CIVIL SOCIETY ORGANISATION (CSO)

Shadow Report on the Performance of the Health Sector in 2011/2012

ACTION GROUP FOR HEALTH, HUMAN RIGHTS AND HIV/AIDS (AGHA) - UGANDA

CONTENTS

ACRONYMS

AGHA	Action Group for Health, Human Rights and HIV&AIDS
AHSPR	Annual Health Sector Performance Report
AIDS	Acquire Immunodeficiency Syndrome
ART	Antiretroviral Treatment
CSO	Civil Society Organization
DHO	District Health Office
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HSSIP	Health Sector Strategic Investment Plan
MoH	Ministry of Health
NHP	National Health Policy
PMTCT	Prevention of Mother to Child Transmission of HIV
PNFP	Private Not for Profit
SARA	Service Availability and Readiness Assessment
TB	Tuberculosis
THE	Total Health Expenditure
UWOCASO	Uganda Women's Cancer Support Organization
WHO	World Health Organization

EXECUTIVE SUMMARY

Introduction and Background

The Action Group for Health, Human Rights and HIV&AIDS (AGHA) is a health rights advocacy organization in Uganda dedicated to raising awareness of the human rights aspects of health, and improving the quality of health and healthcare for all Ugandans. It is underpinned by the principles of the rights-based approach to mobilize health professionals, in collaboration with communities, in health rights advocacy for promoting equity and social justice for all Ugandans.

Led by AGHA and comprising of various human rights organizations, the Civil Society Shadow reporting initiative on the performance of the Health Sector started way back in 2010. The aim of Shadow reporting is to provide the Civil Society Organizations' (CSOs) view on performance of the Health Sector in order to improve health outcomes. One of the objectives of Shadow reporting is to engage CSOs in monitoring and evaluating health sector performance independently.

The goal of the Shadow reporting initiative is to improve the capacity of CSOs to meaningfully engage with government and development partners on health policy processes within the International Health Partnerships (IHP+) framework in Uganda and contribute to efficiency and effectiveness in health service delivery.

Uganda has made progress in improving the health of its population where the life expectancy increased from 45 years in 2003 to 52 years in 2008; HIV prevalence reduced from 27% to 7.3% between 2000 and 2011 and the prevalence of other vaccine preventable diseases has declined sharply. Between 1995 and 2005, under-five mortality rate declined from 156 in 1995 to 137 deaths per 1,000 live births; infant mortality rate decreased from 85 to 75 deaths per 1,000 live births; and maternal mortality rate reduced from 527 to 435 per 100,000 live births. Teenage pregnancy estimated at 25% in 2006 significantly contributed to overall maternal mortality rate in Uganda. The new born mortality rate was 33 per 1,000 live births in 2000 and decreased to 29 in 2006. Despite improvements, these indices remain high. The Annual Health Sector Performance Report 2011/12 further reveals that malaria, malnutrition, respiratory tract infections, AIDS, tuberculosis and perinatal and neonatal conditions

remain the leading causes of morbidity and mortality. Seventy percent (70%) of overall child mortality is due to malaria, (32%) perinatal and neonatal conditions (18%), meningitis (10%), pneumonia (8%), HIV and AIDS (5.6%) and malnutrition (4.6%). Non-Communicable Diseases are an emerging problem; Neglected Tropical Diseases, including those targeted for eradication, are still occurring in Uganda. Seventy five percent of the disease burden in Uganda however is still preventable through health promotion and disease prevention.

Delivery of the Health Sector Strategic Plan III is enshrined in the Uganda National Minimum Health Care package (UNMHCP). However, unsatisfactory implementation of sectoral policies and strategies and weak enforcement of existing legislation are underpinned by the critical shortage of human resources for health, inadequate funding to the health sector to effectively deliver the UNMHCP, and train, recruit, deploy and maintain and adequately motivate health care workers; and redundancy or limited impact/interest for the policy.

This shadow report aimed to establish the progress in implementation of Health Sector Strategic Investment plan in FY 2011/12 in view of the UNMHCP priorities ass elaborated in the UNMHCP under the Health Sector Budget Framework Paper for FY 2012/13. It further outlines the emerging issues which will act as advocacy areas for ensuring improved quality of health services delivered to the population.

Methodology

This was a cross-sectional study which applied qualitative and quantitative methods of data collection covering 21 districts in the five regions of the country. Data was collected from 47 health facilities. The study focused on selected indicators of the HSSIP III on; HIV&AIDS, TB & malaria; human resources for health; essential medicines and health supplies; non communicable diseases; reproductive health; and health financing.

Limitations

This assessment focused on selected performance indicators of the Health Sector Strategic Investment plan III based on AGHA's mandate leaving out other areas of the health sector.

SUMMARY FINDINGS

Districts and Health facilities covered

The assessment covered 21 districts including 3 in the Central region (Lwengo, Mukono and Masaka); 6 in the West (Buliisa, Bushenyi, Kabarole, Kasese, Kiryandongo and Kyenjojo), 6 in the East (Bukedea, Iganga, Namutumba, Soroti, Budaka and Bugiri) and 6 in the North (Nebbi, Gulu, Amuru, Nwoya, Dokolo and Lira) as illustrated in Figure 1. In all the districts, 47 health facilities were visited including 5 regional referral hospitals, 10 District hospitals, 7 HC IVs, 21 HC IIIs and 4 HC IIs. Of these, one was a private teaching hospital in Bushenyi while 4 were faith based HC IIIs.

FINDINGS BY THEMATIC AREAS

HIV & AIDS, TB and Malaria

The percentage of adults and young people with access to male condoms was 78% as achieved under the MoH. The assessment established that access to condoms was 63% for males. Women condoms while they were available in some of the health facilities, access levels were 4%. Awareness of the use of female condoms was low in the community. The male condoms were on high demand resulting into frequent stock-outs.

The percent of TB patients on treatment in health facilities stood at 45% as indicated in the AHSPR 2011/12, while the assessment findings revealed 42% of health facilities providing the service. Access to TB services is still limited especially at HC II level; this is further compounded by the frequent stock out of one or two drugs due to late delivery.

The annual target of districts with neonatal tetanus rates reduced and maintained at zero was 100%, but there were not achievement figures in the AHSPR report. The assessment finding however revealed that 19/21 (90.5%) of the surveyed districts reported zero cases of neonatal tetanus. This is in addition to strengthened EPI cold chain supervision at districts and training of health workers on post certification interventions.

Human Resources for health

The severe shortage of health workers, the inequalities in urban-rural distribution, inadequate facilities at health units demotivates workers in addition to poor remuneration have contributed toward the high rates of attrition. A combination of these factors has resulted into the perpetually high levels of deaths due to preventable diseases. From the Annual Health Sector Performance Report 2011/2012, the percent of approved posts filled by skilled health workers was 58% compared to 56% during the previous financial year. The assessment findings indicated 51% of the posts filled.

The staffing levels were higher in the Regional Referral Hospitals (72% from the AHSPR 2011/2012). This closely related to the assessment findings where the staffing levels stood at 70%. The difference was due to staff transfers given the different timings between the MoH assessment and this study. Functionality of VHTs was not uniform in all districts due to limited resources. Support by CSOs ought to be directed in this area to support government.

Essential medicines and health supplies

The 6 trace medicines used by MoH in the annual performance reviews were used for this assessment. They included ACT, measles vaccine, ORS Sachets, Cotrimoxazole, Depo-Provera and Sulfadoxine/Pyrimethamine. There was a high level of availability of the tracer medicines in all health facilities, the lower health facilities especially HC IIs accounted for the draw back in performance.

Non Communicable Diseases

To date, there is neither an NCD Policy nor a strategic plan and standards and guidelines are available to guide interventions. It is high time that focus is put in addressing NCDs in Uganda by having the relevant policy, plan and guidelines. Save for HC IIIs and HC IIs, other health facilities had essential mental health and anti-epilepsy drugs in addition to trained staff. This findings portrays a big burden of mental health problem in the country whose management needs due attention. The need for strengthening control of mental health cannot be overstated given the increasing trends in incidence. Having appropriate legal and policy frameworks will enhance mental health service provision at all levels.

Reproductive health

From the AHSPR 2011/2012, three in four facilities provided antenatal care services which included IPT, and iron and folic acid supplementation. In the same report, few facilities had all eight tracer items for delivering ANC services; the overall readiness score was 64%, indicating that on average facilities had five of the eight tracer items. Furthermore, Nine in ten facilities had folic acid and iron tablets in stock; however, three in ten facilities providing ANC did not have tetanus toxoid available on the day of the assessment. Compared to the assessment findings, 53% of the health facilities visited had not experienced stock out of essential RH medicines over the last quarter of the last financial year. The low score was due to the high stock out rates in HC IIIs and HC IIs which provide basic reproductive health services. All HC IIIs and HC IIs had limited availability of guidelines and trained staff to a level of 33%. Inadequate staff was due to the rural nature of most districts.

Provision of adolescent RH friendly services was only in Regional Referral and district hospitals. While the other health facilities provided RH services, they were not friendly to the adolescents due to lack of sufficient physical facilities and inadequate human resources. The proportion of health facilities with basic and those with comprehensive emergency obstetric care was 15/47 (32%) including 5 regional referral hospitals and 10 District hospitals. All HC IVs visited were unable to provide these services on account of lack of skilled human resources and inadequate equipment.

The proportion of pregnant women accessing comprehensive PMTCT package depended on the number of health facilities which were delivering the service. There was an increase in PMTCT reporting level from 70% in 2010/11 to 75% in 2011/12 FY. From the assessment, the percentage of women accessing PMTCT services was 74% given that some of the HC IIIs and HC IIs were not providing the service. The percent of districts with reduced unmet need for family planning services stood at 34% during 2011/2012 FY. The assessment finding showed an average of 32% which was close to the national figure.

Apart HC IIs, all other health facilities had between 3 to 6 staff trained in EMOC, MPDR, MIP, ASRH, RH/HIV integration and focused ANC. This figure was even higher in the regional referral and district hospitals with a range of between 7 to 12; the lower being in district hospitals while the higher in the RRHs. This was due to limited number of staff in the health facilities and the high attrition rates plus frequent transfer of staff.

The assessment findings showed that only 2 out of 21 districts did not have RH Policies, laws and guidelines. These were Lwengo and Nwoya which even did not have substantively appointed staff in the District Health Office.

There is minimal involvement of Civil Society in DHMT meetings. When they take place, they do not comply with the planned quarterly schedules. The implication of irregular meetings and minimal involvement of CSOs and development partners is the lack of transparence and poor accountability which affects effective service delivery.

Health Financing

In Uganda, funding modalities under the sector wide approach include on budget and off budget support. With on budget support, the conditions, dialogue and the follow-up of results focus mainly on sector-specific issues. The development partners' on-budget support to the health sector for FY 2011/2012 amounted to 206.10 bn Uganda shillings. On budget support is in line with the sector wide mechanism that was established to align funding to sector priorities. This maximizes efficiency in health improving activities and reduces losses associated with funding activities that may be duplicative or outside the priorities identified to achieve health outcomes. Generally, donors support to NGOs (Off budget support) increased during the last two financial years. This has implications in the ability of the MoH to monitor financial use and minimizing duplication of services. Reliance on donor funding by MoH and CSOs remains a major weakness in health service delivery in Uganda.

Even with increase in the expenditure, from 16 US$ per person in 1999 - 2000, to the current total expenditure on health of over US$ 27 per person per year; it is still less than US$ 44 per person per year recommended by WHO. Given the late disbursement of funds to DLGs and budget cuts, a number of activities are dropped while those which are implemented suffer delays. Weaknesses in the LG capacity in areas of financial reporting, leadership, financial management and low absorptive capacity combined to adversely impacts on the efficiency and effectiveness of service delivery especially in the new districts.

RECOMMENDATIONS

HIV & AIDS, TB and Malaria

- Delivery of PMTCT services should be scaled down to HC IIs in order to improve service access.
- Capacities of HC IVs and HC IIIs to deliver comprehensive HIV&AIDS services should be enhanced. This should take into account capacity to provide safe male circumcision, and laboratory diagnostic services

Human Resources for Health

- The GoU should increase budget allocations for recruitment of more health workers in order to improve the quality of health care especially in the rural and young districts. To this end, the ban on recruitment should be lifted.
- Technical support supervision by the MoH to districts and DHO's office to health facilities should be strengthened through appropriate resource allocations. This will improve on staff performance for improved service delivery.
- DLGs should be supported to strengthen their capacities to effectively plan, budget and absorb resources for health. Particular emphasis should again be placed on young DLGs.
- All new districts should be supported to constitute district service commissions, supported to implement their mandate through orientation and availing the human resources for health code of conducts and ethics; and guidelines for recruitment of health workers
- DLGs should be supported to constitute and functionalize VHTs given their roles on PHC at community level.
- Motivation, retention and training of health workers needs to be scaled up
- Hard to reach policy for HRH need to be revised for effective implementation process.

Essential Medicines and health Supplies

- While data shows a high level of availability of the tracer medicines in all health facilities, more efforts should be put into ensuring that HC IIs are equally supported. This will entail review of the last mile delivery system by JMS as a measure of minimizing stock outs.

Non Communicable Disease

- The process of developing the national policy on NCDs should be expedited in order to guide DLG and other development partners on disease management. Absence of this policy has compromised resource allocation and prioritization of NCDs especially in rural districts.

Reproductive Health

- With the current high MMR and IMR, more resources should be put into RH service delivery. Particular emphasis should be put into provision of adolescent reproductive health friendly services.
- Health facilities should be equipped to provide routine ANC, basic and comprehensive emergence obstetric services. This should involve reskilling and retooling health workers in addition to provision of the necessary equipment. This will improve community confidence in the health facilities and increase supervised deliveries.

Health Financing

- GoU should increase funding for the health sector in line with Abuja declaration of 15% of the total budget. To this end, CSOs should intensify their advocacy efforts to ensure government makes health a priority.
- The GoU should ensure that all development partners direct their funding to the health sector through on-budget support and minimize off-budget support interventions. This will minimize duplication of efforts and endure resources are directed towards national priorities.
- The MoH and Ministry of Finance should design capacity building interventions to strengthen for DLGs technical efficiency in resource management. This will improve on accountabilities and reporting which are important in timely disbursements.
- MoH should improve on accountability of donors funding given the findings of the Auditor General's report on mismanagement of donor funds e.g. Global Fund among others.
- The Ministry of Health should put in place the Health insurance policy and scheme
- National HIV&AIDS fund be established to enhance access to HIV&AIDS prevention, care and treatment in the country.
- Results-based financing programs be adopted by donors to address the challenges of high fertility, poor child and maternal health and nutrition

Who is behind this Report

This report is the product of participatory process in which over 50 civil society organization based in Kampala were invited to submit and to invite their partners to submit. The following list of civil society organization **(in alphabetical order)** encompasses those that have participated in planning, submitted contributions, or validated the report.

- Action Group for Health, Human Rights and HIV, AIDS (AGHA)
- Basic Needs Uganda
- Coalition for Health Promotion and Soical Development (HEPS)
- Commmunity Health and Information Network (CHAIN)
- Epilepsy Support Association Uganda
- Health Rights Action Group
- International Federation of Health & Human Rights Organizations
- National Care Centre (NACARE)
- National Community of Women Living with AIDS (NACWOLA)
- Sickle Cell Association Uganda
- Traditional and Modern Practitioners Together Against AIDS (THETA)
- Uganda Women's Cancer Support Organisation (UWOCASO)
- DSW Uganda
- SALT
- NAFOPHANO

CHAPTER ONE

Introduction

1.1 Introduction

The Government of Uganda developed a new National Health Policy (NHP 2010) II and the Health Sector Strategic Investment Plan (HSSIP) III in 2010. A country compact for the implementation of the HSSIP was developed and signed by not only Development partners, Government representatives but also by CSO representatives. The country compact requires CSOs to independently monitor the implementation of both the HSSIP and the country compact.

Led by the Action Group for Health, Human Rights and HIV&AIDS (AGHA) and comprising of various human rights organizations, the Civil Society Shadow reporting initiative on the performance of the Health Sector started way back in 2010. The aim of Shadow reporting is to provide the Civil Society Organizations' view of the performance of the Health Sector in order to improve health outcomes. This will be achieved through CSO concerted engagement in policy development, and monitoring implementation. One of the objectives of Shadow reporting is to engage CSOs in monitoring and evaluating health sector performance independently of Government. CSOs have formed a Working Group to enable them to constructively engage in health policy processes and to hold donors and government accountable. The Working Group has developed a number of policy briefs. These include a review of the health sector country compact, the development of a CSO shadow report to the Annual Health Sector Performance Report, and had a number of meetings with policymakers at the Ministry of Health (MoH) and health sector in general. The Working Group has decided to develop a CSO shadow report to the annual health sector performance report annually.

The goal of the Shadow reporting initiative is to improve the capacity of civil society organizations (CSOs) to meaningfully engage with government and development partners on health policy processes within the International Health Partnerships (IHP+) framework in Uganda and contribute to efficiency and effectiveness in health service delivery.

Each year, AGHA in partnership with other health rights based organisations provides a complementary 'Shadow' report representing it's assessment of the Uganda Government's progress against its targets stated in the

Health Sector strategic Investment Plan III. This is the third CSO Shadow Report since the inception of the initiative in 2010. The findings from this study will inform advocacy efforts of CSOs in engaging the government and donors to be committed in the implementation of the national health policies and plans. This will contribute to assessing the extent to which the government and donors are fulfilling their promised they made in the country compact they signed under the International Health Partnership (IHP+) agreement in 2009.

In relation to the Health Sector commitments, this shadow report draws from the previous year's Annual Health Sector review report with focus on HSSP III indicators on; HIV/AIDS, TB & Malaria; Human Resources for Health; Essential Medicines and Health Supplies; Non Communicable Diseases; Sexual and Reproductive health; and Health Financing.

Chapter one provides the introduction and background to the Shadow report and its historical perspective. Chapter two outlines the approach and methodology in compiling the report while the third and last Chapters describe the findings and recommendations respectively.

1.1.1 About AGHA

The Action Group for Health, Human Rights and HIV&AIDS is a health rights advocacy organization in Uganda dedicated to raising awareness of the human rights aspects of health, and improving the quality of health and healthcare for all Ugandans. It is underpinned by the principles of the rights-based approach to mobilize health professionals, in collaboration with communities, in health rights advocacy for promoting equity and social justice for all Ugandans. In this regard, particular focus is directed towards marginalized and vulnerable populations. AGHA has a proven track record of addressing health rights violations in Uganda through policy advocacy-oriented research and analysis, education and training.

Founded in 2003 by a group of concerned Ugandan health professionals, AGHA has mobilized hundreds of members, fostered coalitions and local and national networks, conducted numerous health, human rights and advocacy trainings, and brought human rights awareness to key health and policymaking bodies. Building upon its expertise and knowledge, AGHA has started a nationwide movement of doctors, nurses, other health professionals, public health practitioners, lawyers, social workers, policymakers, government officials, and community members, who are committed to addressing the convergence between health and human rights

in Uganda and throughout the world. AGHA is on the forefront of advancing the right to health in Uganda, and continues to forge the link between health and human rights through trainings, public education campaigns, coalition-building; research and policy advocacy.

1.2 Background

By July 2012, Uganda's projected population was 35,873,253 million is within an area of 241,000 km2 and has an estimated average annual growth rate of 3.582% while economic growth averaged 7% per annum over the last 5 years1. Majority of the population (87%) lives in rural areas. According to the National Health policy 2010, the Total Fertility Rate (TFR) stands at 6.7 birth/woman with a contraceptive prevalence rate of 24%. The country's population is expected to increase to 44 million by 2020 raising the population density from 120 to 164 km2. The exponential population growth will strain the limited national resources including the health sector.

The above demographics notwithstanding, Uganda has made progress in improving the health of its population where the life expectancy increased from 45 years in 2003 to 52 years in 2008; HIV prevalence reduced from 27% to 7.3% between 2000 and 2011. The HIV prevalence is higher among women (8.2%) than among men (6.1%)2; and the prevalence of other vaccine preventable diseases has declined sharply.

According to the Ministry of Health3, between 1995 and 2005, under-five mortality rate declined from 156 in 1995 to 137 deaths per 1,000 live births; infant mortality rate decreased from 85 to 75 deaths per 1,000 live births; and maternal mortality rate reduced from 527 to 435 per 100,000 live births. Under-weight prevalence reduced from 23% to 16% over the same period; stunted growth from 41% to 38.5% and wasting increased from 4% to 6%. Teenage pregnancy estimated at 25% in 2006 significantly contributes to overall maternal mortality rate (MMR) in Uganda. The newborn mortality rate was 33 per 1,000 live births in 2000 and decreased to 29 in 2006[4].

Despite improvements, these indices remain high. The Annual Health Sector Performance Report 2011/12 further reveals that malaria, malnutrition, respiratory tract infections, AIDS, tuberculosis and perinatal and neonatal conditions remain the leading causes of morbidity and mortality.

1 Uganda Demographic Profile 2012
2 Ministry of Health 2011; Uganda AIDS Indicator Survey (AIS)
3 Ministry of Health 2012; Annual Health Sector Performance Report 2011/12
4 Uganda Bureau of Statistics, 2007

Seventy percent of overall child mortality is due to malaria (32%), perinatal and neonatal conditions (18%), meningitis (10%), pneumonia (8%), HIV and AIDS (5.6%) and malnutrition (4.6%). Non-Communicable Diseases (NCDs) are an emerging problem due to multiple factors such as adoption of unhealthy lifestyles, increasing life expectancy and metabolic side effects resulting from lifelong antiretroviral treatment. Neglected Tropical Diseases (NTDs), including those targeted for eradication, are still occurring in Uganda. Gender inequalities including sexual and gender-based violence (UBOS, 2007) remain a major hindrance to improvement of health outcomes. Seventy five percent of the disease burden in Uganda however is still preventable through health promotion and disease prevention.

1.2.1 Social determinants of health

With the percentage of the population living below the poverty line standing at 24.5% in 20125, Uganda is still a low income developing country with income disparities spread across the country. A direct relationship exists between poverty and prevalence of diseases such as malaria, malnutrition and diarrhoea as they are more prevalent among the poor than the rich households (UBOS, 2007). The proportion of households with toilet facilities has increased from 57% in 2004/5 to 88% in 2006 (UBOS, 2007). There is limited physical accessibility of health facilities especially for people with disabilities (PWDs). Health facilities infrastructure is old. Access to health services for women is further compounded by decision-making processes in families: 40% of the women report that their husbands make decisions about their own healthcare (UBOS, 2007).

1.2.2 Health service delivery system

The National Health System (NHS) in Uganda constitutes of all institutions, structures and actors whose actions have the primary purpose of achieving and sustaining good health. It is made up of the public and the private sectors. The public sector includes all Government health facilities under the MoH, health services of the Ministries of Defence (army), Internal Affairs (Police and Prisons) and Ministry of Local Government (MoLG). The private health delivery system consists of Private Health Providers (PHPs), Private Not for Profit (PNFPs) providers and the Traditional and Complimentary Medicine Practitioners (TCMPs).

5 Ministry of Finance, Planning and Economic Development: May 2012; Uganda Poverty Status Report 2012

1.2.3 The policy and legal framework

The Ministry of Health coordinates the drafting of bills and policies to promote and regulate health services. There are various bills at different stages of development which include the Pharmacy Profession and Practice Bill, Uganda Medicines Control Authority Bill, Food and Nutrition Bill, Food and Drug Act, National Health Insurance Bill and the Traditional and Complementary Medicines Bill. Even with existence of the relevant laws and policies; and structures mandated to enforce them, limited human and financial resources constrain their performance. The mechanisms for Civil Society Organizations' involvement in monitoring performance of the sector are inadequately coordinated given their multiplicity and divergent interests.

The Local Governments are mandated by the 1995 Constitution and the 1997 Local Government Act to plan, budget and implement health policies and health sector plans. They have the responsibility to deliver health services, recruitment, deployment, development and management of human resource for district health services, development and passing of health related by-laws and monitoring of overall health sector performance6.

Delivery of the Health Sector Strategic Plan III is enshrined in the Uganda National Minimum Health Care package (UNMHCP) which has five clusters namely: (1) Health Promotion, Disease Prevention and Community Health Initiatives, including epidemic and disaster preparedness and response; (2) Maternal and Child Health; (3) Nutrition; (4) Prevention, Management and Control of Communicable Diseases; and (5) Prevention, Management and Control of Non-Communicable Diseases. However, unsatisfactory implementation of sectoral policies and strategies and weak enforcement of existing legislation are underpinned by the critical shortage of human resources for health, inadequate funding to the health sector to effectively deliver the UNMHCP, and train, recruit, deploy and maintain and adequately motivate health care workers; and redundancy or limited impact/interest for the policy.

It is therefore the responsibility of Civil Society Organizations to advocate for realization of the desired achievements of the National Health Policy and the HSSP III through supportive mechanisms that entail increased resource allocation and use in the health sector. There is further need to support facilitation of the regulatory bodies including Commissions, Authorities and the Professional Councils in terms of adequate human, financial and material resources to enable them fulfil their respective mandates including

6 National Health Policy 2010

enforcement of the laws and regulations. Ensuring that the legal and regulatory frameworks are expedited like formation of the Professional body's authority; and the implementation of their mandates enforced will provide an enabling environment for the provision of quality UNMHCP and the provision of adequate resources for policy and legislation up-dates and reviews.

This shadow report aimed to establish the progress in implementation of Health Sector Strategic Investment plan in FY 2011/12 in view of the UNMHCP priorities ass elaborated in the UNMHCP under the Health Sector Budget Framework Paper for FY 2012/13. It further outlines the emerging issues which will act as advocacy areas for ensuring improved quality of health services delivered to the population.

CHAPTER TWO

Technical Approach and Methodology

2.1 Methodology

This was a cross-sectional study which applied qualitative approaches to data collection. The study was conducted during the months of September and October 2012 and covered 21 districts in the five regions of the country. Sample size was determined using the WHO/HAI methodology which recommends that there are 30 outlets per sector for a survey to achieve enough data points for analysis; this is normally five outlets per sector in each of five geographical areas across the country. For purposes of this study, data was collected from 47 health facilities (42 public and 5 private).

2.2 Data collection methods

The study applied the following data collection methods:

2.2.1 Documentary Review: Documents were reviewed to provide deeper contextual underpinnings of the report. The review findings informed readjustments in the field data collection tools. The main documents included the NHP 2010, the HSSIP III 2010, the Health Sector Budget Framework Paper for FY 2012/13, the ART policy, the Annual Health Sector Performance Report 2011/12, 2010/11, country compact between GoU and health development partners 2010, the PMTCT policy, the National Strategic plan for HIV&AIDS, the Uganda AIDS Indicator Survey 2011, the NDP 2010, Uganda Demographic and Health Survey 2011, the National HIV Prevention Strategy 2011 among others.

2.2.2 Field visits to districts and health facilities: These were conducted to get information on availability of essential medicines and assessment of the status of service delivery plus other medical supplies.

2.2.3 Key Informant Interviews: Key informant interviews were conducted with key stakeholders in districts and health facilities, the Ministry of Health, National Drug Authority (NDA), Ministry of Local Government and other line ministries. Other respondents included national and international Non Governmental Organizations, the donor community and other statutory bodies like the National Medical Stores.

2.2.4 Workshop based discussions: These were carried out with the health policy working group and other health rights based CSOs for validation of the findings.

2.3 Scope of the study

The study focused on selected indicators of the HSSIP III on; HIV&AIDS, TB & malaria; human resources for health; essential medicines and health supplies; non communicable diseases; reproductive health; and health financing.

2.4 Limitation of the study

- This assessment focused on selected performance indicators of the Health Sector Strategic Investment plan III based on AGHA's mandate leaving out other areas of the health sector.

CHAPTER THREE
Findings

3.0 Introduction
This section provides the findings of the study presented under two thematic areas. The first area focuses on the general findings; while the second thematic area analyses health sector performance under the different indicators.

3.1 General findings

3.1.1 Districts and health facilities covered
The assessment covered 21 districts including 3 in the Central region (Lwengo, Mukono and Masaka); 6 in the West (Buliisa, Bushenyi, Kabarole, Kasese, Kiryandongo and Kyenjojo), 6 in the East (Bukedea, Iganga, Namutumba, Soroti, Budaka and Bugiri) and 6 in the North (Nebbi, Gulu, Amuru, Nwoya, Dokolo and Lira) as illustrated in Figure 1. In all the districts, 47 health facilities were visited including 5 regional referral hospitals, 10 District hospitals, 7 HC IVs, 21 HC IIIs and 4 HC IIs as shown in Figure 2. Of these, one was a private teaching hospital in Bushenyi while 4 were faith based HC IIIs.

Figure 1: Districts assessed

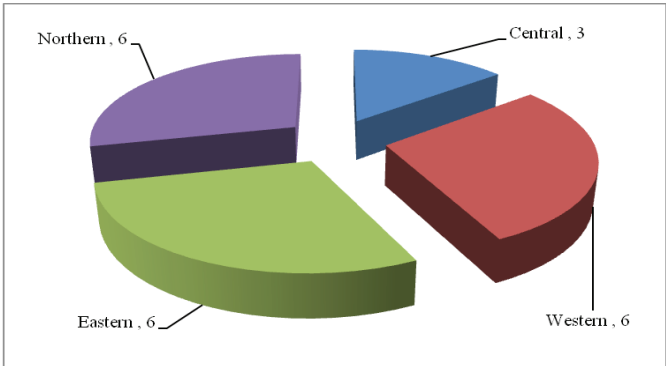
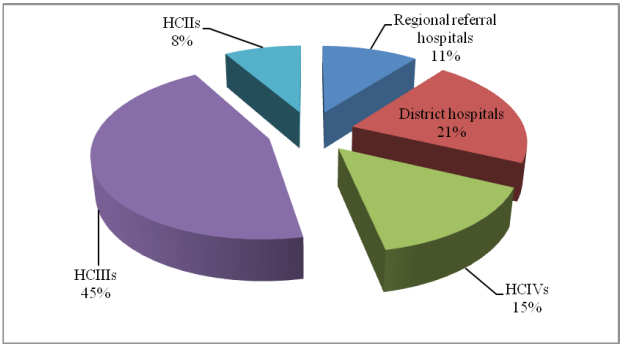


Figure 2: Health facilities assessed



3.1.2 Findings by HSSP III thematic areas and indicators

The survey findings are outlined under a set of thematic areas with their corresponding indicators namely; HIV & AIDS, TB and malaria; human resources for health; essential medicines and health supplies; non communicable diseases; reproductive health; and health financing.

3.1.2.1 HIV & AIDS, TB and Malaria

The HSSIP III targets under this thematic area were guided by a set of indicators outlined in Table 1. The overall five year target on the percent of health facilities with HCT services was set at 100%. By the end of 2011/12 financial year, only 38% (1,905/5,033) of the health facilities were able to provide HCT services. This was in contrast with the assessment findings where all health facilities visited were providing HCT services both static and during outreaches. All HC IIs had HCT outreaches delivered by the higher health facilities. The variation could have been occasioned by the limited sample size for this study and the geographical location of the facilities visited since most of them were located within reach and in urban or periurban areas.

Table 1: Performance against selected HIV&AIDS programme lead indicators

Indicator	HSSIP III target	2010/2011 achievement	2011/2012 achievement	Assessment findings
Number and % of HIV+s eligible for ART	ACP making estimates	577,027	577,027	231/540 (43%)
The proportion of people living with HIV&AIDS who are on ARVs	No target	73, 562	M (122,559) F (206,501) Total (329,060)	142/231 (62%)
% of health facilities with HCT services including HC IIs, and at community level	100%	38% (1,904/4,980)	38% (1,905/5,033)	100%
# of health facilities with PMTCT services available in all health facilities up to HC III's and HC IIs	100% Hospital up to HC III 20% HC II	32% (1,589/4,980)	36% (1,816/4,980)	100% Hospitals, HC IVs and none of the HC IIIs and HC IIs (19/47)
% of pregnant women accessing HCT in ANC	100%	82% at 70% reporting	100% at 75% reporting	100% at 60% reporting
Proportion of health facilities with Safe Male Circumcision	No data available	No data available	No data available	12 District hospitals, 7 HC IVs (out of 47) 40%
Percentage of adults and young people with access to male condoms	No data available	No data available	Male condoms 78%	63% had condoms, others were experiencing stock - outs
% of health facilities providing female condoms	No data available	No data available	6%	2% mainly referral hospitals, district hospital and HCIVs

Indicator	HSSIP III target	2010/2011 achievement	2011/2012 achievement	Assessment findings
% of TB patients on treatment in health facilities	No data available	No data available	45%	42% of health facilities other than HC IIs; but were experiencing stock out of one or two drugs
% of households with access to treated long lasting mosquito nets	85%	No data available	60%	Not assessed due to study design
% of districts with neonatal tetanus rates reduced & maintained at zero	Zero	No data available	No data available	19/21 (90.5%)
DPT-3/ Pentavalent coverage for under 1 year old children	2011/12 target (82%)	80%	85%	Average for districts assessed was 90.5%.
% of coverage of measles vaccination	No data available	No data available	100%	100%
Delivery of vaccines, injection materials and other immunization supplies	No data available	No data available	100%	100%
EPI cold chain supervision at districts	No data available	No data available	62 selected districts	22/47 (47%)

Indicator	HSSIP III target	2010/2011 achievement	2011/2012 achievement	Assessment findings
Proportion of technical support supervision to districts	No data available	No data available	No data available	31/47 (66)%
% of health workers trained on post certification interventions	No data available	No data available	No data available	13/47 (28%)

Adopted from Annual Health Sector Performance Report 2011/2012

From the Annual Health Sector Performance Report 2011/2012, the percent of health facilities with PMTCT services target was 100% of Hospital up to HC III; 20% HC II. The achievement during the second year of the strategy was 36%. The assessment finding showed that 100% Hospitals, HC IVs and HC IIIs visited were providing PMTCT services. However, none of the HC IIs had these services. Unless more resources are invested into having more health facilities deliver PMTCT services, it is unlikely that the HSSIP III target will be realised in the next three years.

The percent of pregnant women accessing HCT in ANC was targeted at 100% for all women reporting. The annual performance achieved was 100% at 75% reporting. The assessment finding was 100% at 60% reporting. The variation in the findings could also be attributed to the sample size used in the study. The difference, however, was not very divergent from the MoH figures which depict a likelihood of achieving the HSSIP III target.

From the AHSPR 2011/12, the number of males circumcised was 380,000 while that of the assessment findings was 764. The overall target for the HSSIP III was 50% of males in Uganda circumcised by 2014/15. In both cases, the number of males circumcised is still minimal give the overall population of males in the country estimated at 17,367,389 in 20127. One of the main limitations in implementing safe male circumcision programme is the limited human resources and inadequate equipment in the health facilities. There is also ignorance in the community on the importance of SMC. Unless these issues are addressed, it is unlikely that the five year target will be achieved.

7 Uganda Demographic Profile 2012

The number and percent of HIV positives enrolled in care had no target in the HSSIP III but the level of achievement during 2011/12 financial year was 92% of adults and 8% children. From the assessment findings, out of the total positives enrolled (540), 76% were adults and 24% were children. Of these, 231/540 (43%) were eligible for ART and 142/231 (62%) were initiated on ART. There were not targets from the HSSIP III to make comparison on performance. However, the number of patients eligible for ART who were actually initiated on treatment was still low from the assessment findings. This was mainly a result of the limited access to health facilities by some of the patients on account of long distances of travel.

The percentage of adults and young people with access to male condoms was 78% as achieved under the MoH. The assessment established that access to condoms was 63% and this was for males only. Women condoms while they were available in some of the health facilities, access levels were very minimal at 4%. Awareness of the use of female condoms was low in the community. The male condoms were on high demand resulting into frequent stock-outs.

The percent of TB patients on treatment in health facilities stood at 45% as indicated in the AHSPR 2011/12 while the assessment findings revealed 42% of health facilities other than HC IIs were providing the service. However, 32% of the health facilities were experiencing stock out of one or two drugs due to late delivery. Overall, there was improvement in TB Case Detection Rate (CDR) from 53.9% in 2010/11 to 57.2% in 2011/12 close to the 2008/09 CDR of 57.4%. TB Treatment Success Rate (TSR) which had declined from 75% in 2007/08 to 67% in 2008/09 has increased from 70% in 2009/10 to 71% in 2010/11; there were no figures for 2011/12. The number of TB patients tested for HIV has increased from 63% in 2008/09 to 81% in 2010/11 and a slight decline to 80.4% in 2011/12. The number of HIV+ TB patients started on Cotrimoxazole has also progressively increased from 71% in 2008/09 to 93% in 2011/12[8].

The MoH annual target for households with access to treated long lasting mosquito nets was 85% but managed to achieve 60% score. This indicator was not assessed under this study due to inadequacies in the study design which did not address household level data collection.

The annual target of districts with neonatal tetanus rates reduced and maintained at zero was 100% but there were not achievement figures in the AHSPR report. The assessment finding however revealed that 19/21 (90.5%)

8 Ministry of Health 2012; Annual Health Sector Performance Report 2011/12

of the surveyed districts reported zero cases of neonatal tetanus. This was a result of the 100% vaccination coverage in all districts including measles. DPT-3/Pentavalent coverage for under 1 year old children was targeted at 82% for 2011/12 but actual performance was 85%. The assessment findings were 92% coverage. The above performance points to significant improvement in the cold chain management system and delivery of vaccines, injection materials and other immunization supplies. This is in addition to strengthened EPI cold chain supervision at districts and training of health workers on post certification interventions.

3.1.2.2 Human Resources for Health

Human resources for health have continued to hinder effective service delivery across the country. The severe shortage of health workers, the inequalities in urban-rural distribution, inadequate facilities at health units demotivates workers in addition to poor remuneration have contributed toward the high rates of attrition. A combination of these factors has resulted into the perpetually high levels of deaths due to preventable diseases. The poor rural communities which have shouldered the biggest burden of these effects have continued to get the least share of health services thus affecting development initiatives in the country. Such developments continue to undermine the government's commitment towards equitable development opportunities for its population.

This assessment analyzed key indicators under the human resources for health in relation to the performance of the health sector in this regard. Table 2 below provides the summary performance for the FY 2011/2-12.

Table 2: Performance against selected human resources for health indicators

Indicator	2011/2012 achievement	Assessment findings
% of posts filled by skilled health workers	58%	51%
% annual reduction in absenteeism rate	Expected at 20% annually	Not possible to assess
# of support and technical supervisions made		(18/21) 86%
% of district service commissions with human resources for health code of conducts and ethics		90.5%

% of district service commissions with guidelines for recruitment of health workers		90.5%
% of districts with functional village health team members	84/112 (75%)	14/21 (67%)
% of districts benefiting from services of graduate health workers and interns facilitated by MoH		7/21 (33.3%)

Adopted from Annual Health Sector Performance Report 2011/2012

From the Annual Health Sector Performance Report 2011/2012, the percent of approved posts filled by skilled health workers was 58% compared to 56% during the previous financial year. The assessment findings indicated 51% of the posts filled. The limited number of health facilities sampled during the assessment could have influenced this result. At the national level including all the hospitals, MoH institutions and LGs, the proportion of filled positions by health workers increased from 56% in 2010/11 to 58% in 2011/12 FY[9] as illustrated in Table 3 below. This includes both the trained health workers, administrative and support staff in public health facilities. There was stagnation in performance of this indicator for the last three years and during the last FY there has been a slight increase to 58%. This increase in staffing is mainly through the central recruitment for referral hospitals and the Ministry reallocation of Uganda shillings 5.7 billion to recruit staff in general hospitals and HC IVs.

Table 3: Staffing Levels for all health workers in the public sector by March 2012

S/N	Cost Centre	# of Units	Total Norms	Filled	Vacant	% Filled	% Vacant
1	Mulago Hospital	1	2,801	2,423	378	87%	13%
2	Butabika Hospital	1	424	393	33	93%	8%
3	RRHs	13[1]	4,331	3,121	1,210	72%	28%
4	General Hospitals	47	7,980	4,905	3,075	61%	39%
5	DHOs Offices	112	1,232	698	532	57%	43%
6	HC IV	166	7,920	4,768	3,152	60%	40%

9 Annual Health Sector Performance Report 2011/2012

7	HC III	962	5,634	3,363	2,271	60%	40%
8	HC II	1,321	4,905	2,197	2,708	45%	55%
9	Urban Authorities HUs	155	20,216	10,083	10,133	50%	50%
	Total	2,763	55,443	31,951	23,492	58%	42%

Source: Uganda Human Resources for Health Biannual Report October 2011 to March 2012

According to the Uganda Health System Assessment 2011, the health system is expected to distribute health care workers to match geographic population and disease burden distributions. This implies that health care workers are allocated to areas where the people are and the needs are the greatest. The situation in Uganda does not reflect this picture to the extent that HRH distribution, particularly among higher-level professional cadres, is skewed toward urban areas. This poses major barriers to access to quality health care in rural, remote, hard-to-reach and hard-to-stay areas. The failure to attract health workers is even worse in young districts with limited social amenities. Table 4 shows the urban distribution and population ratio for health workers cadres.

Table 4: Health worker cadres, urban distribution and population ratio

Health Cadres	Total	% Urban	Population per Health Worker	% Self-Employed
Medical doctors	664	70	7,272	14.0
Nurses and midwifery professionals	3,361	58	36,810	17.5
Dentists	98	75	249,409	23.5
Pharmacists	162	80	150,877	22.8
Other health professionals	3,572	68	6,843	10.2
Allied health clinical	4,378	39	5,583	14.0
Nurses and midwives associate professionals	20,340	41	1,202	14.4
Allied health dental	342	52	71,468	19.3
Allied health pharmacy	600	45	40,737	28.5
Allied health diagnostic	1,622	28	15,069	12.0
Other allied health professionals	5,828	34	4,194	18.0
Nurse assistant/aid	16,621	30	1,471	29.6

Source: Uganda Health System Assessment 2011 (April 2012)

The staffing levels were higher in the Regional Referral Hospitals (72% from the AHSPR 2011/2012). This closely related to the assessment findings where the staffing levels stood at 70%. The difference was due to staff transfers given the different timings between the MoH assessment and this study. The staffing level was even lower in the lower health facilities concurring with the AHSPR 2011/2012 report where at HC II level it stood at 45% and 37% from the assessment finding.

The assessment findings also established that Iganga and Lira districts had staffing levels above 80%. Lwengo, Namutumba and Nwoya districts had staffing levels of less than 40% painting a picture of service delivery constraints faced by young and rural districts. Of the 21 districts assessed, 20 of them had substantively appointed staff in the District Health Office with exception of Lwengo. This placed such district in technical difficulties to manage health service delivery. The district had no service commissions, no guidelines on human resources for health code of conducts and ethics; and also lacked guidelines for recruitment of health workers; compared to all other districts in the study. The MoH should put emphasis on supporting young districts to have the requisite structures in order to recruit adequate human resources for delivery of quality health care services.

During 2011 about 400 graduate health workers were posted to LG health Units. This was reflected during the assessment where seven out of the 21 districts visited (33.3%) had graduate health workers. These included; Masaka, Bushenyi, Kabarole, Soroti, Iganga, Gulu and Lira districts. However, the concentration of the graduate health workers was mainly in hospitals with none of the HC IIIs and HC IIs having any allocation. There being limited number of supervisors to support the graduate health workers in lower health facilities influenced the placement. The implications are that such facilities remain under resourced thus affecting the quality of service delivery and improvement of health outcomes at community levels.

The annual reduction in absenteeism rate could not be assessed during the study due to limitations in the time scope and lack of sufficient record on staff attendance in the health facilities. However, the MoH expected an annual reduction of 20% in the rate of absenteeism using 2009/10 FY as the baseline. Performance for this indicator is to be obtained from the Panel Surveys conducted by UBOS when it is published.

According to World Health Organization (WHO), a country with less than 2.5 health workers (doctors, nurses and midwives) per 1,000 population is regarded to be in severe shortage of health workers to meet its health

needs and is thus considered as country facing a public health emergency. WHO puts the Uganda ratio at about 1.8 health workers to 1,000 people; which paint a bleak picture on the state of the human resources for health in the country. The situation is even more pronounced in the rural districts especially the young ones. From the assessment findings, the ratio of health workers to the population was 1.1 to 1,000 people. The ration was significantly affected by the low number of health workers in the lower health facilities. With the ever growing number of districts, this situation is not about to be solved as depicted in the Uganda Demographic Health Survey, 2011/12 where the ratio of maternal deaths per 100,000 live births has increased from 435 in 2005 to 438 in 2011. Malnutrition is high, with stunting among children under five estimated at 32%. According to the Uganda AIDS Indicator Survey 2011/12, the national HIV prevalence has increased from 6.4% to 7.3%.

Village Health Teams (VHTs) are constituted by volunteers from the community who provide promotive and preventive health interventions among their people. They represent the commitment of Government towards delivery of Primary Health Care at community level as provided for in the 1978 WHO Almata Declaration. With a total of 55,000 villages in the country, the MoH's target was to have 100% of the districts with fully constituted VHTs. From the AHSPR 2011/12, the number of districts that had fully established VHTs was 84/112 (75%) districts, 6/112 (5%) had 50 – 99% coverage and 17% had coverage below 50%. The assessment findings showed that 14/21 districts (67%) had functional VHTs. Functionality was assessed on the basis of availability of reports submitted to the DHO's Office on regular basis. It should be noted that not all districts have an up-to-date register of the trained VHTs that were active; the findings only give an indication of the active VHTs given the resource constraints in following them up. As illustrated in Table 5, Iganga and Nwoya districts had non functional VHTs which was attributed to lack of resources to facilitate them. It should be noted that the data in the table below does not include VHTs trained by different CSOs operating in the districts.

Table 5: Functionality of VHTs in reporting districts

District	Total VHT members	Trained VHTs	Active VHTs	Proportion Trained	Proportion Active
Amuru	616	616	616	100.0%	100.0%
Dokolo	958	958	958	100.0%	100.0%
Lira	3,882	3,882	3,882	100.0%	100.0%
Nebbi	2,402	2,402	260	100.0%	10.8%
Nwoya	200	200	0	100.0%	0%
Gulu	2,529	1,176	509	46.5%	20.1%
Bukedea	417	417	278	100.0%	66.7%
Iganga	931	931	0	100.0%	0%
Namutumba	890	890	890	100.0%	100.0%
Soroti	1,812	1,812	858	100.0%	47.4%
Budaka	786	675	675	85.9%	85.9%
Bugiri	1,585	1,110	1,110	70.0%	70.0%
Buliisa	180	180	169	100.0%	93.9%
Bushenyi	1,705	1,705	1,705	100.0%	100.0%
Kabarole	690	690	690	100.0%	100.0%
Kasese	713	713	713	100.0%	100.0%
Kiryandongo	412	412	365	100.0%	88.6%
Kyenjojo	2,369	2,369	1,889	100.0%	79.7%
Lwengo	1,832	891	891	48.6%	48.6%
Mukono	2,663	1,663	2,663	62.4%	100.0%
Masaka	1,404	671	671	47.8%	47.8%
Total	28,976	24,363	19,792	88.6%	69.5%

Source: HMIS 2011/12

3.1.2.3 Essential medicines and health supplies

The assessment analysed the monthly stock outs of essential medicines and health supplies. The 6 trace medicines used by MoH in the annual performance reviews were used for this assessment. They included ACT, measles vaccine, ORS Sachets, Cotrimoxazole, Depo-Provera and Sulfadoxine/Pyrimethamine (Fansidar). The AHSPR 2011/12 and assessment findings are detailed in Table 6 below. The assessment figures were averages for all health facilities during the last quarter of 2011/2012 financial year.

Table 6: Percent of health facilities with "No Stockout" for the 6 tracer medicines 2011/12

Medicine	Q1	Q2	Q3	Q4	Assessment findings
	2011/12	2011/12	2011/12	2011/12	2011/12*
ACT	93.0%	96.5%	94.6%	89.2%	89.8%
Measles vaccine	95.5%	96.7%	97.7%	96.4%	98.2%
ORS Sachets	95.0%	95.6%	97.0%	90.3%	88.7%
Cotrimoxazole	92.1%	90.4%	90.9%	91.1%	87.5%
Depo-Provera	95.7%	95.4%	96.5%	93.0%	91.2%
Sulfadoxine/ Pyrimethamine	92.6%	94.7%	97.2%	92.6%	88.9%
Calculation is based on "Probability" of no stock out for any of the 6 tracer medicines mentioned above	68.9%	72.9%	76.4%	60.9%	66.8%

Source: MoH HMIS 2011/12 (*Average for the last quarter of the financial year)

While the figures above show a high level of availability of the tracer medicines in all health facilities, the lower health facilities especially HC IIs accounted for the draw back in performance. From the AHSPR 2011/2012 report, there was an improvement in performance under this indicator increasing from 21% in 2009/10 to 43% in 2010/11 and 68.9% in 2011/12 with an average of 69.8% for four quarters. This compared well with the assessment finding where the average no stock out rate was 66.8%. The MoH attributes the improvement in availability of essential medicines and health supplies to increased budget allocation and the medicines grant to private not for profit facilities through Joint Medical Stores (JMS).

The bimonthly deliveries by JMS through the pull system for hospitals up to HC IVs and the push systems to HC IIIs and HC IIs were reviewed in line with the diseases patterns in the country. This contributed to the stock out period to an average of two weeks observed n the assessed health facilities. Apart from Paroketo HCII, in Pakwach, Nebbi district, all other health facilities visited had the new guidelines of essential medicines list of Uganda for

2011. In this health facility, the in charge was not available and the Nursing Assistant found on site had no clue about the list. This was in addition to increased supervision and monitoring of medicines and logistics with support from Securing Ugandan's Rights to Essential Medicines (SURE) Project and other implementing partners. Even then, this rate is still low given the need to have supplies at all times of the year.

Effectiveness of the push system

The push system involves delivery of basic kits to lower level health facilities (HCIII and HCII) by National Medical Stores where the supplies are determined by the MoH. It ensures that the health facilities are regularly provided with stock, but sometimes supplies provided remain unutilized and in some instances expire when not withdrawn. While there were no expired drugs seen in the assessed health facilities, the redundant stock were found in Paroketo HCII, in Pakwach, Nebbi district and Kagwara HCII in Soroti district, Kadungulu Sub County. They mainly included intravenous fluids.

3.1.2.4 Non communicable disease

The Shadow Report assessment focused on availability of a national policy on Non Communicable Diseases (NCDs) and their incidence. NCDs are an emerging problem in all developing countries including Uganda. The MoH established a Programme for the Prevention and Control of NCDs in 2006. NCDs include hypertension, cardiovascular diseases, diabetes, chronic respiratory diseases, mental illness, cancer conditions, injuries and oral diseases. Several factors account for the increase in NCDs including raise in the aging population, change in feeding habits, increasing urbanization and adoption of unhealthy lifestyles among others. The majority of the NCDs are preventable through a wide range of cost-effective public health interventions which target the risk factors.

Availability of an NCD Policy: To date, there is neither an NCD Policy nor a strategic plan and standards and guidelines are available to guide interventions. Whereas the MoH has initiated the NCD programme with a view to reduce morbidity and mortality attributable to NCDs through appropriate interventions; it is high time that focus is put in addressing NCDs in Uganda by having the relevant policy, plan and guidelines.

The incidence of NCDs at district/health facility levels: (Mental health, diabetes, cancer, respiratory diseases and tobacco).

Mental health is a major health problem in Uganda contributing 13% to the national disease burden. Butabika hospital is the only national referral mental health. So far, 6 Regional Mental Health Units have been constructed; the Mental Health Policy has been revised and other policies such as the Alcohol policy, the Tobacco control policy and the Tobacco Control Bill have been drafted. The implementation of mental health programmes is hampered by inadequate staffing, inadequate resource allocation and the lack of mental health drugs on the local market among others[10]. To date, development of the Mental Health Bill, Alcohol Policy, Tobacco Control Bill, Drug Control Master Plan and MH Strategic Plan are in the pipeline. Regional level building workshops for Health Workers in mental health for provision of primary and regional referral mental health services were conducted.

According to the MoH HMIS, reported new mental health problems accounted for almost 1% of all new cases with epilepsy as the most common mental health problem. District specific data from the assessment indicate an average of 843 cases reported in the last financial year with the highest cases (76 average) occurring in the Northern region districts under this study. Table 6 below show the different mental health cases registered over the years. Save for HC IIIs and HC IIs, other health facilities had essential mental health and anti-epilepsy drugs in addition to trained staff. This findings portrays a big burden of mental health problem in the country whose management needs due attention. The need for strengthening control of mental health cannot be overstated given the increasing trends in incidence. Having appropriate legal and policy frameworks will enhance mental health service provision at all levels.

10 **Ministry of Health Uganda (2009).** *Annual health sector performance report 2008/09*

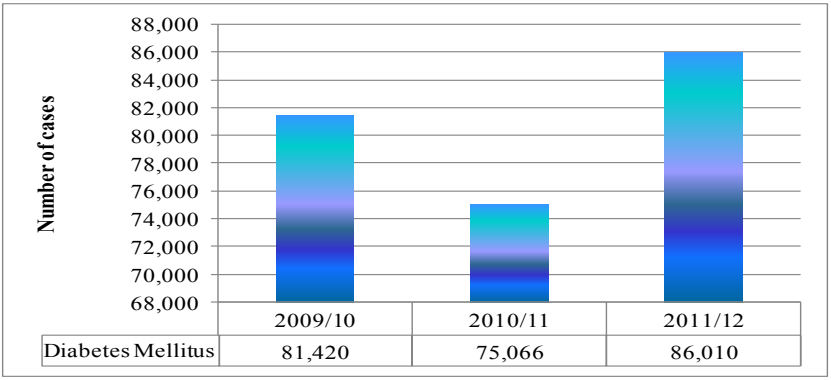
Table 7: Occurrence of mental health cases over the years

Diagnosis	2009/10		2010/11		2011/12	
	No.	% OPD attendance	No.	% OPD attendance	No.	% OPD attendance
Epilepsy	185,709	0.5%	194,018	0.6%	197,272	0.50%
Other Forms of Mental Illness	29,147	0.08%	32,578	0.09%	39,207	0.10%
Anxiety Disorders	21,448	0.06%	23,693	0.07%	38,503	0.10%
Depression	20,523	0.06%	22,069	0.06%	28,012	0.07%
Mania	12,546	0.03%	17,290	0.05%	NA	NA
Schizophrenia	9,429	0.03%	13,722	0.04%	40,647	0.10%
Alcohol and Drug Abuse	8,632	0.02%	12,361	0.04%	12040	0.03%
Total	287,434	0.78%	315,731	0.95%	355,681	0.90%

Source: MoH HMIS

Diabetes Mellitus Available data from the HMIS shows that the number of new patients attending OPD with diabetes is increasing from 86,010 in 2010/11 to 92,875 in 2011/12 as illustrated in the Figure below. Similar trends were observed in the districts surveyed with the districts in the central region having the highest number of cases as illustrated in Figure 2.

Figure 1: Incidence of diabetes mellitus



Adopted from MoH, HMIS data 2011/12

Cancer is one of the NCDs on the increase in Uganda. The Uganda Cancer Institute (UCI) which is a semi-autonomous institution is the lead institution in providing specialized cancer treatment services in the country. During FY 2011/2012, the institute treated up to 33,000 patients against the planned 15,000 patients. Apart from hospitals and RRHs, cancer diagnosis and treatment is very limited in the lower health facilities. This is a result of lack of diagnostic equipment and skilled human resources. To this end, it is likely that many cases go unnoticed in the rural population. This could partly explain the low number of cancer cases registered in the surveyed districts especially the new ones as illustrated in Table 8 below.

Table 8: Number of cancer cases registered

District	No. of cases	District	No. of cases	District	No. of cases	District	No. of cases
Lwengo	8	Bukedea	0	Nebbi	1	Buliisa	0
Mukono	39	Iganga	8	Gulu	17	Bushenyi	13
Masaka	33	Namutumba	0	Amuru	0	Kabarole	13
		Soroti	9	Nwoya	0	Kasese	14
		Budaka	0	Dokolo	0	Kiryandongo	3
		Bugiri	4	Lira	21	Kyenjojo	1
Total	80		21		39		44

According to the World Health Organization, the risk factors associated with breast cancer include; high socio-economic status, early menarche, late first birth, late menopause, and a family history of breast cancer (WHO, 2003). Although there is scanty literature on cancer in Uganda, some studies that have examined issues relating to breast cancer show that about 71% of the women who visited the Radiology department in Mulago hospital had no idea about mammography while a half knew about the risk factors for breast cancer. The attitude towards mammography was generally negative with the main barrier to mammography being lack of information. The study further notes that despite breast cancer being one of the few cancers that can be detected early before seeing symptoms using mammography, mammography is still only performed on a low proportion of the women population in Uganda cancer (Kiguli-Malwadde et al 2010).

Kaposi's sarcoma, cervical cancer and breast cancer are the commonest cancers among women in Uganda (Wabinga et al 2000). Elsewhere trials on breast cancer show that mammography in early diagnosis of breast cancer is effective in decreasing mortality especially in women yet there are inhibiting factors such as fears and concerns about radiation, poverty and

limited services (Miller and Champion 1997). Prostate and Testicular cancer are the commonest in men as well as Kaposi's sarcoma to people living with HIV&AIDS.

A retrospective breast cancer study conducted at Mulago Hospital concluded that patients seen at the Hospital are relatively young, present with advanced disease and since survival is highly dependent on stage at presentation. The overall 5 year survival is as low as 36% compared to patients who present with early disease (66%). The study recommended that health education, regular breast-self examination and mammography be intensified so that the percentage of patients diagnosed with early breast cancer increases (Gakwaya et al, 2006). In Uganda, research also shows that 40% of cancers that could be avoidable remain high (Okiror, 2007) probably because of the less attention given to such diseases.

Uganda is one of the countries with very high morbidity and mortality due to cancer. The age –standardized cancer incidence rate is 187 per 100,000 (Parkin et al, 2009), making cancer about half as common in Uganda as it is in the developed world, but with much poorer survival rates. It is estimated that currently around 62,000 people develop cancer in this country each year (Parkin et al 2009). Uganda is different from that observed in developed countries, with liver, penile, urinary bladder, oesophagus and Kaposi's sarcoma accounting for about 80% of male cancers. In females, cervical cancer has been the commonest cancer since early periods, but the incidence has increased tremendously, (J. Orem and H. Wabinga, 2009). Similarly the trend for breast cancer has tripled since 1961 when it was 11/100.000 women to 22/100,000 women in 1995 and 36/100.000 women in 2009 (Gakwaya et al, 2006).

The trend for cancer incidence over the last 4 decades has been on increase, which is attributed to HIV&AIDS epidemic, life style changes like tobacco smoking, alcohol consumption, fatty diets and poor and virus infections like human papiloma virus (HPV) (Orem and Wabinga, 2009). The cancer scenario above has been mainly attributed to late presentation of the disease, lack of a comprehensive cancer policy, competing priorities like HIV&AIDS, Malaria and other communicable diseases and lack of access to early diagnosis and treatment as a result of poor status of the cancer care system in the country.

Cancer prevention, treatment and care services

Mulago National Referral Hospital is the only hospital with specialized cancer care for the 33 million people, resulting in a situation where 85% of

cancer patients from rural areas do not access the specialized treatment (H. Wabinga et al, 2009). There is one radiotherapy machine which breaks down very often. The Uganda Cancer Institute (UCI) has only four cancer specialist doctors (Oncologists) and relies on voluntary staff to complement the human resource component. The general assessment of cancer services in the country is that they are grossly inadequate. UCI/MoH is planning to set up Regional Cancer Centres in all Regional Referral Hospitals.

A number of private sector health providers have taken up limited cancer delivery services. Some examples are; mammogram services by the Kampala Imaging Centre. Hospitals like International Hospital Kampala, Nakasero Hospital, and Paragon conduct breast and cervical cancer surgery and administer chemotherapy. The business sector and charitable organizations have also taken interest in supporting UCI treatment services. One example is a fridge to store drugs which was in 2009 donated by Rotary club Kampala West to UCI. CSOs like Uganda Women's Cancer Support Organization (UWOCASO) are engaged in raising awareness about cancer. The media has been supportive to UCI and CSOs like UWOCASO in supporting their public awareness activities.

Tobacco and health

Scientific evidence has an unequivocally established that tobacco consumption and exposure to tobacco smoke cause death, diseases, and disability and there is a time lag between use and onset of tobacco related diseases. Cigarettes and other tobacco products are highly engineered so as to create and maintain addiction, and that many of the compounds they contain, and the smoke that they produce are chemically active, affect unborn children, affect genes, and cause cancer.

Globally, out of 57 million deaths due to NCDs annually, tobacco related diseases account for 36 million. The burden of tobacco related illness is higher than that of HIV&AIDS, Malaria, and accidents combined[11]. Tobacco is also a risk factor for other NCDs including; cardiovascular, cerebrovascular, fertility disorders, and skin diseases. Tobacco use also aggravates TB and diabetes and affects the outcomes of HIV&AIDS[12].

Tobacco causes lung diseases such as asthma, bronchitis, heart diseases, high blood pressure and stroke, stomach ulcers, many cancers e.g. lung, throat, uterus and mouth. It is also linked with miscarriages, premature aging and impotence in men. People who use tobacco suffer nutritional

11 WHO / CTFK - Campaign for Tobacco Free Kids records, website

12 WHO report on the global tobacco epidemic, 2011: Warning about the dangers of tobacco.

deficiencies due to loss of appetite. This makes them more vulnerable to infections and other diseases.

A study carried out at Mulago Hospital found that 75% of the patients with oral cancer had a history of smoking with the minimum number of years smoked ranging from 2-38 years. Data available from WHO indicates that in Uganda, 26% of deaths due to cancers of the respiratory system and 14% of deaths due to other respiratory diseases are attributable to tobacco.

In Uganda, a total of 45% of the youth are exposed to tobacco smoke outside their homes while 20% are similarly exposed to tobacco smoke within their homes. These youths are at risk of developing tobacco related diseases at a later stage of their lives. Cigarette smoking among the youth is an entry point to the use of narcotics and other substance abuse (Basangwa et al, 2010).

3.1.2.5 Reproductive Health

Uganda's total fertility rate (TFR) has remained high for over five decades (6.9 children per woman in 1950 and 6.7 children per woman in 2007)[13],[14]. In Uganda, age at first sex (coitache) is similar to other countries (17 years) but the initiation of reproductive life is much earlier in Uganda than in other countries, with a median age at first birth of 18 years[15]. In addition, sexually active young women and men are more likely to report multiple partners, with more than 35% adolescents reporting two or more lifetime sexual partners, who are often much older. Moreover, 45% of married men and 5% of married women have multiple sexual partners[16],[17]. In addition, contraceptive prevalence remains very low. Although adolescent pregnancies have reduced significantly from 45% in the 1990s to 25% in 2006, childbearing in Uganda continues to start very early and end very late, with short birth intervals18. The current population growth rate of 3.2 percent translates into approximately 1.2 million additional people per year. Intimately related to high fertility are the high maternal mortality

13 Blacker, J., et al., *Fertility in Kenya and Uganda: A comparative study of trends and determinants*. Population Studies, 2005. **59**(3): p. 355-373.

14 UNDP, World Population Prospects: The 2008, United Nations Population Division. . 2009.

15 Uganda Bureau of Statistics, U., ORC Macro, Uganda Bureau of Statistics 2002, Uganda Housing and Population Census Results. 2002: Entebbe, Uganda

16 Musinguzi, J., Kirungi, W., Opio, A., Madraa, E., Biryahwaho, B., Mulumba, N., HIV/AIDS surveillance report. 2003, Ministry of Health (MOH): Kampala.

17 UNAIDS/WHO, AIDS epidemic update: Special Report on HIV Prevention. 2005, Joint United Nations Programme on HIV/AIDS/ World Health Organization: Geneva.

18 UBOS, Uganda Demographic and Health Survey 2006. 2007, Uganda Bureau of Statistics, Kampala, Uganda and Macro International Inc, Calverton Maryland, USA.: Kampala

(435/100,000 live births) and infant mortality (76/1,000 live births). The unmet need for family planning has been steadily growing over the years. DHS data show that the unmet need for family planning was 29% in 1995, 35% in 2001 and 41% in 2006. Decreasing unmet need for family planning can directly contribute to reductions in Uganda's high maternal and child mortality. More important is that in addition to reducing the high fertility rates and unintended pregnancies, it would avert the high rates of mother-to-child transmission of HIV&AIDS.

This study focused itself on 12 indicators and the MoH performance was compared with the findings of the assessment. From the AHSPR 2011/2012, three in four facilities provided antenatal care services which included IPT, and iron and folic acid supplementation[19]. In the same report, few facilities had all eight tracer items for delivering ANC services; the overall readiness score was 64%, indicating that on average facilities had five of the eight tracer items. Furthermore, Nine in ten facilities had folic acid and iron tablets in stock; however, three in ten facilities providing ANC did not have tetanus toxoid available on the day of the assessment. Compared to the assessment findings, 53% of the health facilities visited had not experienced stock out of essential RH medicines over the last quarter of the last financial year. The low score was due to the high stock out rates in HC IIIs and HC IIs which provide basic reproductive health services.

The AHSPR 2011/2012 reported low availability of guidelines and staff trained in ANC in the past two years at 50% and 45% respectively. The assessment findings also revealed that all HC IIIs and HC IIs had limited availability of guidelines and trained staff to a level of 33%. Inadequate staff was due to the rural nature of most districts.

Provision of adolescent RH friendly services was only in Regional Referral and district hospitals. While the other health facilities provided RH services, they were not friendly to the adolescents due to lack of sufficient physical facilities and inadequate human resources.

The proportion of health facilities with basic and those with comprehensive emergency obstetric care was 15/47 (32%) including 5 regional referral hospitals and 10 District hospitals. All HC IVs visited were unable to provide these services on account of lack of skilled human resources and inadequate equipment.

19 **Service Availability and readiness assessment report 2012**

The proportion of pregnant women accessing comprehensive PMTCT package depended on the number of health facilities which were delivering the service. With the increase in health facilities with PMTCT services to 36% from 32% in 2010/11 and 23% in 2009/10, more women were able to access services. From the AHSPR 2011/2012 report, the percentage of pregnant women accessing HCT in ANC has increased to 100% in 2011/12 from 83% in 2009/10. However, the reporting levels vary across the years. All mothers attending ANC are counselled and offered HIV testing as individuals or as couples. There was an increase in PMTCT reporting level from 70% in 2010/11 to 75% in 2011/12 FY. From the assessment, the percentage of women accessing PMTCT services was 74% given that some of the HC IIIs and HC IIs were not providing the service.

The percent of districts with reduced unmet need for family planning services stood at 34% during 2011/2012 FY. The assessment finding showed an average of 32% which was close to the national figure. However, the results still show the need for more efforts to address the FP needs of the population.

The MoH target is to reduce the rate of adolescent pregnancy from 24% to 15% by 2015. From the AHSPR report 2011/2012, the performance data was not available; this was equally the case in all districts visited. Calculating this indicator requires national wide survey and a more rigorous methodology beyond the scope of this study. However, the UDHS 2011 shows that 1.7% of the teenagers aged 15-19 years gave their first birth at 15 years. The median age at first birth for women age 20-24 was 19.3 years compared with 18.9 years or younger for older women. The report further noted that the initiation of child bearing in Uganda had not changed much over time.

Apart HC IIs, all other health facilities had between 3 to 6 staff trained in EMOC, MPDR, MIP, ASRH, RH/HIV integration and focused ANC. This figure was even higher in the regional referral and district hospitals with a range of between 7 to 12; the lower being in district hospitals while the higher in the RRHs. This was due to limited number of staff in the health facilities and the high attrition rates plus frequent transfer of staff.

According to the AHSPR report 2011/2012, the number of maternal and perinatal death audits conducted was 315 for maternal and 161 for perinatal deaths. The assessment findings showed a total of 15 for maternal and 8 for perinatal deaths audits performed. This was mainly in the RR and district hospitals. The main limitation again was the general human resource shortages of key cadres to carry out SRH services.

The assessment findings showed that only 1 out of 21 districts did not have RH Policies, laws and guidelines. Lwengo did not have substantively appointed staff in the District Health Office. Being a young district, there is need for affirmative action to address this gap.

The MoH promotes provision of goal oriented ANC and recommends that a woman have at least four ANC visits, the first of which should be in the first trimester. UDHS 2011 shows a slight improvement in women 15 – 49 years who received ANC from a skilled provider in the most recent pregnancy from 94% in 2006 to 95% in 2011. Only 21% of women attended ANC in the recommended first trimester and 47.6% attended at least four visits. From the AHSPR report 2011/2012, the percent of pregnant women attending 4 ANC sessions stood at 35%. From the assessment findings, pregnant women attending 4 ANC sessions were 32.4%. The variation could be due to the limited ANC services provided in the rural health facilities especially HC IIs. In all cases, the figures were far below the HSSIP III target of 53% for 2011/12, hence the need for more focus in this area.

The AHSPR report 2011/2012 showed 40% of the deliveries were in health facilities under the care of skilled health workers. This was against the HSSIP target of 50% for 2011/12. In the health facilities visited, the average health worker supervised deliveries stood at 37%. The UDHS 2011 showed that 90% of women in urban areas delivered in health facilities compared to 52% in the rural. Kampala region had the highest proportion (93%) of health facility deliveries and the lowest was in Southwest (40%) and Karamoja region (27%). The rural nature of health facilities in the surveyed districts could account for the low health facility deliveries. But this also shows the limited confidence the rural population has in the health facility services given the limited number of skilled staff and inadequate equipment.

The number of technical supervision, monitoring and evaluations done were not reported in the AHSPR report 2011/2012. From the assessment, the RRHs and district hospitals reported having received at least two technical supervision, monitoring visits from the MoH while the lower level health facilities reported at least one visit from the higher facilities in the last one year. Resource limitations were again cited as the main reason for under performance under this indicator. According to MoH budget 2011/12 and MoH activity work plan, they are supposed to have 4 area team visits. As per the planned output, 3 visited were to be done per district (vote function-quality assurance); MTEF 80103.

From the AHSPR report 2011/2012, 100% of the targeted coordination meetings were organized and implemented. These included MCH TWG meetings and FP TWG meetings. All these meetings were conducted at the national level. In all districts assessed, coordination meetings are irregular due to limited finances to facilitate them. When they do take place, they are mainly constituted by the District Health Management Team which includes the DHT and Health Sub District and HCIII in charges. There is minimal involvement of Civil Society in DHMT meetings. It is mainly the HIV&AIDS coordination meetings (which include CSOs) that take place when funds are availed from Uganda Aids commission. Even then they do not comply with the planned quarterly schedules. The implication of irregular meetings and minimal involvement of CSOs and development partners is the lack of transparency and poor accountability which affects effective service delivery.

3.1.2.6 Health Financing

In Uganda, health service delivery is financed under the sector wide arrangement where government, private sources and development partners pool resources. Funding modalities under the sector wide approach include the following:

- **Sector Programme Support:** This is financial support to a sector programme/SWAp. The support may concern a whole sector/policy area or a part of a sector/policy area. Sector programme support involves a process where several donors make a coordinated financial support to a sector policy and sector plan under the leadership of the partner country. The sector programme support can take the form of on budget support where the donor funds are channeled through a pool common for the participating donors.

- **On Budget Support:** This is a financial contribution to the partner country's budget in order to support the implementation of a country's policy and plan for a sector, part of sector or policy area. When applying sector budget support, the funds are part of the partner country's budget process and managed according to the country's systems and procedures for public financial management, as for general budget support. The difference is that with sector budget support, the conditions, dialogue and the follow-up of results focus mainly on sector-specific issues.

There has been significant increase in the expenditure, from 16 US$ per person in 1999 - 2000, to the current total expenditure on health of over US$ 27 per person per year (representing a 69% increase in total health

expenditure). However, this is less than US$ 44 per person per year the WHO World Health Report 2010 defined as the current estimates needs for provision of an appropriate basic package of services in low income settings 20. The Abuja Declaration requires government to invest 15% of national budget on health in a progressive manner until the target is realized. The Uganda situation is however different with the health sector dropping from key government funding priorities. The Inter Parliamentary Union conference in Kampala in 2012 recommended that the GoU increase budget allocations to achieve MDG targets and NDP targets. The Ministry of Health has perpetually advocated for increases budget allocation to address inequalities in human resources for health and quality of service delivery with minimal success.

Efficiency, effectiveness and equity in resource allocation: These were assessed on the basis of financing priority areas which result in optimal health care outcomes with focus on the different geographical areas, population size and disease burden. Annually, the MoH issues budgeting and planning guidelines to the District Local Governments (DLGs) where national priorities are stated. Priorities are set based on the disease burden and available resource envelop. It is on this basis that DLGs develop their activity plans and budgets. However, given the late disbursement of funds to DLGs and budget cuts, a number of activities are dropped while those which are implemented suffer delays. Weaknesses in the LG capacity in areas of financial reporting, leadership and financial management combined to adversely impacts on the efficiency and effectiveness of service delivery especially in the new districts.

Financial disbursements and utilization: The Ministry of Finance, Planning and Economic Development (MFPED) disburses funds to the MoH are based on the approved ceilings set during the budgeting process. The releases are made depending on availability of funds from the treasury on a quarterly basis. Utilization of funds by the health sector in District Local Governments is based on their approved activities and budgets which are guided by the national priorities. The MFPED provides indicative dates when funds will be released but there is always a gap with the actual release which ranges from days to months. To this end, at no given time did the MFPED disburse funds to districts in a timely manners resulting into irregular activity implementation.

20 MoH 2010; The Health Financing Review 2009/2010

Trends in health sector funding

During FY 2011/12, the Government of Uganda budget for health (excluding donor) capital expenditure accounted for 15% of health sector public expenditure while recurrent expenditure such as wages, utilities and other operational costs accounted for 85%. The recurrent budget outturn was 93% (U Shs 468.83 bn) while that of the development budget 92% (U Shs 82.63 bn)21. The trend in allocation of funds to the health sector shows that there has been a steady increase in budget allocation over the past 10 years. From the AHSPR report 2011/2012, most of the increment was on the wage component of the budget which is meant for payment of salaries for staff in post. It should be noted that with the raising trends notwithstanding, the proportion of the GoU budget for health still averages at 9% which is far below the Abuja target of 15%. Table 9 illustrates the trends in health sector funding over the last 10 years.

Table 9: Government allocation to the Health Sector 2000/01 to 2011/12

Year	GoU Funding (U Shs bns)	Donor projects and GHIs (U Shs bns)	Total (U Shs bns)	Per capita public health exp (UGX)	Per capita public health exp (US$))	GoU health expenditure as % of total GOU expenditure
2000/01	124.23	114.77	239.00	10,349	5.9	7.5
2001/02	169.79	144.07	313.86	13,128	7.5	8.9
2002/03	195.96	141.96	337.92	13,654	7.3	9.4
2003/04	207.80	175.27	383.07	14,969	7.7	9.6
2004/05	219.56	146.74	366.30	13,843	8.0	9.7
2005/06	229.86	268.38	498.24	26,935	14.8	8.9
2006/07	242.63	139.23	381.86	13,518	7.8	9.3
2007/08	277.36	141.12	418.48	14,275	8.4	9.0
2008/09	375.46	253.00	628.46	20,810	10.4	8.3
2009/10	435.8	301.8	737.6	24,423	11.1	9.6
2010/11	569.56	90.44	660	20,765	9.4	8.9
2011/12	593.02	206.10	799.11	25,142	10.29	8.3

Source: Annual health sector performance report 2011/12

21 Ministry of Health Uganda (2009); *Annual health sector performance report 2011/12*

Health financing strategy
Preliminary works on the development of the health financing strategy were undertaken and a new resource allocation formula for the sector was developed and is expected to be applied in the FY 2013/14 budget. It is important that the financing strategy is finalized in order to improve on resource mobilization; equity and allocative efficiency.

Transparency and accountability in resource allocation and management
The MoH manages the planning and budgeting process through involving the Civil Society Organizations which are represented on the Health Policy Advisory Committees (HPAC). In addition, DLGs are involved in the financial allocation process through regional workshops where national priorities are elaborated. The annual health sector performance review also provides an avenue for accountability on sector performance. In addition, the National Health Accounts tracks the flow of funds in the health system; from sources through uses of funds. Tracking of resources provides valuable information that can be utilized by policy actors in making health system strengthening decisions.

Health aid funds going to on-budget and off- budget support
The development partners' on-budget support to the health sector for FY 2011/2012 amounted to 206.10 bn Uganda shillings. This was higher than 90.44 bn provided during FY 2010/2011. On budget support is in line with the sector wide mechanism that was established to align funding to sector priorities. This maximizes efficiency in health improving activities and reduces losses associated with funding activities that may be duplicative or outside the priorities identified to achieve health outcomes. Generally, donors and NGOs increased during the last two financial years. For example in Table 9, donors and NGOs' financing as a percent of total health expenditure (THE) excluding household contribution increased from 61% in 2008/09 to 64% in 2009/10. In the same period, financing sources as a % of THE: including household contribution also increased from 34% to 36%.

Off-budget support by development partners was provided through several projects and amounted to USD 120,100,000 during the FY 2011/2012 **(See appendix 1)** which was far above what was provided under sector budget support. The prevalence of Off-budget/project funding does not necessarily address key sector priorities but leads to duplication of efforts. To this end, alignment of development assistance to key sector priorities is usually adversely affected. It is further compounded by the inability of the MoH to effectively monitor resource use under off budget funding modalities.

Table 9: summary of key indicators from general national health accounts-2012

Indicators		
Financing sources as a % of THE: (Excluding HH Contribution)		
Public	**28%**	**26%**
Private (excluding-Households)	**11%**	**10%**
Donors and NGOs	**61%**	**64%**
Other		
Financing sources as a % of THE: including HH Contribution		
Public	**16.0%**	**14.6%**
Private others	**6.4%**	**6.2%**
Private(Households)	**43.2%**	**42.4%**
Donors and NGOs	**34.4%**	**36.8%**
Financing sources as a % of THE: including HH Contribution		
Public	**16.0%**	**14.6%**
Private	**50.0%**	**49.0%**
Donors and NGOs	**34.0%**	**36.0%**

Reliability of donors fund to support key sector priorities has been fluid given the changes in priorities among development partners and global financial downturns. Most development partners provide off-budget support which has the effect of duplication of efforts and administration cost related to project management. It is imperative that GoU mobilizes more internal resources to fund the health sector and minimize reliance on donor funding.

3.1.2.7 Summary of emerging issues

The major issues emerging from this report include the following:

Policy and legal framework

- Civil Society Organizations should advocate for realization of the desired achievements of the National Health Policy and the HSSP III through supportive mechanisms that entail increased resource allocation and use in the health sector. The need to support facilitation of the regulatory bodies including Commissions, Authorities and the Professional Councils in terms of adequate human, financial and material resources to enable them fulfil their respective mandates including enforcement of the laws and regulations cannot be overemphasized.

- Ensuring that the legal and regulatory frameworks are expedited like formation of the Professional body's authority; and the implementation of their mandates enforced will provide an enabling environment for the provision of quality UNMHCP and the provision of adequate resources for policy and legislation up-dates and reviews.

HIV & AIDS, TB and Malaria

- With only 38% (1,905/5,033) of the health facilities able to provide HCT and 36% PMTCT services; there is need to advocate for increased coverage in these areas of service provision in the country.
- More efforts should be placed in covering more males through human resources and equipment in the health facilities plus sensitizing communities on the importance of SMC.
- Women condoms availability should be improved and their use enhanced through awareness campaigns.
- Access to TB services is still limited especially at HC II level; this is further compounded by the frequent stock out of one or two drugs due to late delivery.

Human Resources for Health

- Human resources for health in the country is still inadequate hence the need for targeted advocacy to address this gap.
- Having all districts with fully established VHTs will facilitate improvement in service delivery at community level. CSOs should support government efforts in this regard.

Essential medicines and health supplies

- Availability of the tracer medicines in the lower health facilities especially HC IIs accounted for the draw back in performance. More resources need to be put into essential medicines and health supplies. The push system should be reviewed to address supply of redundant stock.

Non Communicable Diseases

- CSO advocacy should also focus on having the NCD Policy, strategic plan, standards and guidelines in place to guide interventions.
- Facilities for diagnosis and treatment of NCDs are limited in district and lower level health facilities. A number of cases go unnoticed due to lack of equipment and skilled human resources. There is need to direct advocacy efforts in this regard.
- Advocacy efforts towards ensuring strong legislative and policy frameworks should be the focus of CSOs to address this tobacco consumption.

Reproductive health

- Decreasing unmet need for family planning can directly contribute to reductions in Uganda's high maternal and child mortality. Addressing stock out of essential RH medicines in HC IIIs and HC IIs which provide basic reproductive health services should be an area of CSO advocacy.
- Provision of adolescent RH friendly services was only in Regional Referral and district hospitals hence the need to scale them to lower level health facilities.
- The proportion of health facilities with basic and those with comprehensive emergency obstetric care is still low.
- Access to comprehensive PMTCT package is limited especially in HC IIIs and HC IIs.
- Reducing unmet need for family planning services is still low hence the need for more efforts to address the FP needs of the population.
- There is limited number of health workers trained in EMOC, MPDR, MIP, ASRH, RH/HIV integration and focused ANC especially in HC IIs.
- There is need to support deliveries in health facilities under the care of skilled health workers especially in rural areas. The limited confidence the rural population has in the health facility services given the limited number of skilled staff and inadequate equipment should be addressed.
- CSOs need to actively involve themselves in routine technical supervision, monitoring and evaluations. This should also include participation in coordination meetings at national and district levels. This will strengthen enhancement of transparency and accountability which affects effective service delivery.

Health financing

- There is high reliance on donor funding by government which need to be addressed through advocating for increased government allocations to the health sector. Also the current approaches of of-budget support to CSOs need to be addressed given the high levels of service duplication.
- District local government capacities in financial utilization are still weak and needs redress. Equally, disbursements by Ministry of Finance, Planning and Economic Development are irregular and disrupt activity implementation.

CHAPTER FOUR

Recommendations

This section provides a set of recommendations which CSOs can use for advocacy purposes. They are structured along the thematic areas which informed this study.

4.1 HIV&AIDS, TB and Malaria

- Delivery of PMTCT services should be scaled down to HC IIs in order to improve service access.
- Capacities of HC IVs and HC IIIs to deliver comprehensive HIV&AIDS services should be enhanced. This should take into account capacity to provide safe male circumcision, and laboratory diagnostic services

4.2 Human Resources for Health

- The GoU should increase budget allocations for recruitment of more health workers in order to improve the quality of health care especially in the rural and young districts. To this end, the ban on recruitment should be lifted.
- Technical support supervision by the MoH to districts and DHO's office to health facilities should be strengthened through appropriate resource allocations. This will improve on staff performance for improved service delivery.
- DLGs should be supported to strengthen their capacities to effectively plan, budget and absorb resources for health. Particular emphasis should again be placed on young DLGs.
- All new districts should be supported to constitute district service commissions, supported to implement their mandate through orientation and availing the human resources for health code of conducts and ethics; and guidelines for recruitment of health workers
- DLGs should be supported to constitute and functionalize VHTs given their roles on PHC at community level.
- Motivation, retention and training of health workers needs to be scaled up
- Heard to reach policy for HRH need to be revised for effective implementation process.

4.3 Essential Medicines and health Supplies

- While data shows a high level of availability of the tracer medicines in all health facilities, more efforts should be put into ensuring that HC IIs are equally supported. This will entail review of the last mile delivery system by JMS as a measure of minimizing stock outs.

4.4 Non Communicable Disease

- The process of developing the national policy on NCDs should be expedited in order to guide DLG and other development partners on disease management. Absence of this policy has compromised resource allocation and prioritization of NCDs especially in rural districts.

4.5 Reproductive Health

- With the current high MMR and IMR, more resources should be put into RH service delivery. Particular emphasis should be put into provision of adolescent reproductive health friendly services.

- Health facilities should be equipped to provide routine ANC, basic and comprehensive emergence obstetric services. This should involve reskilling and retooling health workers in addition to provision of the necessary equipment. This will improve community confidence in the health facilities and increase supervised deliveries.

4.6 Health Financing

- GoU should increase funding for the health sector in line with Abuja declaration of 15% of the total budget. To this end, CSOs should intensify their advocacy efforts to ensure government makes health a priority.

- The GoU should ensure that all development partners direct their funding to the health sector through on-budget support and minimize off-budget support interventions. This will minimize duplication of efforts and endure resources are directed towards national priorities.

- The MoH and Ministry of Finance should design capacity building interventions to strengthen for DLGs technical efficiency in resource management. This will improve on accountabilities and reporting which are important in timely disbursements.

- MoH should improve on accountability of donors funding given the findings of the Auditor General's report on mismanagement of donor funds e.g. Global Fund among others.

- The Ministry of Health should put in place the Health insurance policy and scheme
- National HIV&AIDS fund be established to enhance access to HIV&AIDS prevention, care and treatment in the country.
- Results-based financing programs be adopted by donors to address the challenges of high fertility, poor child and maternal health and nutrition

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APPENDICES

Appendix 1: USG Support to Health FY 2011/12

Project name	Name of counterpart/ partner if any	Total expenditure for 2011/12 (less administration expenses for the organisation/ institution)
IRS - Uganda Indoor Residual Spraying Project	ABT ASSOCIATES INC	USD 9,790,000
A2Z/ The Micronutrient Project	AED - ACADEMY FOR EDUCATIONAL DEVELOPMENT INC	TBD*
SCORE - Scaling Up Community Based OVC Response	AVSI FOUNDATION	USD 2,530,000
HIPS- Health Initiatives in the Private Sector	CARDNO EMERGING MARKETS USA, LTD	USD 4,170,000
SDS	CARDNO EMERGING MARKETS USA, LTD	USD 5,290,000
Civil Society Fund (CSF) - MEA	CHEMONICS INTERNATIONAL INC	USD 580,000
Civil Society Fund (CSF) - TMA	CHEMONICS INTERNATIONAL INC	USD 800,000
UNITY - Uganda Initiative for Teacher Development and Management Systems and Presidential Initiative for AIDS	CREATIVE ASSOCIATES INTERNATIONAL INC	USD 5,690,000
Civil Society Fund (CSF) - FMA	Deloitte & Touche Uganda	USD 5,420,000
STAR-SW	ELIZABETH GLASER PEDIATRIC AIDS FOUNDATION	USD 7,000,000
Fistula Care	ENGENDERHEALTH INC	USD 1,030,000
Community Connector	FHI DEVELOPMENT 360 LLC	TBD*
FANTA II -Food and Nutrition Technical Assistance	FHI DEVELOPMENT 360 LLC	TBD*
PROGRESS	FHI DEVELOPMENT 360 LLC	TBD*
SAFE T STOP	FHI DEVELOPMENT 360 LLC	USD 10,000

Project name	Name of counterpart/ partner if any	Total expenditure for 2011/12 (less administration expenses for the organisation/ institution)
Palliative care	HOSPICE AFRICA UGANDA	USD 1,130,000
SUNRISE-OVC - Strengthening the Ugandan National Response for Implementation of Services for OVC	IHAA - INTERNATIONAL HIV/ AIDS ALLIANCE	USD 4,280,000
Faith and Community Based HIV/AIDS Prevention, Care and Treatment (FBHAI)	INTER-RELIGIOUS COUNCIL OF UGANDA	USD 4,930,000
CAPACITY	Intrahealth International	USD 2,390,000
THALAS	JCRC - JOINT CLINICAL RESEARCH CENTRE	USD 3,680,000
AFFORD	JHU - JOHNS HOPKINS UNIVERSITY	USD 5,580,000
HCP 2 - Health Communication Partnership 2	JHU - JOHNS HOPKINS UNIVERSITY	USD 2,370,000
Uganda Stop Malaria	JHU - JOHNS HOPKINS UNIVERSITY	USD 4,510,000
Support to PNFPs for medicines	JMS - Joint Medical Stores	TBD*
HIV/AIDS response	JOINT UNITED NATIONS PROGRAMME ON HIV/AI	USD 80,000
Deliver Project	JSI - JOHN SNOW INC	TBD*
NUMAT	JSI - JOHN SNOW INC	USD 4,490,000
STAR-EC	JSI - JOHN SNOW INC	USD 5,200,000
TB Care	KNCV	TBD*
UAMIS - Uganda AIDS and Malaria Indicator Survey	MACRO INTERNATIONAL, INC	USD 1,670,000
STAR -Eastern	MSH - MANAGEMENT SCIENCES FOR HEALTH	USD 6,520,000
STRIDES for Family Health	MSH - MANAGEMENT SCIENCES FOR HEALTH	TBD*

Project name	Name of counterpart/ partner if any	Total expenditure for 2011/12 (less administration expenses for the organisation/ institution)
SURE- Securing Ugandans' Right to Essential Medicines	MSH - MANAGEMENT SCIENCES FOR HEALTH	USD 7,370,000
Long Term Methods Family Planning Program	MARIE STOPES UGANDA	USD 1,230,000
Realizing Expanded Access to Counseling and Testing for HIV in Uganda (REACH-U) Project	MJAP - Mulago Mbarara Joint AIDS Program	USD 2,060,000
Quality Assurance	NDA - NATIONAL DRUG AUTHORITY	TBD*
Peace Corps SPA	Peace Corps	TBD*
SEARCH	POPULATION COUNCIL	TBD*
RUTF	RECO INDUSTRIES LTD	USD 600,000
Comprehensive Community Based HIV/AIDS Prevention Care & Support	REPRODUCTIVE HEALTH UGANDA	USD 730,000
MEEPP II- Monitoring and Evaluation of Emergency Plan Progress	SSS - SOCIAL AND SCIENTIFIC SYSTEMS, INC.	USD 2,450,000
NUHITES	Plan International	TBD*
Comprehensive Community Based HIV/AIDS Prevention Care & Support (TASO)	TASO - THE AIDS SUPPORT ORGANIZATION	USD 1,820,000
UMEMS - Uganda Monitoring & Evaluation Management Services (UMEMS)	TMG - THE MITCHELL GROUP INC	USD 1,820,000
DHS - Demographic & Health Survey	UBOS - UGANDA BUREAU OF STATISTICS	USD 3,300,000
SMMORE - Strengthening Ministry of Gender's Management of the OVC Response	UNICEF	USD 70,000
NULIFE	URC - University Research Co., LLC	USD 630,000

Project name	Name of counterpart/ partner if any	Total expenditure for 2011/12 (less administration expenses for the organisation/ institution)
SUSTAIN - Strengthening Uganda's Systems for Treating AIDS Nationally	URC - University Research Co., LLC	USD 7,030,000
WHO Polio grant	World Health Organization	TBD*
World Health Organization Umbrella Grant	World Health Organization	TBD*
SPEAR- Supporting Public sector workplaces to Expand Action and Responses	WVI - WORLD VISION, INC	USD 1,850,000
		USD 120,100,000

(Footnotes)

1 The 13 RRH exclude Naguru RRH whose HRH situation had not been established by March 2012.