supported by USAID and CDC.

- Procured 17,925 VHT registers and 18 regional Radio stations to mobilize the community to increase demand of Reproductive Health and child health services country wide.

- Recruited additional critical cadres (196 doctors, 1,067 midwives, and 53 anesthetics officers) to offer RH services among other cadres that were recruited.

- 100% of hospitals offer comprehensive EmONC while all HCIIIs offer basic EmONC.

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

- A number of Advocacy and campaigns including the Every Woman every child campaign, the UN Commission on information and accountability, UN Commission on Life Saving Commodities, Born Too Soon Campaign, Advocacy campaigns among MPs especially the Women members of parliament to increase Reproductive Health funding and advocacy for the Family Health/Child Days were carried out.

Best Practices:

- VHT involvement in RMNCH in provision of Depo, ICCM, Pregnancy registration, post natal home visits and Mobilization of immunization

- Reproductive Health Vouchers for poor mother for ANC, Transport, EmONC including C/S

- Parliamentarians’ mobilization for increasing funding for Reproductive Health services including procurement of the World Bank loan and the recruitment of critical cadres of HWS to offer RH and CH

- Integrated community outreach – FP, Child, Family Health Days

- Reproductive Health Commodity security strategy that Priorities lifesaving medicines for every woman and every child including contraceptives

- Regional mentoring of health workers on MNH standards

- Mother Child Health passport that will have services offered to both the mother and the child

- Maternal Death Notification and Maternal and Perinatal Death Reviews as Quality improvement tool.
Main Challenges:
- Inadequate critical cadre of Health workers to offer Reproductive Health services at all levels
- Long procurement processes
- Low demand for Reproductive Health services.
- Lack of vital tools like partograph, MPDR and side effects management protocols
- The new financial guidelines that require allowances to be paid directly to participants/beneficiaries.

Conclusions:
The Government of Uganda is committed to achieve the commitments pledged to improve the Reproductive Health, Maternal, Newborn and child health services to all people in Uganda particularly given impetus by the FP2020 presidential commitments

Implications for policy adjustments:
- Operationalizing Reproductive Health Voucher system
- Harmonize the functions of AIDS Control programme and those of Uganda AIDS Commission for proper response to the AIDS epidemic.


Context:
Maternal and Under-five mortality is declining but too slowly for the country to achieve the desired MDG targets for 2015. The MoH with support from Unicef embarked on a process to accelerate the achievement of MDG 4 and 5 in Uganda. There is a renewed global effort including funding commitments to accelerate progress towards the maternal and child health related MDGs 4 and 5 in recent years. Uganda is commitment and unites with global partners to scale-up action on three fronts: (1) sharpening the national RMNCH plan, (2) strengthening accountability and monitoring mechanisms and (3) developing/strengthening partnerships for social mobilization, funding and technical assistance.

This national effort to improve health outcomes for women and children and accelerating progress towards reaching MDGs 4 and 5 was guided by the Rapid Landscape Analysis of RMNCH Programs and Commodities framework. The tool provided relevant data collection and analysis tools, principally: the computer aided Lives saved Tool (LiST), the Checklist for RMNCH programmes, the Rapid Assessment of Interventions and Commodities Tool, the Bottleneck Analysis and the OneHealth Tool that harmonised the costing.

Brief description of the established system

Supportive policies exist and technically feasible and cost-effective interventions to reduce maternal, newborn, and child mortality are known. However, their potential has not been fully realized due to critical bottlenecks in the health service delivery. Consequently, delivery and uptake of high impact priority interventions, particularly amongst the most vulnerable women and children has remained fragmented and low especially around delivery and immediate postnatal period when most women and children die. The existing national RMNCH plans do not adequate prioritise these interventions.
and the low funding has limited collective impact in reducing mortality and improving survival of especially mothers and newborns.

**Summary of System Gaps:**

**Leadership and governance:** Weak leadership of RMNCH especially at district level with less than 10% of districts having a focal point person (Assistant DHO for MCH). At facility level, facility management committees are non-functional. There are many new RMNCH interventions introduced quickly and these are developed without accompanying or realistic costing for dissemination and implementation and don't correspond with capacity to implement including updating private sector regulatory bodies. Consequently implementation of clinical guidelines and protocols is weak due to slow uptake by lower levels.

**Health financing:** No or little budgets for essential RMNCH commodities from government and about three quarters of expenditure is out of pocket. There are informal payments and inpatient stay such as for emergency admissions increase the cost for non-medicine (e.g. food) not supplied by facilities. Facility budgets too limited, and district have limited allocative autonomy. Among the key issues identified was that many RMNCH commodities are not in essential medicine list (EML), or poorly quantified. This is because they have been predominantly funded by donors.

**Health workforce:** The key challenges were that staffing skewed against rural, lower level facilities and new districts, staffing norms not based on workload but funding availability, low staff morale and high absenteeism and standard job descriptions for midwifery personnel and those involved in newborn care are inappropriate regarding, for example, prescription and administration of emergency parenteral antibiotics.

**Essential medical products & technology:** The key gaps are that formularies for newborn treatment are lacking especially HC II & III. Key essentials, like Partographs, are not generally available in health facilities. Commodities are not supplied to facilities as mandated. Facilities lack full package of essential RMNCH commodities and equipment for services with very low priority on supporting commodities like clean water, cups, NG tubes, breast milk containers, beds, cupboards and room dividers. The ministry is developing a plan for improving the supply of 13 essential commodities for reproductive maternal, newborn and child health (RMNCH).

**Health service delivery:** There is poor adherence to national standard treatment guidelines or clinical protocols in both public and private sector. The emergency referral system to send mother and baby from one facility to next is weak. Facilities mandated to offer EmONC do not have the 24 hour readiness and there is no clear management system in place to ensure that EmONC is available 24 hours a day. Furthermore, many facilities lack the basic amenities of water and lighting.

**Health information systems:** The key gaps identified were that HMIS products are not being used for RMNCH decisions at all levels. This is related to quality of data, some key RMNCH indicators not being captured adequately from both the public and private sector and little RMNCH information demand by stakeholders. The MPDR system has still got low coverage and the national vital registration system remains very weak.
Community ownership: The community component remains weak with many of the promising interventions done in pilot districts. Even where VHTs exist, they are empowered only to identify, register, refer and follow and fail to provide pre-referral care. There are other challenges in involving community representatives in audit committees and reviews and weaknesses, on part of providers and the community, regarding the rights approach. Continued use of RMNCH services is low and this is attributed to poor perceived quality of services.

Key barriers:

RMNCH interventions are grouped according to three delivery platform or channel used to provide them by the health system; (2) schedulable interventions often provided through outreach activities and (3). The key barriers were thus assessed according to each platform as shown below:

- Interventions provided in the community and at household level: Inadequate supply of commodities to facilitate VHTs function and lack of trained VHTs, and/or lack of effective linkages to the health system.
- Outreach and Outpatient services: Erratic supply of essential commodities and diagnostics and; inadequate numbers of skilled personnel
- Interventions targeting one individual provided at health facilities Clinical care: Lack of skilled personnel, particularly in hard to serve areas; low coverage and poor quality of EmONC services and large out of pocket payments even among the poor.

Recommendations:

On leadership and management

a) Consolidate policy documents and provide funding to produce and disseminate to all actors
b) Consolidate job aids of recent interventions and commodities to improve usability

On financing

c) Negotiate free examination for pregnant women and sick neonates in private sector
d) Establish centralized output-based financing system for RMNCH

On Human resource for Health:

c) Review mandatory retirement of midwives
f) Link training schools with lower level facilities as practicum sites
g) Revise and clarify job descriptions and appraisal
h) Empower nurses for RMNCH including in use parenteral antibiotics

On Commodities

i) All essential RMNCH medicines including those for the newborn, be included in the EML
j) Pool donor funds to reduce piecemeal procurement of commodities
On health service delivery

k) Institutionalization of quality improvement systems at point of delivery of services
l) Provide guidelines on mobile phones
m) Tap into public-private partnerships for emergency ambulance services
n) Ensure standards based case management

On HMIS

o) Capacity building for private sector to report
p) Quarterly RMNCH reporting to all levels and sectors (using MPDR, Scorecards and HMIS)
q) Establish M&E position in programs to link to HMIS system

On Community ownership

r) Focus on building VHTs in districts and populations under served by formal facilities
s) Increase user community participation in reviews and audits
t) Empower VHTs to offer emergency pre-referral emergency care
CHAPTER FOUR

Assessment of objective 2: Improve Levels and Equity in Access and Demand for Services

a) Health Infrastructure & Service Delivery:

Main findings:

The Twelve (12) indicators that were selected to monitor the HSSIP implementation by the domain of Health Infrastructure and Hospitals (clinical services) were assessed as shown in the table below. Out of the 12 indicators, only 3 (23%) of the indicator target had been achieved or showed good progress. The rest were unlikely to be achieved by 2015.

During the review period, the functionality of the HC IVs increased from 5% to 36%, a draft hospital operation manual and an integrated infection control guideline were developed including a fistula service delivery tools.

Accident and emergency units were constructed in Masaka, Mubende and Mbarara Regional Referral Hospitals, Blood Transfusion Centers were built in Mbarara, Mbale, Gulu, and Fort Portal Regional Referral Hospitals which now stands at 29%, and one Intensive Care Unit (ICU) was constructed and equipped in Jinja Regional Referral Hospital. In addition, Health Unit Management Committee guidelines were reviewed, printed and disseminated.

The proportion of the population of Uganda living within 5 km of a health facility remains at 72%. A new survey can only be done after UBOS provides the GPS parish population data. The proportion of HC IVs and hospitals with functional ambulances for referral increased, And medical equipment in good condition and maintained currently is at 51%.

HSSIP 2010-14-15 Indicators and targets

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline (Year)</th>
<th>Achievement</th>
<th>Target 2015</th>
<th>Progress</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>The functionality of the HC IVs (providing EMOC)</td>
<td>5%</td>
<td>36%</td>
<td>50%</td>
<td></td>
<td>Slow progress, the definition of a functional HCIV has not harmonized</td>
</tr>
<tr>
<td>Standards for best practice in hospitals established by 2012.</td>
<td>None</td>
<td>A draft hospital operation manual in place</td>
<td>Final copy of manual</td>
<td></td>
<td>The manual will be finalized soon</td>
</tr>
<tr>
<td>Infection control guidelines finalized and being used in all hospitals by 2012/2013.</td>
<td></td>
<td>An integrated Infection control guidelines was launched</td>
<td>Final copy of guidelines</td>
<td></td>
<td>Achieved</td>
</tr>
<tr>
<td>Functional Accident and Emergency Units established in all RRHs by 2014/15.</td>
<td>None</td>
<td>23%</td>
<td>100%</td>
<td></td>
<td>Constructed accident and emergency Units in Masaka, Mubende and Mbarara Regional Referral Hospitals</td>
</tr>
</tbody>
</table>
Blood Transfusion Centers set up in all RRHs (2 each year) None 31% 100% Blood Transfusion Centers were set up in Mbarara, Mbale, Gulu, and Fort Portal regional referral Hospitals

ICU/CCU established in 40% of the RRHs (1 ICU in RRH each year) by 2014/15 None 20% 40% One ICU unit was constructed in Jinja Regional Referral Hospital

Proportion of districts where Health Unit Management Committees in HC II – IV, general hospitals are functional (meeting at least once a quarter) (75%). None Health Unit Management Committee Guidelines were printed and disseminated 75% No study has been done

The proportion of the population of Uganda living within 5 km of a health facility 72% 72% 90% All health Facilities mapped on GIS awaiting population projection – by Parish - by UBOS in order to determine population density around health facilities

The number of health facilities increased by 30% by 2015. 4,333 5,229 5,712 Good progress

The proportion of HC IVs and hospitals with functional ambulances for referral increased to 100%. HC IV: 37% Hospitals: 69% (Estimate) 100% No data. Need to collect data from stakeholders

Percent of medical equipment are in good condition and maintained. 40% 51% 60% Results based on only 25 Health facilities. Need to conduct an Inventory for a more representative sample

Percentage of mobile population physically accessing health facilities. 50% No data. Pilot mobile clinics in Moroto and Kotido districts due to lack of facilitation

Best Practices:
- Regular support supervision to the health facilities at all levels of management
- Specialists outreach services carried out by flying doctors to hard to reach areas of the country from the National and Regional Referral Hospitals
- Technical support supervision in terms of coaching and mentoring from National and Regional Referral Hospitals to the Lower Level Health facilities
- In service training through workshops, seminars and short courses by partnering with the stakeholders
- Improving working conditions as a motivating factor so that the health workers can perform better
Challenges:

- Few health workers
- Funding of the hospital and other health facilities in terms of medicines and health supplies has been a problem
- Lack of motivation to the staff
- Frequent stock out of the medicines and other supplies
- Poor management structures of the health facilities
- Lack of a referral protocol for better referral system using ambulances at all levels
- Lack of the vital data to track the progress

Conclusions:

- There is need to strengthen the referral system by having in place a National Ambulance Service.

b) Medicines

Main findings:

There has been steady improvement in the availability of essential medicines in the country. The indicators that were assessed show progress towards the HSSIP target by 2015.

Regarding the availability of the six tracer medicines (ACT, Cotrimoxazole, measles vaccine, Oral Rehydration salt, Depo-Provera and Sulphadoxine pyramethamine), this has been increasing steadily with 53% of health facilities without monthly stock outs in 2012/13, Further analysis by level of care shows availability of all the six tracer medicines increasing from 30% and 42% in 2010/11 to 53% and 48% in 2012/13 for HC2 and HC3 respectively compared to 20% and 18% in 2010/11 to 47% and 40% in 2012/13 for HC4 and Hospitals. however stock outs are still experienced in half of the health facilities.

In the area of Financing for EMHS, there has been significant increase in per capita expenditure from $0.5, 2010/11 to $0.9, 2012/13, with budget out turn of 79%, 2010/11 to 96% 2011/12. Further analysis on the proportion of government funding for EMHS increased from 52 billion of shillings to 86 billion of shillings with NMS utilizing 95% of this budget. 38% of the vote spent mostly at district level. Despite these increases, EMHS funding is still insufficient and equitable distribution needs to be realized.
## HSSIP 2010-14-15 Indicators and targets

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline (Year)</th>
<th>Achievement 2010/11</th>
<th>Achievement 2011/12</th>
<th>Achievement 2013/14</th>
<th>Target 2015</th>
<th>Progress</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of health units without monthly stock outs of any indicator medicines increased from 10% to 51% using survey data</td>
<td>21% 4</td>
<td>43% 4</td>
<td>49% 4</td>
<td>41% 3</td>
<td>60/80%</td>
<td></td>
<td>Steady progress in medicine availability but half of facilities experience stock out. Drop seen in DHIS 2 data 2011/12-2012/13 from 70% to 53% was as a result of transition from HMIS to DHIS 2. Target adjustments from 60/80% were as a result of the perceived results in 2010/11(70%).</td>
</tr>
<tr>
<td>Government of Uganda budget for procurement of EMHS increased from meeting 38% to 66% of MoH estimated need(^1)</td>
<td>-</td>
<td>38% Need-90bn</td>
<td>72% Need-107bn</td>
<td>66% Need-130bn</td>
<td>80% Need-159bn</td>
<td></td>
<td>Estimated targets not achieved for review period due to inadequate funding for EMHS from government. There is need to advocate and lobby for more funding and identify other funding mechanisms to fill the gap.</td>
</tr>
<tr>
<td>Utilization of government funds spent by NMS increased from 59% to 95%</td>
<td>59%</td>
<td>75% Need-90bn</td>
<td>95% Distribution to districts not yet known</td>
<td>80%</td>
<td></td>
<td></td>
<td>Increased government funding and timely disbursements to NMS. Availability of EMHS at NMS, Better order processing time. Should not deviate by 5% of the allocated budget.</td>
</tr>
</tbody>
</table>

\(^1\)Estimated need calculated based on National Quantification and considered the inflation rate (7%) and population growth rate (3%)
The % of NDA budget directly financed by GoU (consolidated funds at 0 %).

<table>
<thead>
<tr>
<th>%</th>
<th>0%</th>
<th>0%</th>
<th>0%</th>
<th>0%</th>
<th>25%</th>
<th>MoH Funds have not been disbursed to NDA</th>
</tr>
</thead>
</table>

Guidelines for donated medicines developed by 2012: - - - Adopted existing guidelines

Guidelines for donated medicines in place: Guidelines for donated medicines in place

MoH developed guidelines based on WHO but need to be disseminated

Key Achievements /Progress of activities:

- Published and launched the 2012 edition of Uganda Clinical Guidelines (UCG) and Essential Medicines and Health Supplies List for Uganda (EMHSLU). The EMHSLU was harmonized to include laboratory supplies. To date 6000 copies of 2012 EMHSLU and 15,000 UCG have been printed and being disseminated.

- Harmonized the procurement and distribution of pharmaceuticals to include lab commodities through rationalization (one facility one supplier) of ARVs, TB, Lab commodities and Cotrimoxazole supply management through streamlined reporting by NMS, JMS and Maul.

- Revised the national distribution guidelines and developed a strategy to strengthen the role of wholesalers.

- Developed the NDA information strategy and procurement of a new server to host the Verification of Imports (VOI) system at National Drug Authority (NDA) to increase efficiency in tracking the drug imports and exports. NDA procured equipment to test sub standard and counterfeit medicines.

- Under the National Drug Authority Mandate, developed 16 statutory statements, amendments to the National Drug Policy and Authority Act to include National Food Authority (NFA) and guidelines for minimum regulatory requirements (MRR) for traditional and herbal medicines.

- Adopted WHO guidelines for donated medicines.

- Implemented the Kit System for lower level facilities (HC2&3) to increase availability of EMHS.

- Established the Quantification, Procurement, and Planning Unit (QPPU) in pharmacy as a hub for projecting and quantifying national requirements for EMHS and to coordinate donors’ supply planning to ensure that appropriate products in adequate quantities are supplied on a timely basis.

- Established the Monitoring and Evaluation Unit (M&E) at Pharmacy Division to strengthen the division in its role of coordinating, reporting and exchanging information on EMHS.

- Conducted 16 Medicines Procurement Management Technical Working Group monthly meetings (MPMTWG) and four Bi annual meetings with Regional Pharmacists and Implementing Partners.

- Developed concepts for Financial and Commodity Tracking Systems (FACTS) and Pharmaceutical Information Portal (PIP).
Conducted a costing study to inform on NDA's fee structure changes to enable it operate in a financially healthier environment.

Developed Adverse Drug Reaction (ADR) – Pharmacovigilance reporting forms and set up 14 Pharmacovigilance centre's based in regional hospitals.

Centralized quantification and rationalized procurement and supply of Laboratory, HIV, TB and Malaria commodities.

Developed hospital procurement plans.

Advocated for adequate financing of essential medicines and health supplies in the national budget that realized increased VOTE 116 budget from 41 billion to 86 billion see table 1 and government contribution to Reproductive Health (RH) commodities from 2.4 billion to 8 billion, world bank grant to RH commodities, Global Fund, GAVI and PEPFAR.

Expansion of Pharmacy Division housing two new units (QPPU and M&E) with seven seconded staff.

Strengthened leadership role at Pharmacy Division.

Implementing Supervision Performance Assessment Strategy (SPAS) nationally, currently covering 112 districts.

Formed the Uganda Medicines and Therapeutic Committee (UMTAC).

Reestablished MTCs in 14 Regional Referral Hospitals.

Train a total of 456 Medicines Management Supervisors (MMS) at district level, 2-4 MMS per district and contracted pharmacists at public General Hospitals.

Introduced two new tools: (1) Stock Book that enforces regular physical stock counts are done at least monthly and (2) Supervision Book to institutionalize and harmonize reporting of supervision findings at the health facility which informs the institution management and the next supervision team(s) of issues to handle and/or emphasize in every visit.

Assessed store requirements for all health facilities in Uganda.

Procured 3, 212 shelves and distributed 1600 of them by the MTR.

Plans to rehabilitate and construct UNEPI stores are in advanced stages.

Reviewed central warehouse business processes (NMS and JMS). Currently utilization of government funds spent by NMS has increased from 59% to 95%.

Implemented the last mile delivery through 3rd party providers and strict adherence to delivery schedules for public and PNFP sectors.

**Best Practices:**

- Harmonized the procurement and distribution of pharmaceuticals to include lab commodities through rationalization of ARVs, TB, Lab commodities and Cotrimoxazole supply management and streamlined reporting (One Supplier One Facility)
- Timely review of the Uganda Clinical Guidelines (UCG)
- Review and consolidation of the Essential Medicines and Health Supplies List Uganda (EMHSLU).
- Integration of TB commodities at NMS to strengthen, harmonize, streamline and optimize supply chain systems.
• Implementation of the last mile delivery through a 3rd party providers and strict adherence to delivery schedules for the public and private sector.

• Implementation of Supervision, Performance, Assessment Strategy (SPAS) in all the 112 districts in the management of EMHS.

• Establish a mechanism for coordinating information management in the pharmaceutical sector

• Establishment and building the capacity of the Quantification and Procurement Planning Unit (QPPU) within the Pharmacy Division.

• Periodic reporting on the stock status

• Use of e-pharmaceutical management systems

• Introduction of Good Pharmaceutical Practices certification in public facilities

• ARV web based ordering (WAOs) rollout

**Main Challenges:**

• Guidelines and lists not yet widely distributed due to limited numbers printed

• Freeze of e-health development initiatives has delayed implementation of e-logistics management information systems

• Shortages in laboratory supplies due to apparent absolute dependence on donor financing for Laboratory Supplies for critical and priority programmes.

• Realizing equity in budget allocation for EMHS

• Sustainability of the organizational structures of the pharmaceutical sector management

• Over dependence on human resource technical assistance for logistics management

• Gaps in government funding despite increased funding

• Managing and achieving harmony of multiple stakeholders in the sector

**Conclusions:**

• The government of Uganda has made significant improvements in her levels of financing for EMHS, however, there is still need for further improvements in the financing of EMHS to enable the sector achieve the much desired zero stock out for EMHS in health facilities. In addition, the criteria for financing for EMHS has not changed for a considerable period of time, it is becoming increasingly clear that a new budget allocation for EMHS in the sector is instituted that addresses equity as well as actual (realistic) work load per facility and or facility level.

• There is clear need now for a deliberate targeted recruitment, retention and motivation of HR for management of EMHS at all levels as the sector continues to realize ever increasing investments targeted at provision of adequate EMHS from both the GoU and development partners supporting the sector.

• The adoption of and use of a standardized e-health logistics management information system and the related data warehouse design for the management of EMHS in the public health facilities is long overdue and needs special attention to facilitate real time reporting and monitoring stock status generally and particularly for supplies related to priority programmes.
Implications for policy/plan adjustments and challenges:

- The increasing need for overall policy review of the national mechanisms for financing EMHS including the various modalities
- There is need to review the National Drug Policy to incorporate mandatory accreditation of public sector facilities for Good Pharmacy Practices.

c) Human resources for Health

Main Findings:

In 2012 there was a nation-wise effort to recruit staff into positions at Health Centre II I and Health Centre IV. Of the 10,210 positions advertised, about 71% were filled and this resulted into increased proportion of positions filled at both Health Centre III and Health Centre IV. Proportion of filled positions in Health Centre rose from 56% in 2012 to 70 and for Health Centre IV it increased from 60% in 2012 to 71% in 2013. There were variations in cadre recruited ranging from 86% for all nurses, 53% doctors and only 12% for anaesthetic officers/assistants. There were also major variations by district ranging from 199% in Mbale to 08% in Buliisa.

Despite the recent drive to recruit into Health Centre III and Health Centre IV, there still remain disparities by district. While Kiruhura district only has 28% of the positions filled, Iganga district on the other hand has over 90% of the positions filled.

Indicators and Targets

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline (2009/10)</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>Target 2014/15</th>
<th>Status / comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of approved positions filled by trained health professionals</td>
<td>51%</td>
<td>53%</td>
<td>55%</td>
<td>60.5%</td>
<td>75%</td>
<td>Positive trend but below HSSIP target</td>
</tr>
<tr>
<td>Annual reduction in absenteeism rate</td>
<td>Absenteeism rate: 46%</td>
<td>1% increase</td>
<td>No data</td>
<td>No data</td>
<td>20% reduction</td>
<td>(Abs. rate=47%)</td>
</tr>
</tbody>
</table>

Progress of Activities:

- Supporting 112 districts to develop annual recruitment and HRH action plans to advocate for increased HRH funding.
- Recruitment of new health workers in districts to increase staffing levels i.e. 10,210 targeted in FY 2012/2013.
- Strengthening capacity of 112 DSC to recruit health workers through provision of office equipment, finances to advertise and interview health workers, training DSC members in e-shortlisting
- Development of schemes of service for nurses and diagnostic cadres to enhance absorption and appropriate deployment to improve service coverage
- Establishing electronic HRHIS databases in 74 districts, 13 regional referral hospitals, Mulago and Butabika National Referral hospitals, Ministry of Health (MOH), the 4 HPCs, Uganda Virus Research Center and Uganda Blood Transfusion Services, with interconnections to allow HRH managers at different levels share HRH data.
• Dissemination of special HRH reports annually including the HRH audit, HRH Biannual and licensure and registration reports to enable Managers access analyzed data for monitoring and planning for the health workforce.

• Training 109 HRH managers in Leadership & Management.

• Providing technical support to 112 districts to prioritize HRH issues during planning processes through provision of planning guidelines and tools.

• Accelerating production of midwives by: training 2000 Comprehensive nurses to acquire midwifery skills through a six month remedial training, and supporting midwifery training schools to increase enrolment of midwifery trainees to 200 per year, so far 86 additional midwives have enrolled at 14 midwifery schools.

• Scaling up production of Pharmacy technicians. Currently supporting Gulu and Makerere Universities to increase annual intake of pharmacy technicians by 150 per year, so far 22 have enrolled at Gulu University.

• Strengthening practicum training for doctors, nurses, midwives and clinical officers through training of mentors and practicum site supervisors and provision of training materials and tools

• Other IST programs by vertical programs e.g ACP, Malaria

• Training national, District and Health facility level HRH managers in HR management. So far 109 HRH managers have completed the a six month course in L&M, 124 in charges of lower level health facilities completed six month course in management of lower level health facilities.

• Strengthening payroll management through training district payroll managers to improve access to payroll. Access to payroll within 3 months of recruitment improved from 32% in 2009/10 to 73% in 2011/2012.

• Strengthening performance management systems in districts, regional referral hospitals, HRM department of MOH through training of HR managers in developing individual performance plans and appraising health workers.

• Training district HR managers and DSC members in using computer aided short listing to quicken short listing process.

• Launching client charter for MOH and regional referral hospitals

• Promoting use of WISN in 16 districts enable HR managers deploy staff according to workload to ease work pressure and utilize the scarce health workers more efficiently.

• Revitalizing HUMC/HMBs to support health workers and monitor service delivery

• Strengthening service supervision systems by conducting quarterly visits by area teams
Conclusion:

Health workers are the most important component of any Health System: they design it, manage it, and deliver preventive and curative services. However there is shortage of health workers and the available health workers perform below expectation. The health workforce crisis is characterized by inadequate number and skill mix to effectively respond to the health needs, low retention and motivation, poor performance and high rate of absenteeism. The total estimated health workforce is about 45,598, serving a total projected population in Uganda of about 31.8 million. This means that there is one health worker for over 697 people, taking the entire health workforce together. According to WHO, a country with less than 2.28 health workers (doctors, nurses and midwives only) per 1000 population is regarded to be in severe shortage of health workers to meet its health needs. For Uganda this ratio is about 1.55. Despite the achievements and progress made so far, the HRH systems are still generally weak and the achievements need to be scaled up, consolidated and sustained.
CHAPTER FIVE

Assessment of Objective 3: Accelerate Quality and Safety Improvement of Services

Main Findings:

Four (4) indicators out of eight (8) that were assessed under this objective were either achieved or on track, giving a 50% performance.

The National Quality Improvement Framework and Strategic Plan 2011/12 to 2014/15 FY was developed, launched and is being implemented. This has created more focused involvement on the different stakeholders in implementing Quality Improvement (QI) activities in the health delivery system.

As a foundation for QI, 5S has been introduced in 8 Regional Referral Hospitals and selected health facilities within these regions. This process shall be extended to the remaining health facilities in the sector by 2015. Specific quality improvement initiatives are also being implemented across the Country.

To ensure safety improvements, the National Infection Prevention and Control guidelines and the Standards for Diagnostic Imaging and Therapeutic Radiology were developed and launched for use throughout the country.

The Patients Charter was disseminated to all districts and translated in Ateso and Luganda to stimulate demand for better services by users. The MoH Client Charter was reviewed and the RRHs supported to develop their own charters. This is expected to improve responsiveness and build a more client focused service delivery system for the health sector where feedback can be used to improve the quality of health services.

There was slow progress in developing the Comprehensive Support supervision Strategy for the sector, mainly because of procurement delays and inadequate funding. This is expected to be completed in the course of the remaining period of HSSIP.

The 14 Area Teams (AT) carried out regular quarterly supervision to Local Governments and Hospitals during the first two years of the HSSIP. However, in the third year of the HSSIP implementation, because of budget constraints, AT supervision was done only once and covered only 50% of the districts. During the visits onsite feedback was given to the supervisees. Supervision within local governments also remains very weak.

Client satisfaction with the services based on waiting time in 2009/10 and 2010/11 indicated that 71% and 72% of clients respectively were satisfied with the services, according to the panel surveys. This was an improvement from the baseline of 46% at the end of HSSP II. Another study under the 5S CQI TQM project done in 2013 in all RRHs and selected HFIs showed that in general, 67% of clients were satisfied with the services while client satisfaction based on waiting time was 54%. A country wide Client Satisfaction survey will be conducted during FY 2013/14.
### HSSIP 2010/11-14/15 Indicators and targets

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Achievements</th>
<th>Target</th>
<th>Progress</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>National supervisory framework operational</td>
<td>2009/10</td>
<td>Proposal</td>
<td>Procurement of consultancy initiated</td>
<td>By July 2011</td>
<td>Delayed procurement of consultant</td>
</tr>
<tr>
<td>Reviewed supervision guidelines and tools disseminated</td>
<td>2001 Guidelines</td>
<td>Proposal</td>
<td>Procurement of consultancy initiated</td>
<td>By 2012</td>
<td>Delayed procurement of consultant</td>
</tr>
<tr>
<td>% of districts where capacity for internal supervision has been built</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>100%</td>
<td>Inadequate funding. Indicator should be reviewed.</td>
</tr>
<tr>
<td>% of supervisory reports shared by supervisees</td>
<td>NA</td>
<td>No assessment</td>
<td>100%</td>
<td>100%</td>
<td>On site feedback always provided at health facilities and local governments.</td>
</tr>
<tr>
<td>% of planned visits that are carried out</td>
<td>100%</td>
<td>Area Team 100%</td>
<td>Area Team 75%</td>
<td>Area Team 25%</td>
<td>100% During 2012/13 only one AT visit was carried out and to only 50% of the districts due to financial constrains. In the first 2 years of the HSSIP, quarterly AT supervision visits were carried out to all the districts</td>
</tr>
<tr>
<td>QI mentoring/ coaching conducted in selected districts</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>QI mentoring/ coaching conducted in selected districts</td>
<td>Regional QI Learning Networks are irregular</td>
</tr>
<tr>
<td>% of facilities attaining at least xx of set standards</td>
<td>Not assessed</td>
<td>Not assessed</td>
<td>Not assessed</td>
<td>Not assessed</td>
<td>75% Indicator not clear and not assessed. Need to review the indicator</td>
</tr>
<tr>
<td>Indicator</td>
<td>Baseline</td>
<td>Achievements</td>
<td>Target 2014/15</td>
<td>Progress</td>
<td>Comments</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>----------</td>
<td>------------------------------------------------------------------------------</td>
<td>-----------------</td>
<td>----------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>An Inspectorate Division at MoH headquarters created.</td>
<td>0</td>
<td>None</td>
<td>None</td>
<td>By 2013</td>
<td>Recommendation made to the MoPS restructuring review team</td>
</tr>
<tr>
<td>National quality improvement framework and Strategic plan operational</td>
<td>0</td>
<td>Draft developed</td>
<td>Health Sector QIF &amp; SP is operational</td>
<td>By July 2011</td>
<td>Dissemination of the QIF &amp; SP is in progress.</td>
</tr>
<tr>
<td>Yellow Star Programme reviewed.</td>
<td>0</td>
<td>Not done</td>
<td>Not done</td>
<td>By 2012</td>
<td>Not yet streamlined.</td>
</tr>
<tr>
<td>% / number of districts implementing the QI strategy</td>
<td>Had not been developed</td>
<td>NA</td>
<td>100%</td>
<td>100%</td>
<td>QI Strategy launched in 2012 and districts are at various level of implementation of QI.</td>
</tr>
<tr>
<td>Indicator</td>
<td>Baseline</td>
<td>2010/11</td>
<td>2011/12</td>
<td>2012/13</td>
<td>Target</td>
</tr>
<tr>
<td>-----------</td>
<td>----------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>--------</td>
</tr>
<tr>
<td>Number of performance monitoring activities carried out (Annual QI stakeholders meetings).</td>
<td>Nil</td>
<td>Nil</td>
<td>National QI conference held in February 2012.</td>
<td>National QI Conference held May 2013</td>
<td>Annual National meetings</td>
</tr>
<tr>
<td>Number of surveys conducted to assess client satisfaction and gender responsiveness.</td>
<td>2008/09 survey</td>
<td>None</td>
<td>None</td>
<td>Concept note for client satisfaction survey developed</td>
<td>Client satisfaction survey to be conducted with support from UHSSP</td>
</tr>
<tr>
<td>Mechanism for client / right holders redress established and operational.</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Done for MOH Central and 3 RRHs</td>
<td>By 2015</td>
</tr>
<tr>
<td>Clients’ Charter reviewed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Best Practices:
There has been involvement of key stakeholders in monitoring of health sector performance which has resulted in the following:

- A Country-led M&E platform especially in the use of harmonized data collection tools and reporting system using the DHIS 2.
- Harmonization of the Quality Improvement approaches and operationalisation of the QIF & SP with close collaboration between the MoH and QI partners.
- Close collaboration and buy-in from partners has also resulted in increased technical and financial support for M&E and quality improvement.
- Joint monitoring of local governments with Development / Implementing Partners and Civil Society Organizations

Challenges:

- Inadequate human resources to effectively fulfill the mandate and increasing responsibilities like operationalization of the M&E Plan for the HSSIP and the QIF & SP.
- Inadequate funding and capacity for regular and effective supervision and monitoring of service delivery at all levels. Supervision within local governments is still very weak.
- The creation of new districts necessitates capacity building for the districts (DHTs) in supportive supervision.

Deficiencies and areas for change or modification in the planned strategies:
The planned strategies for accelerating quality and safety improvement interventions are still relevant and applicable however the following should be addressed:

- Quality of health services delivery is still poor due to irregular and ineffective supervision. Planned priority actions to strengthen support supervision at all levels were not implemented due to inadequate funds.
- There are still weak mechanisms for establishing dynamic interactions between health care providers and consumers of health care. Client satisfaction surveys are not conducted regularly and mechanisms for client / right holders redress have not yet been fully established. Results of the Panel surveys come late, two years after the survey.
- Low level of utilization of available information and research findings for evidence based decision making, sector learning and improvement. The development of the e-Health Policy and Strategic Plan, as well as adoption of e-Health initiatives is envisaged to lead to improvements in data management and use.
- Data quality at all levels is still a big challenge.

Recommendations for adjustment to the HSSIP strategies and implementation modalities for the remaining years of the HSSIP:

- Allocate adequate resources for strengthening effective supervision at all levels especially within local governments.
- Institutionalize mechanisms for client feedback and redress at all levels.
Establish a comprehensive M&E structure and build capacity to ensure effective coordination of M&E activities for provision of timely and accurate information, effective use of statistical data and health research at all levels.

Conclusion:

The health sector has made remarkable progress in areas of streamlining QI. This should be strengthened further by expediting the rolling out process of the QIF &SP to all districts by 2015. Support supervision has not been sufficiently carried out at all levels. This has to be given priority in order to provide onsite mentorship to districts and health facilities.

Although a number of standards and guidelines were developed before and during the period under review, dissemination to end users remains poor. In the remaining part of HSSIP more effort should be made to ensure that more guidelines and standards developed and effectively disseminated.
CHAPTER SIX

Assessment of Objective 4: Improve Efficiency and Budget Effectiveness

The commitments in the HSSIP under this objective were develop Health Insurance (risk pooling), Strengthen Financial Management, Risk Mitigation and management, reduce out of pocket expenditure, and strengthen Procurement and Supply Chain Management.

Main findings:
Assessment of performance of the indicators under the domain of Health Financing shows that all the selected indicators are off track and the HSSIP targets are unlikely to be achieved. It is important to note that most of the indicators here such as Government allocation to health, external funding as percentage of health expenditure, out of pocket expenditure etc are actually beyond the control of the health sector.

The HSSIP target aimed at increasing the level of Government's annual budget allocation to Health from 9.6% to a minimum of 15% by 2014/15. The General government expenditure on health as a proportion of General Government expenditure which is also a commitment to health sector funding suggests a slow progress to the target of 15% by 2015. Key policy issues identified during the HSSIP review were Public Health budget as percentage of Total government budget was 7.9% which is still far below the recommended 15% in the Abuja declaration and was lowest among other countries in the East African region.

Government needs to explore alternative financing mechanism to increase resources for health sector, reduce dependency on donors, introduce national pre-payment schemes, improve resource allocation criteria to address inequities, build a better link with the private sector and better coordination of partners to attain policy goals.

The general per capita expenditure for the base year was at US $ 47 (NHA 2013) and this has not significantly changed over the years of review given the level of funding for the years under review. This is still below the WHO recommendation of US $60 per capita if a country is to have better health outcomes.

The target of the public health expenditure per capita of US$ 22 during the HSSIP period is not on track as it is currently at US $ 10.8. This is still lacking in adequacy compared to the enormous health needs of the population. Much of the funding about 75% during the HSSIP period for primary health care was utilized for wages leaving very little funds for service delivery.

The ratio of household expenditure to total health expenditure (financial risk protection) is currently at 43% (NHA 2013) compared to the WHO recommended figure of 15%. Private health expenditure by region suggests that the relatively better off regions pay more than the poor ones. Thus Northern and Eastern regions pay lower out of pocket payments than the moderately well off Western and Central. Similarly the average expenditure by wealth quintile shows the richest quintiles spend more than poorer quintiles. But all income groups registered an increase in expenditure (NHA 2013). It should also be noted that the fact that it is the richest quintile that spends more, points to the inability by the poor to afford payment for the services that are sought for other than the public services. As is mostly the case, a large proportion of private HH expenditures were on medicines. This is an indicator of out-of-stock and inadequacy of the medicines in public health facilities. This could also be largely related to low per capita public expenditure on medicines and supplies.
The service availability and readiness assessment study needs to be used to inform the current situation. The high OOPs of over 43% (NHA 2013), suggests catastrophic expenditure that leads to impoverishment of households.

As already pointed out, external funding for health as a % of total health expenditure was 36% (NHA 2013) which is still a significant proportion. Proper coordination and monitoring and management of this source of funding is vital in facilitating the attainment of the objectives of the HSSIP.

The percentage of expected quarterly donor project reports on disbursements and commitments that are received timely was targeted at 60% by 2014/15. With only 20% of the reports received (Annual Health sector reports), there is likelihood that efficiency, coordination and prioritization has been compromised. It is likely that despite the many health development partner assistance, the results are not commensurate with the resources.

### HSSIP 2010-14-15 Indicators and targets

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline (Year)</th>
<th>Achievement</th>
<th>Target 2015</th>
<th>Progress</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase level of Government allocation to Health from 9.6% to a minimum of 15% of the total GOU budget by 2014/15.</td>
<td>9.6</td>
<td>7.9</td>
<td>15%</td>
<td>Off track</td>
<td>Decline note, target may be attained</td>
</tr>
<tr>
<td>Government per capita expenditure on health increased to 12 by 2014/2015.</td>
<td>11.1</td>
<td>9.0</td>
<td>$12</td>
<td>On track</td>
<td>Attainable but not sufficient based on the current needs</td>
</tr>
<tr>
<td>% of expected quarterly HDP donor project reports on disbursements and commitments that are received timely. Target 60% by 2014/15</td>
<td>Data Not available</td>
<td>Data Not available</td>
<td>60%</td>
<td>Off track</td>
<td>Not adequately tracked</td>
</tr>
<tr>
<td>External funding for health as a % of total health expenditure</td>
<td>41%</td>
<td>Data Not available</td>
<td></td>
<td>On track</td>
<td>Progress being made</td>
</tr>
<tr>
<td>Per capita out of pocket expenditure on health reduced from US$14 to 10 by 2015</td>
<td>US$14</td>
<td>US$22</td>
<td>$10</td>
<td>Off track</td>
<td>The NHA 2013 found the figure still high at US$22, may not be achieved.</td>
</tr>
</tbody>
</table>
Key Achievements /Progress of activities:

- Timely preparation of quarterly reports using the Output Budgeting tool
- Mentoring and capacity building for local Governments and RRHs
- Monitored and Regulated the private sector Health Service providers
- Studied the Result Based Financing and voucher system with a view to introducing performance based financing
- Developed a Draft Health Financing Strategy and reviewed the health financing situation in Uganda
- Strengthened fiduciary capacity in Ministry of Health through mentoring and training of the planning department staff
- The Institutionalization of the National Health Accounts (NHA) is ongoing.
- Prepared National Health Accounts report and efficiency studies report
- Regularly publicized grant releases to the Health sector institutions and Local Governments
- Framework contracts at the Ministry have been instituted to improve on procurements
- The HSSIP period received resources mainly from national treasury through tax revenue. Though this is the most sustainable and equitable source of health financing, it is still inadequate compared to the health needs.

Challenges:

- The general population increase as compared to the sector funding that has remained (stagnant) non responsive to the population change and the disease burden such as HIV/AIDS and Malaria.
- Still very high Out Of Pocket (catastrophic) expenditures attributable to lack of universal coverage of quality services that tend to plunge such households deeper into poverty and vulnerability.
- Issues of governance, leadership and sector management including financial access and management guidelines greatly influenced planning, implementation and management of the interventions in the sector.
- The persistent low staffing in all the public health facilities translated into fewer health staff being available to deliver the service
- The spirit of partnership was betrayed by lack of transparency and accountability in some sectors of Government leading to government recalling some funds to refund some cash
- High level of off budget expenditures that need realignment to sector priorities (strong leadership and coordination)
- High cost of goods and services and medical technology
- Capacity gaps especially in health financing, budget monitoring, and costing.
- The indicators selected to monitor performance are not in the control of the health sector.
**Conclusions:**

With an ineffective health system, poor motivation, weak leadership, and inappropriate infrastructure, health financing functions may not be realized. Thus focus on health system reforms.

Discuss, and address comprehensively, the governance issues (review financial management guidelines, improve trust, and improve work environment) for health workers.

Strengthen partnerships for a harmonious implementation of the sector interventions.

Implement health financing reforms and interventions that address more the risk protection, equity, efficiency, transparency, and accountability in the use of available resources.

**Harness the private sector contributions.**

**Implications for policy adjustments and challenges:**

- Propose a gradual shift towards performance-based financing.
- Need to review indicators that are within the control of the Health Sector and which can effectively and objectively be used to monitor health financing performance.
- Review health financing allocation criteria and disbursement modalities.
- Equitable resource allocation formula/criteria need and outputs.
- Emphasize NHIS as key deliverable.
- Strengthen PPPH approach.
- Introducing reforms: health financing reforms such as PPF/RBF, prepayment schemes.
- Strengthen Leadership and Stewardship of the health sector in directing resource allocation both the use of project/partner funding and on-budget (TWG and Top Management).
- Restructuring the health sector in order to fill the current capacity gaps and address weaknesses in health systems.
- Finalize a Health Financing Strategy and its implementation.
- Build strategic alliances, advocacy with key stakeholders the MOFPED and Parliament and civil society for an increased resource allocation and health reforms.
CHAPTER SEVEN

Assessment of Objective 5: Deepen Health Stewardship

The key interventions in the HSSIP objective five were Strengthen Organization and Management, Create culture of applying Health Research to guide policy and management, Review and develop policies, Acts and regulations, Build and harmonize Public Private Partnerships, Strengthen Inter-sectoral collaboration between Ministries, Implement the plan through IHP principles and SWAps through single harmonized in-country effort.

Main findings:

Under this objective five (5) indicators were on track to reach the HSSIP target or had been achieved, a good progress of 50%.

It was also found that the health sector had made progress towards strengthening organizational and management capacity at the lower levels through the recruitment of additional human resources at HC IV and HC III and training of Village Health Teams (VHTs) and in the area of evidence based decision making, sector learning and improvement by development of the comprehensive M&E plan for the HSSIP and rolling out the DHIS-2.

In addition to the many bills and policies that were under review or development, the Public Private Partnership for Health Policy (PPPH) was approved by Cabinet. The guidelines for the implementation of the PPPH Policy is being developed and once concluded, actual implementation will begin. The Country Compact for Implementation of the HSSIP 2010/11 – 2014/15 (IHP+) was signed between the GoU, Development Partners and CSOs.

HSSIP 2010/11-14/15 Indicators and targets

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline (Year)</th>
<th>Achievement</th>
<th>Target 2015</th>
<th>Progress</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of approved filled positions at local government (district) level</td>
<td>49%</td>
<td>61%</td>
<td>75%</td>
<td></td>
<td>About 7,000 health workers recruited for HC IVs and HC IIIs in 2012/13</td>
</tr>
<tr>
<td>% of districts with trained VHTs</td>
<td>31%</td>
<td>55%</td>
<td>100%</td>
<td></td>
<td>Positive trend but far below target</td>
</tr>
<tr>
<td>Completeness of reports</td>
<td>98%</td>
<td>88.7%</td>
<td>100%</td>
<td></td>
<td>Only 11 districts are below the level of 80%. The slight decrease in 2012/13 can be explained by the transfer to the DHIS-2</td>
</tr>
<tr>
<td>Development of a prioritized national research agenda</td>
<td>0</td>
<td>Initiated</td>
<td>By 2012</td>
<td></td>
<td>Delays in development and approval of policy and strategic plan</td>
</tr>
<tr>
<td>A Joint Professional Council with Decentralized Supervisory Authorities established</td>
<td>0</td>
<td>Decentralized supervisory authorities are established</td>
<td>By 2015</td>
<td></td>
<td>Draft bill for the Joint Professional Council developed</td>
</tr>
<tr>
<td>National Policy on PPPH is approved by the Cabinet</td>
<td>0</td>
<td>Done 2012</td>
<td>By 2011</td>
<td></td>
<td>Implementation guidelines under review</td>
</tr>
</tbody>
</table>
Key Achievements /Progress of activities:

Strengthen Organization and Management:

- There was continued advocacy for increasing the health workforce through stakeholder meetings e.g. Joint Reviews, Social Services (Health) Committee of Parliament and this resulted in a lift on the ban on recruitment in the health sector. About 7,000 HWs recruited in 2013 increasing staffing levels from 58% to 63%. A hard to reach/stay strategy and the motivation and retention strategy developed and operationalized. The revised VHT Strategy was launched and VHT established fully in 75% of districts. Only 55% of villages/wards have trained VHTs which is below the target of 75% for 2012/13 FY.

- The UNMHCP is delivered in an integrated manner. The major programmes e.g. Malaria, TB, HIV/AIDS, EPI have maintained the role of technical supervision and programming however, at district level the integrated approach is applied.

- Management structures were clearly defined and Governance and Management Structures guidelines for the MoH were developed. The Planning guidelines were revised and disseminated to all Local Governments.

- With the support of the GFTAM a regional structure to support planning, monitoring and supervision of health services delivery was proposed and the MoH is in the process of establishing and functionalizing this structure.

- The Resource functions of information management and dissemination was strengthened by adopting the DHIS-2 as the official MoH web-based aggregate reporting tool for health facility data. The DHIS-2 can be accessed by all levels as and when access is given.

- The performance of central level institutions is monitored regularly through the quarterly health sector performance reviews.

- Strengthen Organization and Management

- Developed a comprehensive M&E Plan for Implementation of the HSSIP with clear indicators, taking onto consideration disaggregation by sex and age.

- Customized and rolled out the electronic system of reporting HMIS data using the web-based District Health Information Software (DHIS)-2 to all districts. All District Biostatisticians and HMIS Focal Persons were trained in use of the DHIS-2.

- Data demand and use manuals were developed and 34 districts trained to improve sharing at district level and lower levels.
• Introduction of e-health innovations e.g. mTRAC, U-reporting
• Revision of HMIS tools e.g. Mother-Child health Passport and registers. Printing and distribution of HMIS tools recentralized to NMS.
• Support to train private sector partners and stakeholders in the DHIS-2 has been secured and training scheduled for 2013/14 FY.

Create culture of applying Health Research to guide policy and management

• UNHRO developed the National Health Research Policy and Strategic Plan. The research agenda is still under development. Mapping, capacity assessment and inventory of institutions that conduct health science research was done.

Review and develop policies, Acts and regulations

• Reviewed or developed of a number of policies related to health some of which are still in progress e.g. Medical Legal Policy, HR Training Policy, National Health Insurance Bill, Immunization Policy, Immunization Bill (Private Members of Parliament), Mental Health Policy, Mental Health Bill, Tobacco Control Policy, e-Health Policy and Strategy, Indigenous and Complementary Medicines Bill, PPPH National policy finalized (March 2012); Draft National Health financing Strategy, Health Tertiary Institutions Bill. The Public Health Act is under review. Preliminary stage in development the Joint Health Professional Council Bill and Uganda Heart Institute Bill.

• Consultations for policy development in MoH and key stakeholders conducted mainly with support from Development Partners.

• Established a District Supervisory Authority to support the inspection and monitoring function of the Professional Councils. Preliminary stages in development of the Joint Professional Council Bill. Reviewed guidelines for establishing and operating private guidelines and made recommendations to the health training institutions for improving quality of training.

Build and harmonize Public Private Partnerships

• The PPPH policy was approved by the Cabinet and disseminated. The Implementation guidelines are being revised.

• Streamlined PHC Grant funding transfer to PNFP facilities discussed and will be fully effective by 2013/14.

Strengthen Inter-sectoral collaboration between Ministries

• Other GoU Ministries (e.g. MoES, MoFPED, MoPS, MoGLSD, MoW&H, MoAAIF, MoLG, MoW&E, MoL&UD) and departments (e.g. UBOS) are invited to participate during the NHAs and JRMs or relevant planning meetings. Adhoc inter-departmental consultations initiated for specific tasks or problems.

Implement the plan through IHP principles and SWAps through single harmonized in-country effort.

• Financial management procedures reviewed and implemented. Developed the Country Roadmap for Implementation of the Accountability Framework.
Main Challenges/Good Practices:

- Extension of HMIS to the entire private sector and operation of the Community Based-HMIS
- Operationalization of the National Health Research Strategic Plan is still pending development of the research agenda.
- Capacity of the sector including the Policy Analysis Unit with regard to enforcement of legislations and policies, including regulatory bodies is curtailed due to inadequate human resources, inadequate facilitation including communication, obsolete laws and decentralization (share of responsibilities between central and decentralized level).
- Weak coordination and stewardship capacity for PPPH at the MoH limited by the absence of human resources dedicated to PPPH.
- The issue of intersectoral collaboration with the line Ministries remains unacceptably weak, especially with regard to addressing the social health determinants which are of increasing importance due to modification of the epidemiological profile of the country as a result of the growth and development, and increase of the life expectancy at birth.
- Capturing information on off budget funding by Development Partners is still a big challenge.
- Regular performance reviews conducted and priority actions identified resulting in increased funding for medicines and human resource however, the budget allocation does not allow to fully address implementation of key interventions that remain essential to achieve the HSSIP and MDG objectives.

Conclusions:

- The health sector has made significant progress towards deepening health stewardship in the areas of HR recruitment, PPPH, alignment and harmonization of partners and accountability.
- There has been support towards some major policy orientations like PHC using the VHTs but concrete results are still to be demonstrated.
- Notwithstanding progress already made, there is strong need for improvement in the areas health financing, information management, research, implementation and enforcement of policies and regulations.
- The weakest aspects of stewardship addressed in this report are intersectoral collaboration and information on financial flows between the health sector and some partners.

Implications for policy adjustments:

- The stewardship of the MoH should be improved through the acceleration of approval procedures for the bills and policies.
- Ways and means to improve the enforcement capacity of the health sector should be discussed and adopted before the end of the HSSIP 2010/11 - 2014/15.

There is an opportunity to increase the stewardship of the MoH by revitalizing the MoH Health Partner Coordination mechanism (HP Coordination Unit).
CHAPTER EIGHT

Health Investments:
The HSSIP explicitly singled out the following domains for key investments in the 5 year period:

Pharmaceuticals and health supplies, Health Infrastructure, Health Education and Promotion; Environment health and Nutrition, Health Information System M & E, and Human Resources for Health Management and Operations.

Assessment of Financing and Investments in the last 3 years of HSSIP:

Health sector Government allocation
Government allocation to the health sector over the HSSIP period has steadily increased from Ush 735.76bn in FY in 2010/11 to Ush 835.22bn in FY 2012/13 and are projected at Ush 1,127.3bn for FY 2013/14.

Government health sector allocation over the HSSIP mid-term Ush.Bn)

As shown in the figure above, there has been a steady nominal increase in government allocations to the health sector. However, the per capita government funding and the share of the government budget allocated to the health sector have reduced as shown in the figure below.
The per capita government allocation to the health sector and the sector allocation as a percentage of the total government budget respectively reduced from USD 9.4 to USD 9 and 8.9 to 7.8 from FY 2010/11 to FY 2012/13. A fall in the per capita allocation to health implies that the ability of the sector to provide a package of health services to every Ugandan necessarily diminishes. This, coupled with a reduction in the sector allocation as a percentage of the total government budget, implies that there is need for extra government commitment in order to provide a minimum package of services to every Uganda which is projected at a minimum USD 40 for the HSSIP period.

**Health sector Investments (2010/11-2012/13)**

The projected cost for financing the capital and recurrent inputs for the HSSIP in the FY 2012/13 was Ush. 2,894.1 bn. Public investments into the health sector for the FY 2012/13 were Ush. 852.2 bn. Donor off-budget funding to the health sector is projected to be at least twice the public investment according to the results of the National Health Accounts 2008/9 and 2009/10. Therefore, the total investment in health by both the government and donors for FY 2012/13 is estimated at 2,556.6 bn. The donor off-budget funding to augment investments projected in the health sector is estimated at Ush. 1,039.57 bn in FY 2012/3. This brings the total investment to finance health inputs at Ush. 2,041.8 bn in FY 2012/13. This leaves a gap of Ush. 852.25 bn to finance the projected health inputs in the HSSIP for the FY 2012/13 alone.

However, given the alignment challenges of off-budget funding, its effect is not likely to match the critical inputs including human resource training, attraction, retention; medical products, health infrastructure.

**PRIMARY HEALTH CARE GRANTS FY 2000/2001-2012/13**

All figures in Billions of Shs.

<table>
<thead>
<tr>
<th>FY</th>
<th>PHC (WAGES)</th>
<th>PHC (NON-WAGE)</th>
<th>PHC NGOs (PNFP)</th>
<th>GENERAL HOSPITALS</th>
<th>PHC (DEV'T GRANT)</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000/01</td>
<td>9.6</td>
<td>8.8</td>
<td>6.7</td>
<td>6.3</td>
<td>10</td>
<td>41.4</td>
</tr>
<tr>
<td>2001/02</td>
<td>35</td>
<td>14.9</td>
<td>11.6</td>
<td>8.9</td>
<td>11</td>
<td>81.4</td>
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<td>2002/03</td>
<td>43.9</td>
<td>19.7</td>
<td>16.7</td>
<td>8.7</td>
<td>7.6</td>
<td>96.6</td>
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<td>2003/04</td>
<td>44.7</td>
<td>23.2</td>
<td>17.7</td>
<td>10.4</td>
<td>9.2</td>
<td>105.2</td>
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<td>2004/05</td>
<td>68</td>
<td>23.2</td>
<td>17.7</td>
<td>10.4</td>
<td>6.1</td>
<td>125.4</td>
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<td>2005/06</td>
<td>72</td>
<td>22.4</td>
<td>17.7</td>
<td>10.4</td>
<td>5.9</td>
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<td>2006/07</td>
<td>74.6</td>
<td>22.9</td>
<td>17.7</td>
<td>10.6</td>
<td>6.1</td>
<td>131.9</td>
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<td>2007/08</td>
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<td>17.7</td>
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<td>15.84</td>
<td>17.19</td>
<td>5.94</td>
<td>34.81</td>
<td>243.16</td>
</tr>
</tbody>
</table>

Source: Approved Budget Estimates of Revenue and Expenditure- MOFPED. Excludes credit line for medicines and health supplies
### Projected Health Sector Investments (Ugx in billions) to achieve HSSIP Objectives

<table>
<thead>
<tr>
<th>Investment area</th>
<th>HSSIP target for FY 2012/13</th>
<th>GoU allocation FY 2012/3</th>
<th>Gap after GoU funding</th>
<th>Comment on 2012/13 allocation</th>
<th>Recommendations/Prospects by the end of HSSIP period</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HRH</strong></td>
<td>889</td>
<td>252</td>
<td>637</td>
<td>Includes MOH training (16.632bn) and sector wage. Training and other human resource investments have benefited from other funds from WB, Belgian support and USAID.</td>
<td>Government has included Ushs. 70.54bn in the budget for FY 2013/14. More investments are expected for training health workers</td>
</tr>
<tr>
<td><strong>Infrastructure</strong></td>
<td>633</td>
<td>244</td>
<td>390</td>
<td>Includes MOH Infrastructure, Butabika allocation and general capital development</td>
<td>Funds for infrastructure need to be identified especially to ensure that the existing one is well maintained and full functional. Detailed health sector infrastructure investment needs to be identified for both public sector and otherwise and leverage existing PPPH frameworks to attract private players to fill existing gaps</td>
</tr>
<tr>
<td><strong>Pharmaceuticals</strong></td>
<td>956</td>
<td>247</td>
<td>709</td>
<td>Government funding to Pharmaceutical is mainly to NMS (208bn) and MOH products (38.27bn), however, govt also receives products in kind from donors like the Global Fund, GAVI and other partners</td>
<td>Need to track all off-budget funds for pharmaceuticals and mobilize resources to fill any gaps.</td>
</tr>
<tr>
<td><strong>Operational costs including HMIS and HP&amp;E</strong></td>
<td>415</td>
<td>111</td>
<td>305</td>
<td>HMIS, HP&amp;E activities benefit from other off-budget support in HMIS tools, e-health and m-health support and disease prevention and VHT support etc.</td>
<td>Efforts need to be put to identify resources to especially fund disease prevention and harness efficiency gains from intra-functional allocations</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2,894</td>
<td>852</td>
<td>2,042</td>
<td>Estimate of Actual Gap=2041.778- (82%*1039.57bn)= 858.252. Donor funding for donors are expected to be atleast twice the government funding (From NHA). Donor funding = Public funding (630.79bn)*2 = 1,261. Off budget (1039.57) = Total (1,261bn) minus on-budget (=221.43). From NHA 82% of donor off-budget is spent in NGOs and PNFPs, 18% in government.</td>
<td>All efforts need to be put in place to fill the gap created by the deficit of Ush. 858bn (for FY 2012/13) and probably higher onwards in order to adequately finance the HSSIP on the basis of costs projected at HSSIP planning.</td>
</tr>
</tbody>
</table>
**Recommendations:**

1. In order to able to achieve the HSSIP targets, there is need for extra efforts to;
   - Track off-budget resources and align them better to sector priorities necessary to achieve sector targets
   - Promote allocative efficiency and re-prioritize sector interventions and programs that have the maximum impact in achieving sector goals.

2. Going forward, there is need to for the public health sector to design a good investment plan to stimulate private sector actions that will fill key investment gaps in infrastructure and technologies that will save the country a lot of resources currently lost in referrals abroad.
CHAPTER NINE

e-HEALTH:

The profile of technology or eHealth initiatives and activities in the Uganda health was not coordinated effectively. An analysis of the eHealth environment had the following summary conclusions:

- There was a significantly high number of uncoordinated eHealth Initiatives (+60).
- The eHealth initiatives were driving investment in the health sector in multiple and different directions.
- The degree of impact of each eHealth initiative was not adequately quantified.
- It was difficult to coordinate all the eHealth initiatives to ensure maximum impact individually and collectively.
- Furthermore, for interconnected eHealth initiatives, it was difficult to transition from one e-Health initiative or solution to another or even to integrate the outcomes to ensure systemic and comprehensive sustainable impact.
- The total cost of ownership per project and per environment was not clearly quantified and/or managed which made effective governance of impact a difficult goal to attain.
- The inadequate quantification of the Total Cost of Ownership had the result that funds to extend currently running projects or to initiate new ones could not be effectively raised due to the lack of sufficient clarity in terms of direction, impact and total cost of ownership.
- The described eHealth environment made it difficult to build and nurture effective partnerships in all aspects.

In response to the large number of health related ICT (eHealth) projects across Uganda, the MoH issued a moratorium on all e-Health projects in January 2012 until these projects can be evaluated and approved by the newly formed MoHeHealthTechnical Working Group.


The Ministry of Health has initiated a number of interventions in order to address the challenges in the health sector. The cornerstone for all the eHealth initiatives is the creation of effective world class Resource Center. The primary objective is that technology is utilised in a manner that accelerates the delivery of health services to all stakeholders in the country.

There are essentially three major phases to the achievement of the national eHealth Strategy goals which is essentially “Same Quality and Visibility of Care in Every Location” :Stabilise, Modernise and Extend.
### STABILISE (Create a strong foundation of policy, processes, strategy and systems to enable the creation of a World Class Health Information Services capability within the Ministry of Health)

<table>
<thead>
<tr>
<th>Key Intervention</th>
<th>Key Deliverables</th>
</tr>
</thead>
</table>
| 1. Moratorium on all eHealth Activities: This is the placement of a stop on all eHealth activities | • Elimination of unnecessary and uncoordinated eHealth programs  
• Ensure that interim “special approval” is given to aligned eHealth programs |
| Key Responsibility: Ministry of Health | |
| 2. Development of National eHealth Policy, Strategy and Governance models: This is focused on providing guiding principles to facilitate coordinated design, implementation and management of eHealth programs | • National eHealth Policy model  
• National eHealth Strategy model  
• National eHealth Governance model |
| Key Responsibility: Ministry of Health | |
| 3. Development of National eHealth Technology Framework: This is focused on providing guiding principles to facilitate coordinated design, implementation and management of eHealth technology systems | • National eHealth Technology Framework  
• National eHealth Technology roadmap  
• National eHealth Roadmap Implementation Governance Structure |
| | |
| 4. Stabilisation of the Ministry of Health Resource Center: This is the replacement of obsolete or out of service or damaged key technology components and critical operational and human resource elements within the Resource Center | • Stable MOH Resource Center Data Center  
• Recruitment of minimum Human Resource skills and capacity  
• Acquisition of minimum secure space  
• Transfer key systems being managed outside MOH Resource Center |

### MODERNISE (Design, Test and Implement centralised system which can be cost effectively shared across the country by all health facilities, both private and public.)

<table>
<thead>
<tr>
<th>Key Intervention</th>
<th>Key Deliverables</th>
</tr>
</thead>
</table>
| 1. Finalise ICT4MPOWER: This is focused on the completion of the software focused on Community Health Systems and Health Facilities developed jointly with Karolinska University, Sweden. | • Complete the development of the 16 modules in the current version of software to include all the comments and updates  
• Finalise the legal framework of ownership  
• Finalise the testing of developed software |
| | |
| 2. National Health Information Shared Services: This is focused on building the centralised capability to host all health facilities across the country and ensure similar access to world class systems | • Primary and Secondary Data centers  
• Private Health Cloud Hosting  
• Health Facilities Tools and Systems  
• Village Health Team tools and systems  
• Emergency Operations Center tools and systems |
| | |
| 3. Health Facility and Community eHealth Readiness Assessment and Investment plan: This is focused on the evaluation of every health facility against the minimum requirements for a successful eHealth environment | • Development of minimum eHealth standards for each type of facility  
• Evaluation of every facility by type across the country  
• Estimation of the cost of upgrading and investment for each facility across the country |
<table>
<thead>
<tr>
<th>Key Intervention</th>
<th>Key Deliverables</th>
</tr>
</thead>
</table>
| 1. National Roll-Out program: This is the roll out of the modernised environment to every part of the country based on centralised hosting model | • Public Facilities roll out  
• Private Facilities roll out |
| 2. National Health Insurance: This is the collaboration with the national health insurance program to ensure access at all levels across the country | • National Health Insurance solution  
• National Health Insurance technology integration |
| 3. Health Accreditation and Certification Program: This is the creation of a validation system for all health workers, institutions and transactions | • Health transaction validation system  
• Health worker validation system  
• Health facility and service provider validation system |
| 4. eHealth House of Value: This is the implementation of the rest of the pillars in the eHealth House of Value | • National eHealth Research  
• Health Sector comprehensive architecture  
• Health Sector detailed standard operating procedures |

Progress:
The eHealth roadmap has made significant progress in the last 15 months. Achievements to note include the following:
• Significant reduction of uncoordinated efforts and programs in eHealth
• Clear strategic direction and principles governing investment in eHealth
• Accelerated completion of ICT4MPower as a key element of the eHealth architecture
• Increased awareness and interest in funding the improvement of the capacity within the Ministry of Health Resource Center.

**Best Practices / Lessons Learned:**

The following are some of the best practices and lessons learned

• Change efforts must be driven around strengthening and building capacity of an existing government structure
• Proportionally higher time should be spent on planning before implementation
• Unclear budget requirements to run solution will significantly affect development of national infrastructure due to projects not proceeding beyond “Pilot” phase or implementation only being done in a “few districts”
• Strong and dedicated government led implementation governance structures will ensure sufficient focus on outcomes to ensure adequate outcomes are achieved
• Revenue generation is a critical component of design and implementation of eHealth infrastructure to support the raising of investment capital and to ensure that implemented solutions are sustainable
• Extended collaborative partnerships are a key element to obtain the minimum scale of skills and financial capacity to support capital raising, implementation, maintenance and upgrading of the appropriate eHealth infrastructure.
• Appropriate research and adaptation of global experiences and solutions is critical to ensure that solutions and infrastructure relevant to the Ugandan context without compromising world class standards are implemented.

**Key Issues / Challenges:**

• **Hosting Environment:** It is critical to the continued development of eHealth infrastructure that a health information shared services environment is created to support the entire country and all stakeholders.

• **Skills Capacity:** The range of focus areas and depth of technical issues that have to be addressed demands that a broad range of technical skills is attracted and retained.

• **Finance:** The comprehensive eHealth House of value and roadmap requires a significant amount of sustained investment for both implementation and operation/maintenance of the infrastructure.

• **Revenue:** Alternative sources of funding apart from the traditional government or development partners should be obtained in order to fund the minimum components of the eHealth infrastructure investment and to contribute and ensure sustainability of the deployed solutions. Generating higher levels of revenue due to deployed eHealth solutions therefore becomes one of the key priorities and challenges to be addressed.

• **Implementation Structure:** The range and breadth of implementation areas is extensive and the implied number of projects and activities numerous. This requires that a dedicated implementation structure is setup within the Ministry of Health Resource Center to ensure
that continued focus is maintained without distraction from day to day responsibilities which are also growing in scale and depth.

- **Stakeholder Management**: The involvement and consistent communication of the status and value of outputs from the eHealth roadmap is a key component in building understanding, support and involvement of all stakeholders.

**Recommendations:**

- **Accelerated Implementation of the eHealth roadmap**: The implementation of the outlined eHealth roadmap should be started with urgency so that the defined value and benefits to the people of Uganda are achieved.

- **Focused Implementation Structure**: An implementation structure/program within the Ministry of Health Resource Center should be setup to manage on a day to day basis the implementation of the eHealth Roadmap.

- **eHealth Infrastructure Assessment**: Assessment of the readiness and the requirements for each health facility should be done in preparation for roll-out and to also assess the scale and priority of investment in each health facility across the country.

- **eHealth Revenue Model and Business Case**: In parallel with the infrastructure assessment, a detailed operation and financial business case with a revenue generation perspective should be developed as a foundation for possible public private partnerships focused on building sustainable eHealth infrastructure.
## ANNEXES:

### A) INVESTMENTS IN HEALTH INFRASTRUCTURE, PRDP

#### 1) SECOND NORTHERN UGANDA SOCIAL ACTION FUND (NUSAFT1):

**COMMUNITY INFRASTRUCTURE REHABILITATION (CIR); MID-TERM REVIEW BRIEF**

**Health Sector**

**Table 3a: Funds Approved and Disbursed for CIR Subprojects in the Health Sector – June 2013**

<table>
<thead>
<tr>
<th>SN</th>
<th>DISTRICT</th>
<th>NO. OF SUBPROJECTS</th>
<th>APPROVED BUDGET (UGX)</th>
<th>AMOUNT-1ST TRANCHE (UGX)</th>
<th>AMOUNT-2ND TRANCHE (UGX)</th>
<th>TOTAL AMOUNT DISBURSED (UGX)</th>
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<td>Total Expenditure</td>
<td>Total Budget</td>
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<td>3,602,486,374</td>
<td>21,501,742,945</td>
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</table>
2) Implementation status in Health Sector as at 31st March 2013

<table>
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<tr>
<td>Pre-Construction</td>
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<td>14</td>
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<td>Roofing</td>
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<tr>
<td>Finishing</td>
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<tr>
<td>Completed</td>
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<td><strong>75</strong></td>
<td><strong>203</strong></td>
<td><strong>249</strong></td>
</tr>
</tbody>
</table>

Source: District Quarterly Reports & Output Tracking Data, as at March 31st, 2013 [OPM].