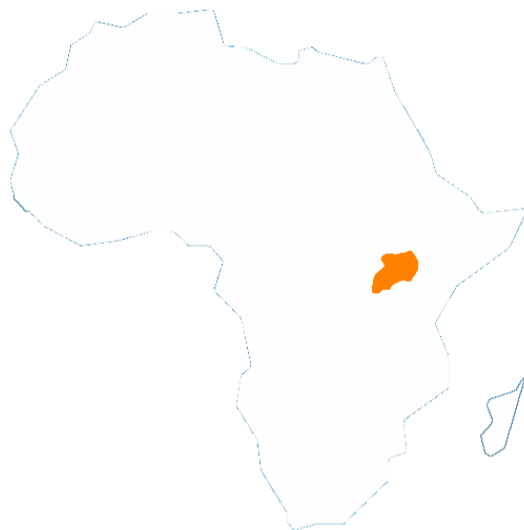


UGANDA

EAST AFRICAN COMMUNITY INTEGRATED REPRODUCTIVE, MATERNAL, NEWBORN AND CHILD HEALTH/HIV/TB/GBV SCORECARD



Ministry of Health
REPRODUCTIVE HEALTH | KAMPALA, UGANDA



EXECUTIVE SUMMARY

The goal of this summary is to give the highlights in the process to review of the country's progress towards the set EAC targets of the key RMNCAH/HIV/TB/GBV outcome indicators. Furthermore, to document implementation of the action plan/commitments derived from the 2018 Regional scorecard review and also prepare for the 2019 Annual country status scorecard.

To accomplish this, the objectives set out to:

- To support the Ministry of Health Uganda to review progress on the implementation of the action plans/Commitments resulting from the 2018 Regional EAC integrated SC.
- Update the indicators of the EAC Integrated RMNCAH/HIV/TB/GBV scorecard and upload the agreed results onto the EAC web portal

The assessment used a range of qualitative tools and rigorous evaluation. This was conducted by data collection through desk reviews, document reviews, key informant discussions, interviews, in depth stakeholder meetings, and stakeholder's consultative, and validation workshops.

Overall for the indicators on RMNCAH/HIV/TB/GBV, focusing on the indicators for Maternal Health, The Institutional Maternal Mortality Ratio has steadily dropped over the past 10 years to 91.7 per 1,000 live births, other indicators like Total fertility rate, and Child Mortality have followed a similar pattern and reflect a drop. Other indicators like The modern Contraceptive Prevalence Rate at 36.4, and the reduction in the prevalence of malaria and diarrhoeal diseases also replicate the patterns as seen in the indicators above.

A key observation made was in terms of the trends in Health Financing which reflect a significant increase in funding by the GOU from 25.8% in 2011/12 to 42% in 2018/19.

Challenges :

Opportunities:

Recommendations:

ACRONYMS

ACT	Artemisinin-based Combination Therapy
AHSPR	Annual Health Sector Performance Reports
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infection
ART	Anti Retroviral Therapy
BCG	Bacille Calmette-Guérin
BMI	Body Mass Index
CBR	Crude Birth Rate
CPR	Contraceptive Prevalence Rate
CRP	C-Reactive Protein
DHS	Demographic and Health Survey
DHIS2	District Health Information Software
DPT	Diphtheria, Pertussis, and Tetanus vaccine
EAC	East African Community
ECDI	Early Child Development Index
EMNOC	Emergency Obstetric and Neonatal Care
GAR	Gross Attendance Ratio
GAVI	Global Alliance for Vaccines and Immunization
GBV	Gender-Based Violence
GFR	General Fertility Rate
HDP	Health Development Partners
HepB	Hepatitis B
Hib	<i>Haemophilus influenzae</i> type b
HIS	Hospital Information System
HIV	Human Immunodeficiency Virus
HRP-II	Histidine-Rich Protein II
HSDP	Health Sector Development Plan
HSSP	Health Sector Strategic Plan
HTC	HIV Testing and Counselling
ICD-10	International Classification of Diseases-10
ICF	<i>(originally, Inner City Fund)</i>
ICPD	International Conference on Population and Development
iMMR	Institutional Maternal Mortality Rate
IPPF	International Planned Parenthood Foundation
IPTp	Intermittent Preventive Treatment during pregnancy
IPV	Inactivated Polio Vaccine

IRS	Indoor Residual Spraying
ITN	Insecticide-Treated Net
IUD	Intrauterine contraceptive device
IYCF	Infant and Young Child Feeding
LAM	Lactational Amenorrhoea Method
LLIN	Long-Lasting Insecticidal Net
MAD	Minimum Acceptable Diet
mCPR	modern Contraceptive Prevalent Rate
MSPH	Makerere University School of Public Health
MAM	Moderate Acute Malnutrition
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MoFPED	Ministry of Finance Planning and Economic Development
MPDSR	Maternal Perinatal Death Surveillance and Response
MTCT	Mother-To-Child Transmission
NAP	National Action Plan
NAR	Net Attendance Ratio
NDP	National Development Plan
NGO	Non-Governmental Organization
NHA	National Health Accounts
NPHC	National Population and Housing Census
NTLP	National Tuberculosis and Leprosy control Program
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PCV	Pneumococcal Conjugate Vaccine
PEP	Post-Exposure Prophylaxis
Pf	<i>Plasmodium falciparum</i>
PHC	Primary Health Care
PHIA	Population-Based HIV Impact Assessment
PMA	Performance Monitoring for Action
PMTCT	Prevention of Mother-To-Child Transmission
PNFP	Private Not For Profit
PRMR	Pregnancy-Related Mortality Ratio
Pv	<i>Plasmodium vivax</i>
RDT	Rapid Diagnostic Test
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SAM	Severe Acute Malnutrition
SC	Sectoral Council

SDGs	Sustainable Development Goals
SDM	Standard Days Method
SP	Sulfadoxine / Pyrimethamine
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
TWG	Technical Working Group
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNRMCIP	Uganda National Reproductive, Maternal and Child health Improvement Project
UPHIA	Uganda Population based HIV - Impact Assessment
USAID	United States Agency for International Development
WCAH	Women Children and Adolescent Health
WHO	World Health Organization

ACKNOWLEDGEMENT

The Compilation of the EAC scorecard for Uganda has been developed through a consultative process involving key stakeholders in the health sector. A steering committee chaired by was constituted to backstop the consultant and provide necessary guidance in the compilation of the report. A series of meeting were held with key stakeholders to review and refine the report.

We acknowledge all individuals and agencies that participated in the compilation of this report in various capacities including as respondents to interviews. We are grateful for the support provided by other development partners in compilation and finalization of this report.

The Ministry of Health in Uganda would like to thank in a special way the AIDS Information Center and the United Nations Population Fund for the technical leadership and administrative follow-up. In addition, the technical support extended through the different partners in very much appreciated. Special thanks goes to the individuals who worked tirelessly to ensure that the report in complete.

Finally special appreciation is made to of the valuable inputs from the steering committee constituted to support the compilation of the report.

Ministry of Health

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1.0 INTRODUCTION

From early on in the century it has been a documented fact that the majority of HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding while sexually transmitted infections also increase the risk of HIV acquisition and transmission (WHO,2005). In addition, sexual and reproductive ill-health and HIV share root causes, including poverty, gender inequality and social marginalization of the most vulnerable populations. (UNFPA, 2009)

Optimizing utilization of sexual and reproductive health services through integrating HIV and SRH services is a key step to mitigating and effective management of the sexual reproductive and HIV related challenges but also an effective and efficient way of using the little available resources. This definitely requires alignment of the Policies, Guidelines and the health system.

Integrating SRH and HIV/AIDS policies, programs and services is essential for meeting international and national goals including the SDGs particularly Goals 3, 5 and 10 (WHO, UNFPA, UNAIDS and IPPF 2005). It is also an important human rights obligation particularly for people living with HIV, key populations, women and girls (UNAIDS 2010).

Since the Alma-Ata Conference, the health policy frameworks of PHC included reproductive health, mainly maternal and child health care including family planning (MCH/FP). Following the ICPD when the current understanding of reproductive health and its full scope took effect, other more areas of reproductive health such as Management of sexually transmitted diseases, adolescent health, prevention & management of infertility among others, were progressively included to the MCH/FP programs. The SDG

Even though the HIV/AIDS epidemic was recognized at that time as an important component of SRH, its programming and funding was considered in a vertical manner due to the scale and scare of the epidemic. Taking HIV/AIDS and Sexual and Reproductive Health and Rights (SRH&R) as totally separate entities is counterproductive and cannot assist in achieving goals and targets for either HIV or SRHR hence the need for Integration of Services and Programing.

1.1 Background

Uganda is an active member of the East African Community (EAC) and signatory and committed to the Provision of Health services especially HIV and SRHR services among other health service priorities with specific Strategic targets set as a region.

The Ministry of Health of Uganda has prioritized SRH/HIV integration through the service and Programs Integration strategy since 2006 revised the Strategy in 2012 and 2018. The Ministry since then has conducted some SRH/HIV integration interventions through AIDS Control Program and Reproductive Health division in an integrated manner.

The National policy guidelines and service standards for SRHR have since 2006 particularly emphasized SRHR and HIV integration as a key approach for effective and efficient service delivery. In the same way, The National HIV Strategic plans 2011/2015 and 2015/2020 also have identified SRH/HIV integration as a priority strategy for effective management of the Clients. A strategy to ensure this integration was developed in 2012 and revised in 2018 and to track implementation, monitoring and supervision tools and Service delivery guidelines realigned especially for MCH services to integrate HIV have also been put in place. These establishments demonstrate the government's Commitment to ensure services are provided in an integrated manner.

The 11th Sectoral Council of the EAC on Health approved the 1st EAC RMNCAH Scorecard endorsed in August 2015 by the 32nd EAC Council of Ministers, which directed the preparation of the scorecard on an annual basis. In 2016, the scorecard was expanded to include key HIV/AIDS and STI indicators hence overarching health sector management and accountability tool. The current report on the state of Women's, Children's and Adolescents' Health and HIV/AIDS is in response to the above provisions.

In view of the implementation of the commitments, it is important for member states to review their status as indicated in the Regional scorecard, the WCAH/HIV status report and also collect data to support the preparation of the annual country status to feed into the regional scorecard. In the same vein, action plans are reviewed to ensure accountability within the country.

It is against this background that the Ministry of Health in collaboration with and support from Partners like Aids information Center and UNFPA find it necessary to compile a country status report in relation to the Regional scorecard indicators to which will be validated and endorsed by the country and form a basis for the Sectoral commitments for 2020.

Setting up the National Steering Committee on SRH/HIV integration provide a platform for paving the best means to systematically ensure integration at the management level with the key stakeholders to strengthen integrated programming and Financing.

1.2 Outline of the broader context of the RMNCAH /HIV integration and Health system

how the health system in the country is organized

1.3 Aims and objectives of the report

Aim

The purpose of this report is to give a review of the country's progress towards the set EAC targets of the key RMNCAH/HIV/TB/GBV outcome indicators and Document implementation of the action plan/commitments derived from the 2018 Regional scorecard review and also prepare for the 2019 Annual country status scorecard.

Objective

- To provide a review of the progress made on the implementation of the action plans/ Commitments resulting from the 2018 Regional EAC integrated SC.
- To provide an update of the indicators of the EAC Integrated RMNCAH/HIV/TB/GBV scorecard and upload the agreed results onto the EAC web portal.

1.4 Events and milestones, 2016 to 2019

1.5. Strategic Directions and Priorities in the Uganda RMNCAH and HIV strategies

2.0 APPROACH

For this assignment, the consultant used a combination of desk review, stakeholders review meetings and key informant interviews for information collection from the key officials responsible for delivery of the Ministerial Commitments. The Task team on SRHR/HIV/GBV integration will be considered as the Technical advisory team, during whose meetings and other relevant stakeholder's meetings data collected and draft reports will be validated.

A desk review of relevant literature was conducted and it informed the development of an interview guide (Annex 2) for key informants, identified the key stakeholders (Annex 3) to interview and the proposed field sites. A comprehensive EAC scorecard indicator mapping tool (Annex 1) specifying data source and status has been developed. With support from the client, the consultant will organize a stakeholder's consultative workshop to brief all relevant stakeholders on the assignment.

The data collection phase includes visit to relevant stakeholders and Institutions to conduct in-depth interviews and collect relevant data and documents held by the stakeholders. This phase will also include a field visit component to a selected number of districts (Annex 3) that will be mapped to have applied the Integrated RMNCAH scorecard for accountability and planning as indicated in the Uganda National Reproductive, Maternal and child health improvement project (URMCHIP) progress reports and the annual Health sector performance reports (AHSPR) of Ministry of Health. In the field data collection, the consultant will collect information to enable documentation of good practices and lessons learned by the different stakeholders at National and Subnational level.

The consultant will compile and analyse the quantitative and Qualitative data collected, both at Sub-National and National level, for submission into the regional scorecard and for compilation of the draft Country progress review report. A template for upload of the data into the regional EAC scorecard will be provided by the client in liaison with the EAC secretariat and the consultant.

The consultant in collaboration with the client and the Ministry of Health will then hold and facilitate a stakeholder's validation workshop to review the draft progress/ status review report and compiled data for the National EAC scorecard for concurrence and

provision of comments. This workshop will use plenary presentations and group work in way of approach. During the Validation workshop, the consultant together with Ministry of Health will facilitate a session to generate key strategic recommendations which can be used by the Ministry to Draft the Ministerial commitment paper for the Minister to Use during the Regional EAC Sectoral council of Ministers.

After the Validation, the consultant will present the preliminary findings to the SRHR/HIV/GBV Integration core group / task team and then MCH TWG for review, input and adoption before sign off by the Director General of Health services for full Ministry adoption.

Inputs from the validation workshop will then be incorporated into the draft report and a final report compiled and submitted to the client. Feedback on the data for the scorecard will also be incorporated before the data is uploaded into the portal. A final dissemination workshop will then be organized where the final report and compiled scorecard will be presented and dissemination.

Layout of the report

3.0 PROGRESS AND TRENDS IN EAC SCORECARD INDICATORS

3.1. National Priorities: Progress towards Targets

Table 3.1 Status of EAC Regional Scorecard Indicators for Year 2018

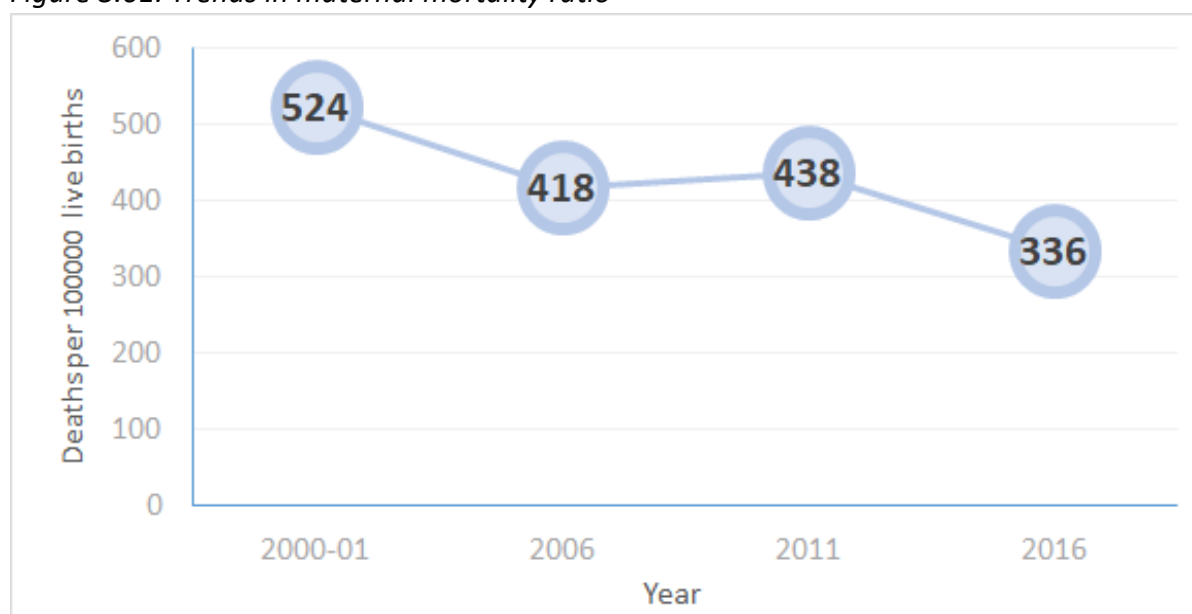
	EAC integrated Scorecard Indicator	Uganda Indicator Status	Data source	Comments
1	Maternal Mortality Ratio	336	Udhs 2016	Per 100,000 live births
2	Under-five Mortality Rate	64	Udhs 2016	Per 1000 live births
3	Neonatal Mortality Rate	27	Udhs 2016	Per 1000 live births
4	Under 5 Stunting Rate	29%	Udhs 2016	
5	Antenatal care (4+ visits)	60%	Udhs 2016	
6	Health Facility Delivery Rate	73%	Udhs 2016	
7	Postnatal Care-mother (within 2 days)	54%	Udhs 2016	
8	Postnatal Care-baby (within 2 days)	56%	Udhs 2016	
9	DPT3/Pentavalent Coverage	79%	AHSPR, - DHIS2 2019	
10	Percent HIV+ pregnant women receiving ARVs for PMTCT	90.7%	AHSPR	This comprises the Pregnancy in ANC, in labour and in PNC
11	Contraceptive Prevalence Rate	34	PMA 2020, 2018	
12	Adolescent Pregnancy Rate	25	Udhs 2016	
13	Total Health Expenditure per Capita (\$USD)	53	NHA report 2015/16	Proportion of the National budget to the Health sector is approx. 6.9%
14	Density of Skilled Health Personnel (midwives, nurses and physicians) per 10,000 population)	16	HRH AUDIT REPORT, 2018	Per 10,000 population

	EAC integrated Scorecard Indicator	Uganda Indicator Status	Data source	Comments
15	Percentage of people living with HIV who know their status	66.2%	UPHIA, 2018	
16	Percentage of people currently receiving antiretroviral therapy. among those diagnosed with HIV	88.4%	UPHIA, 2018	
17	Proportion PLWHA screened for TB	30.8%	NTLP REPORT	
18	Percentage of pregnant women accessing antenatal care services who were screened for syphilis	86%	HIS, 2018	% Pregnant Women attending ANC tested for syphilis for first time during the Current pregnancy

3.1. Maternal Mortality

Complications during pregnancy and childbirth are a leading cause of death and disability among women of reproductive age in developing countries. The maternal mortality ratio (MMR) represents the risk associated with each pregnancy, i.e. the obstetric risk. In Uganda, the maternal mortality ratio is measured every five years through the Uganda Demographic and Health survey. Below is a figure with MMR from 2000 to 2016.

Figure 3.01: Trends in maternal mortality ratio

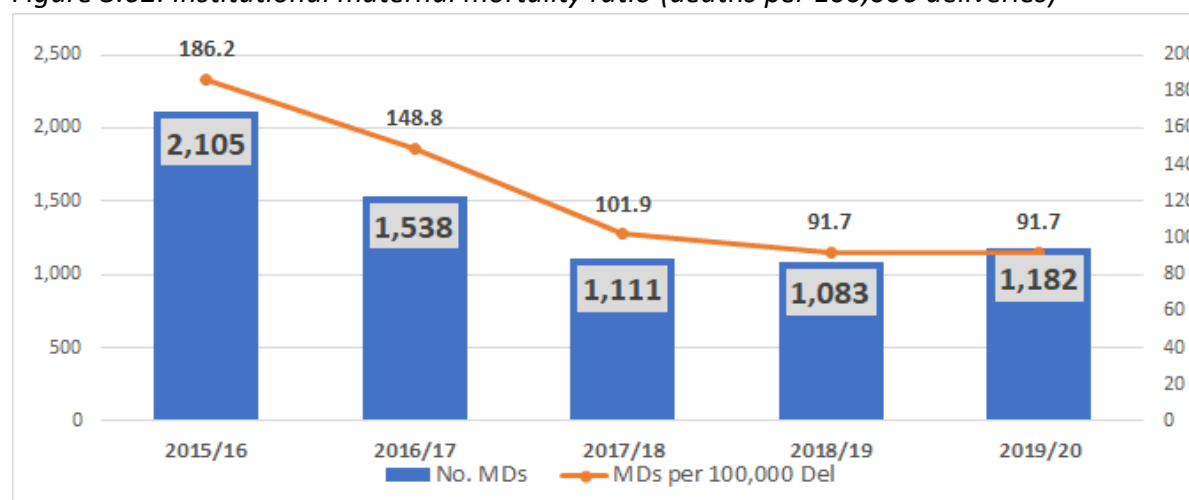


The 2015 global maternal mortality ratio was estimated to be 216 maternal deaths per 100,000 live births. Whereas the global maternal mortality ratio SDG target 2030 is to achieve less than 70 deaths per 100,000 live births, Uganda's statistics show that there has been a significant reduction in maternal mortality from 524 deaths in 2001 to 336 deaths per 100,000 live births in 2016.

Institutional maternal mortality ratio (iMMR) is a proxy for maternal mortality ratio and can show patterns in the trend of maternal death over time by the use of service data collected at health facilities. The Health Sector Development Plan uses this Proxy as an outcome measure for Quality of care and set out to Improve Quality of Maternal Health care and thus a target to reduce to 98 per 100,000 deliveries in Unit by 2020. There has been remarkable reduction. Since FY2015/16, the iMMR has shown a declining trend from 186, to 149 in FY2016/17, 102 in FY 2017/18 and 92 in FY2018/19 **Achieving the Set 2020 Target.** The reducing trends observed with iMMR is presumably directly related to that of the MMR. Figure 3.02 below shows the trend of iMMR in Uganda between FY2015/16 and FY2018/19.

Target 2020; 98 /100,000 del

Figure 3.02: Institutional maternal mortality ratio (deaths per 100,000 deliveries)



Source: DHIS2

MPDSR

Under the IDSR maternal and perinatal death notification and review must be conducted for each maternal or perinatal death recorded at a health facility. The notification and review of these deaths serve to establish the cause of death allowing for corrective action to be taken in the future. The notification rate and review rate and indicators used to measure these. It is a requirement that every death should be reviewed to Isolate the cause especially the Gaps in Care hence avoidable factors and Through QI interventions by the different levels ranging from Facility, District region and National level are implemented as recommended to improve quality of care and prevent death from similar circumstances.

Figure 3.03 below gives a summary of trends observed in Uganda in the level of notification and review of maternal deaths.

Figure 3.03: Maternal death notification and review

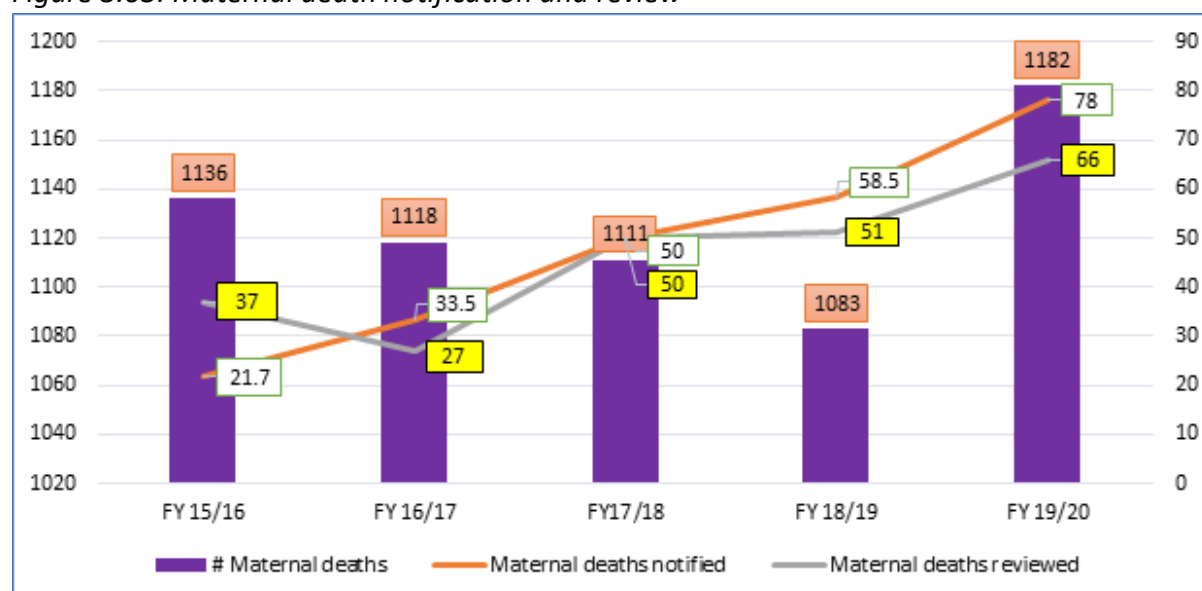


Figure 3.04 below gives a summary of trends observed in Uganda in the level of notification and review of perinatal deaths.

Figure 3.04: Perinatal deaths notification and review

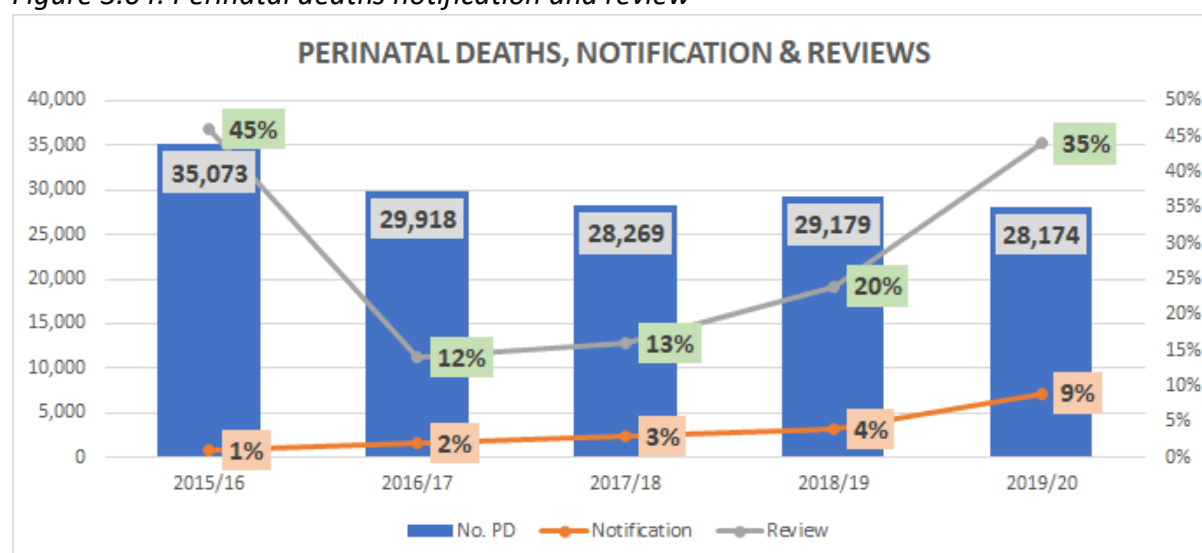


Table 3.2: Causes of maternal deaths (DHIS2)

	FY 2016/17	FY 2017/18	FY 2018/19
Major Cause of Maternal Deaths	Hemorrhage (34%)	Hemorrhage (35.2%)	Hemorrhage (33%)
	Pregnancy related	Obstructed	Obstructed

	Sepsis (18%)	labour/ruptured uterus (13.3%)	labour/ruptured uterus (13%)
	Eclampsia (16%)	Eclampsia (12.5%)	Eclampsia (11%)
	Obstructed labour/ruptured uterus (15%)	Indirect causes of MD (malaria, severe anaemia and other infections) (11.4%)	Indirect causes of MD (malaria, severe anaemia and other infections) (9%)
	Ectopic Pregnancy (10%)	Pregnancy related Sepsis (8%)	Pregnancy related Sepsis (6%)

MPDSR annual report 2016/17, 2017/18 & 2018/19

2.2. Child mortality

The SDG 3 3.2 Health targets by 2030, is to end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births.

Figure 3.5 below gives a summary of trends observed in Uganda in the level of infant and Neonatal Mortality. Infant mortality has reduced from 88 per 1000 in FY2000/01 to 64 per 1000 in FY2015/16 whereas Neonatal mortality reduced from 33 per 1000 in FY2000/01 to 27 per 1000 in FY2015/16. As shown in the trends, Neonatal mortality has not further reduced since 2006.

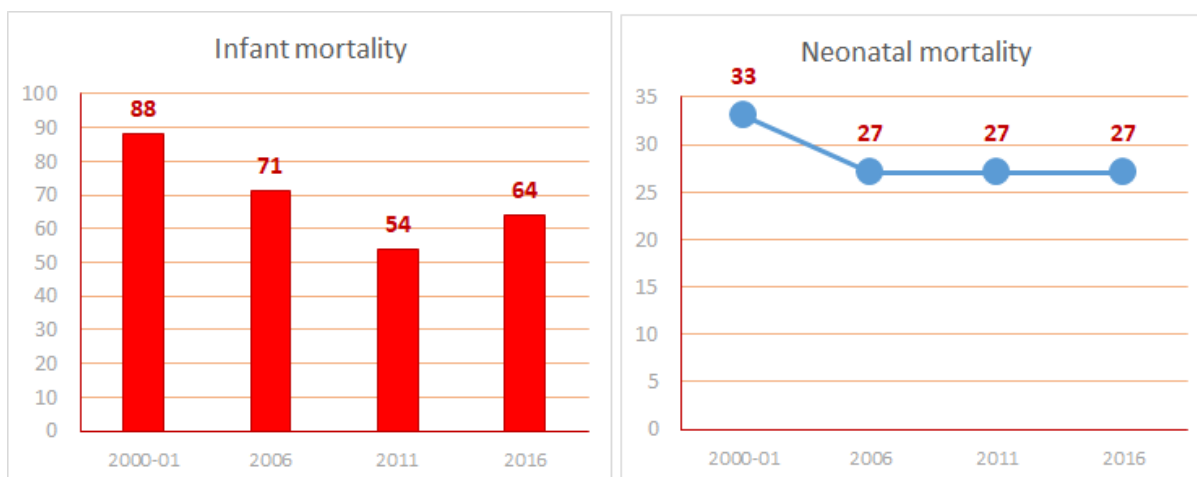


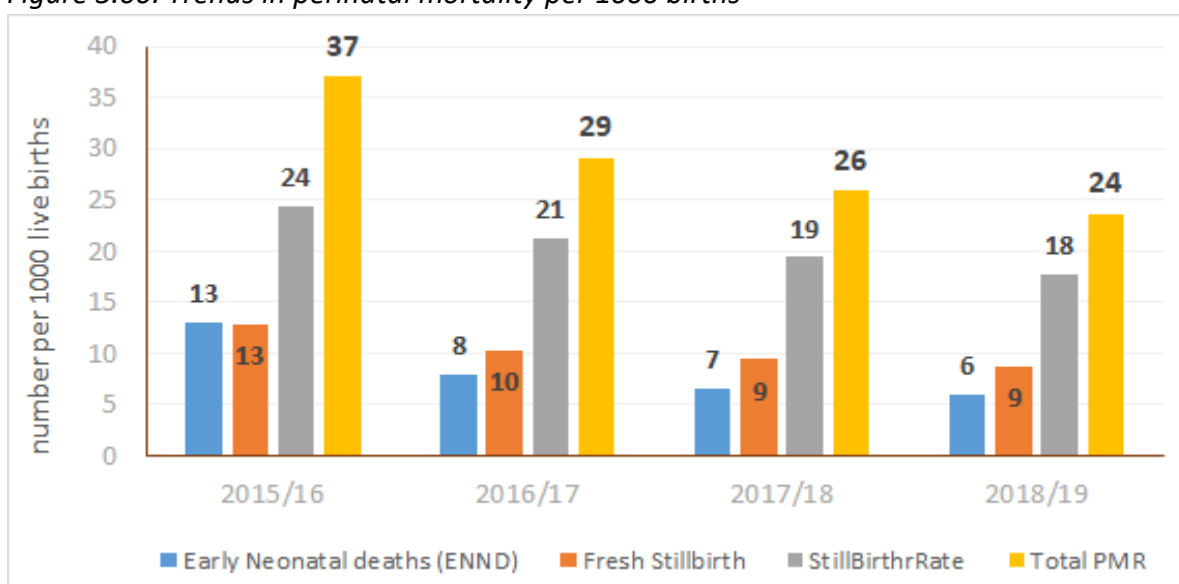
Figure 3.05: Trends in Infant and Neonatal mortality

Perinatal mortality rate (PMR) by type (DHIS2)

Globally, the perinatal mortality rate (PMR) is 53 per 1000 live births. The SDG target for all countries aims at reducing neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births.

Figure 3.06 below gives a summary of trends observed in Uganda in the level of Early Neonatal Deaths and Total Perinatal Mortality Rate. Early Neonatal deaths and perinatal mortality rates reduce significantly from 13 and 37 in FY2015/16 to 6 and 24 per 1000 live births in FY2018/19 respectively.

Figure 3.06: Trends in perinatal mortality per 1000 births

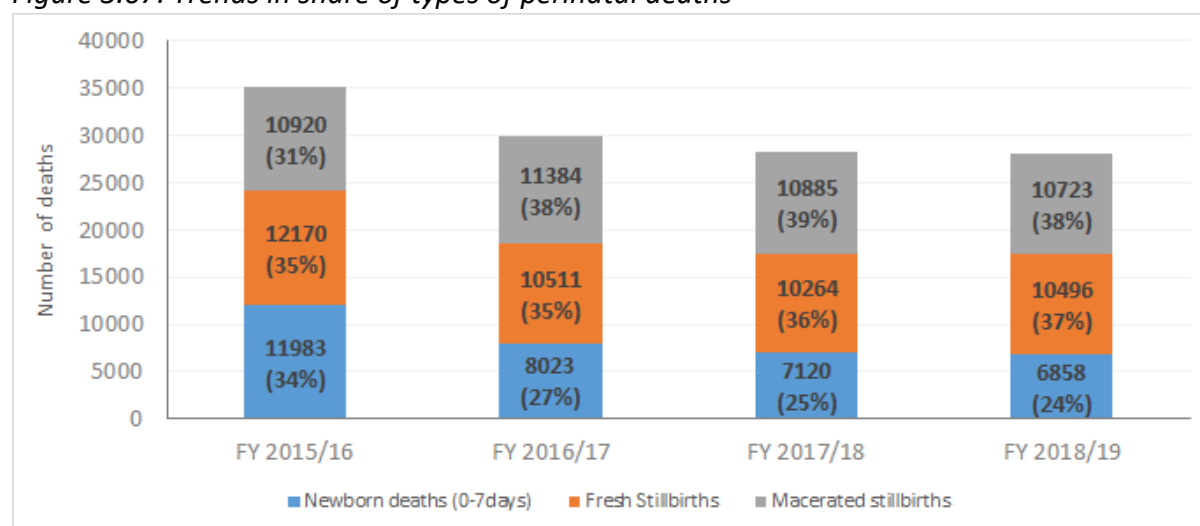


Source: DHIS2

ENND per 1000 live births

Even though there has been a significant reduction in perinatal mortality in the past 4 years, Figure 3.07 below gives a summary of perinatal deaths and whereas Newborn deaths (0-7 days) have reduced from 11983 in FY2015/16 to 6858 in FY2018/19, Fresh stillbirths and Macerated births still make up the biggest percentage of perinatal deaths although overall figures show that they have slightly reduced since 2016.

Figure 3.07: Trends in share of types of perinatal deaths



Source: MoH-DHIS 2019

Table 3.3: Leading Causes of Perinatal Deaths

	2017	2017/18	2019
Major Cause	Birth asphyxia (48.7%)	Birth Asphyxia (69.3%)	Birth Asphyxia 35%
	Infections (34.5%)	Infections (13.9%)	Complications of Pre-Maturity 12%
	Complications of prematurity (14.4%)	Complications of Prematurity (10.7%)	Infections 6%
	Birth trauma (subdural hemorrhage, CNS/scalp injuries) (2.5%)	Birth Trauma (subdural hemorrhage, CNS/scalp injuries) (3.6%)	Birth Traumas (subdural hemorrhage, CNS/scalp injuries) (2%)
		Congenital Syphilis (1.9%)	Tetanus 1%

MPDSR annual report 2016/17, 2017/18 & 2018/19

2.3. Fertility

2.3.0 Reproductive Health Profiling 2018

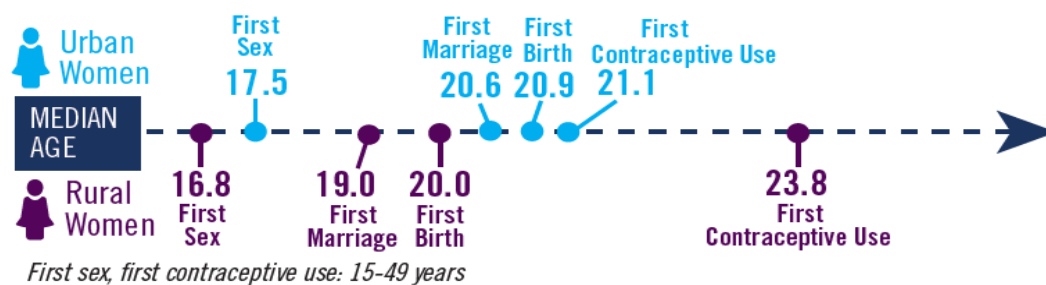
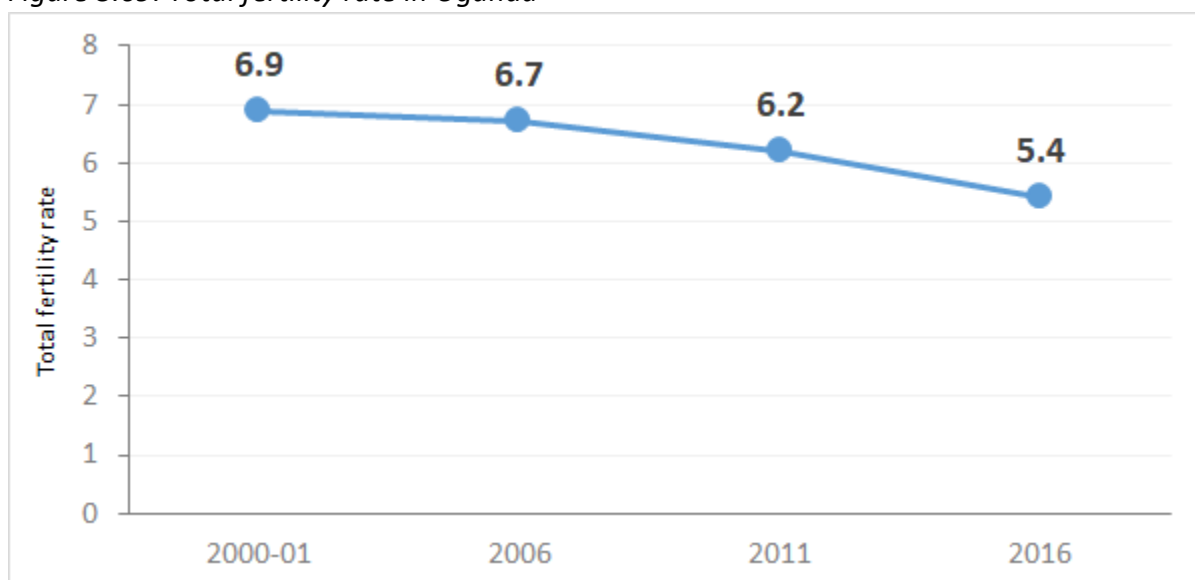


Figure 3.08: Median age for key events for women

Total Fertility Rate

Total Fertility Rate has continued to decline worldwide with global TFR of 2.4 reported in 2019. Figure 3.09 below gives a summary of trends observed in Uganda in the Total Fertility Rate, and as shown in the trend it has declined from 6.9 in FY2000/01 to 5.4 in FY2015/16.

Figure 3.09: Total fertility rate in Uganda



Total fertility by Region (2016-UDHS)

According to UDHS 2016 findings, Total Fertility Rate was highest in Karamoja with a record 7.9 followed by Busoga and Bukedi sub-regions with 6.1, whereas Kampala

at 3.5, Kigezi at 4.6, Ankole at 4.9 and South Central at 4.7 were the sub-regions with the lowest TFR.

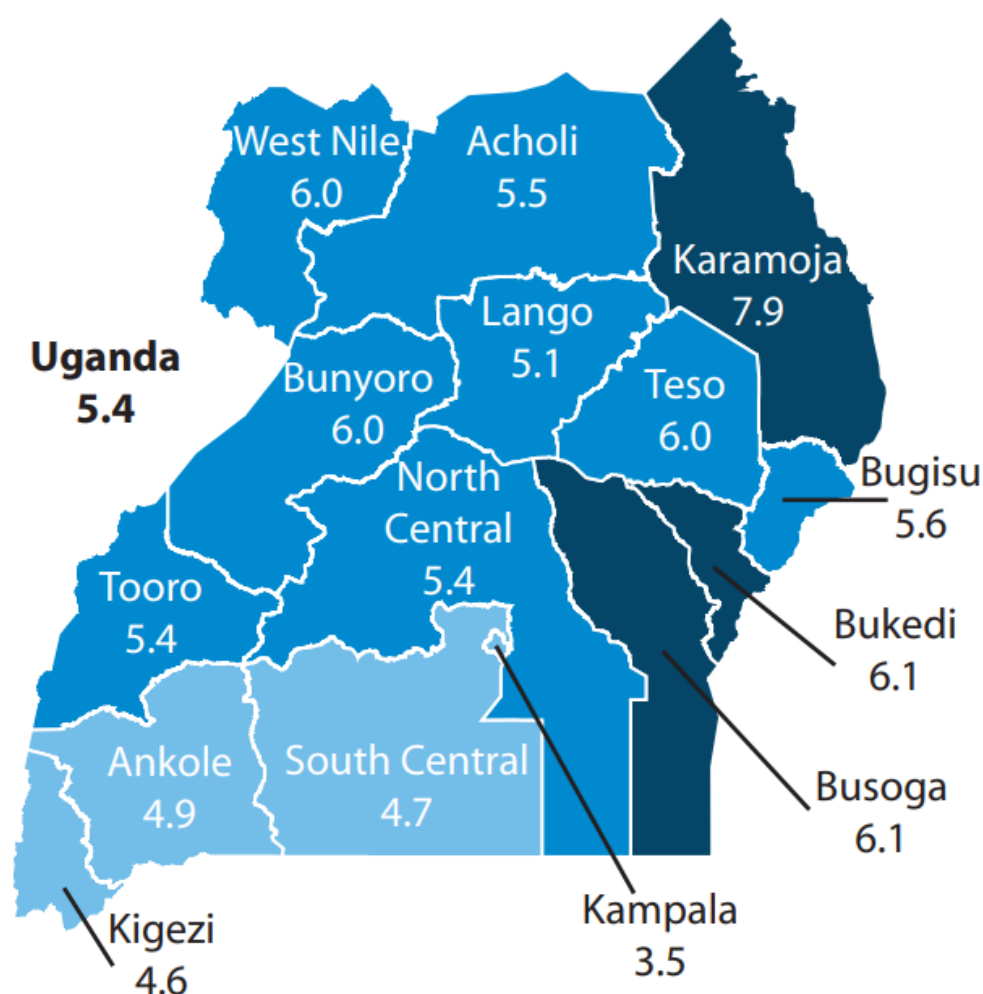
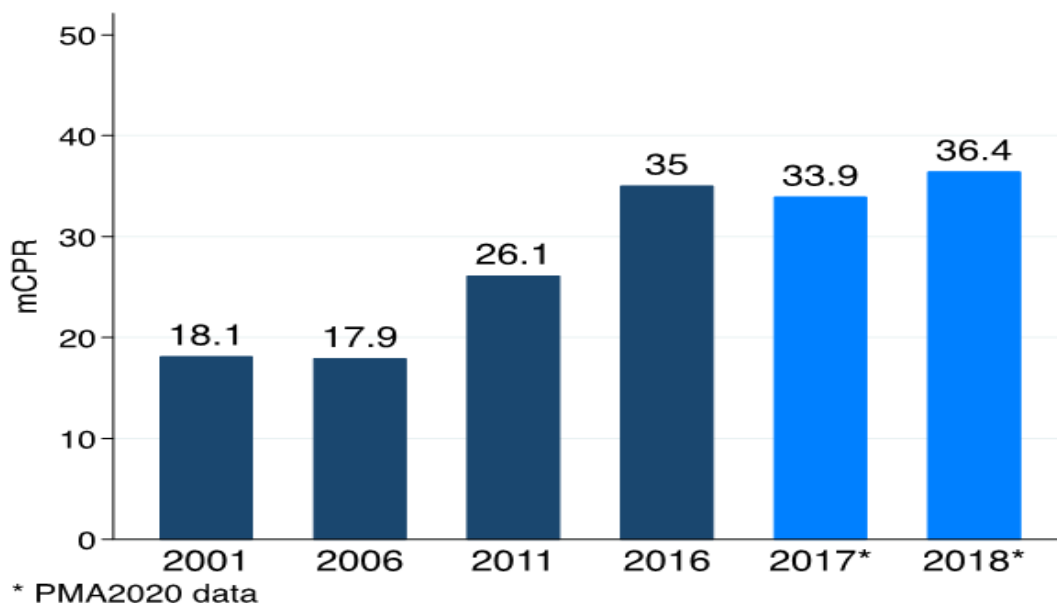


Figure 3.10: Contraceptive prevalence Rate.

The SDG 3 Target 3.7 by 2030, is to ensure universal access to SRH care services, including for family planning, information and education, and integration of reproductive health into national strategies and programmes. mCPR focuses on Indicator 3.7.1: Proportion of women of reproductive age (15-49 Years) who have their need for family planning satisfied with modern methods.

Figure 3.11 below gives a summary of trends observed in Uganda in the level of modern Contraceptive Prevalence rate. The trends have improved with 36.4% of women in reproductive age having access to family planning methods in 2018 compared to only 18.1% in 2001.

Figure 3.11: level of modern Contraceptive Prevalence rate



Unmet need FP2020 set the target of reaching 120 million new contraceptive users globally by 2020, which equates to around 15 million a year.

Figure 3.12: UNMET NEED (Sexually active and among married)

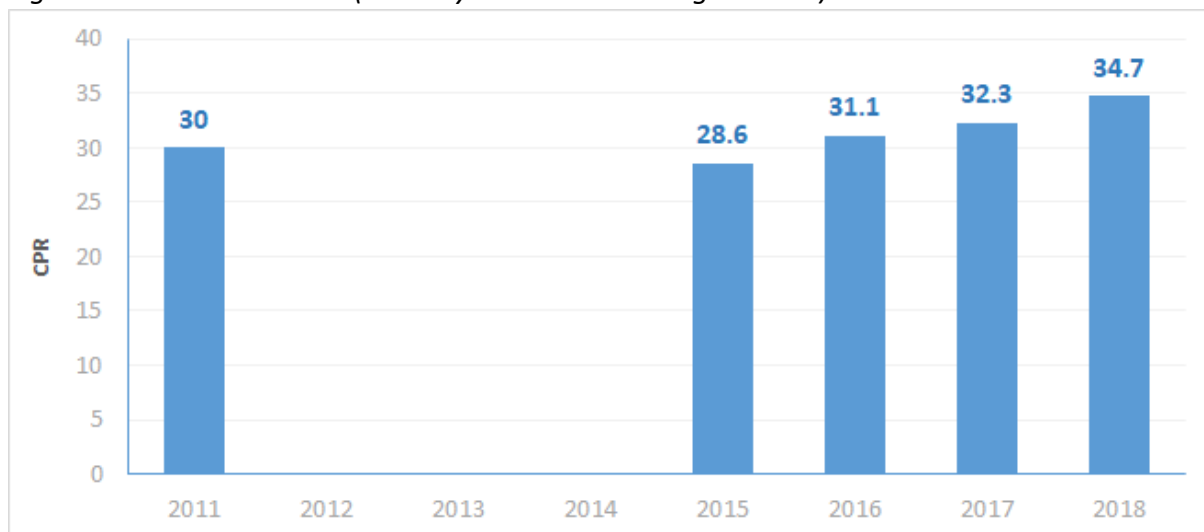
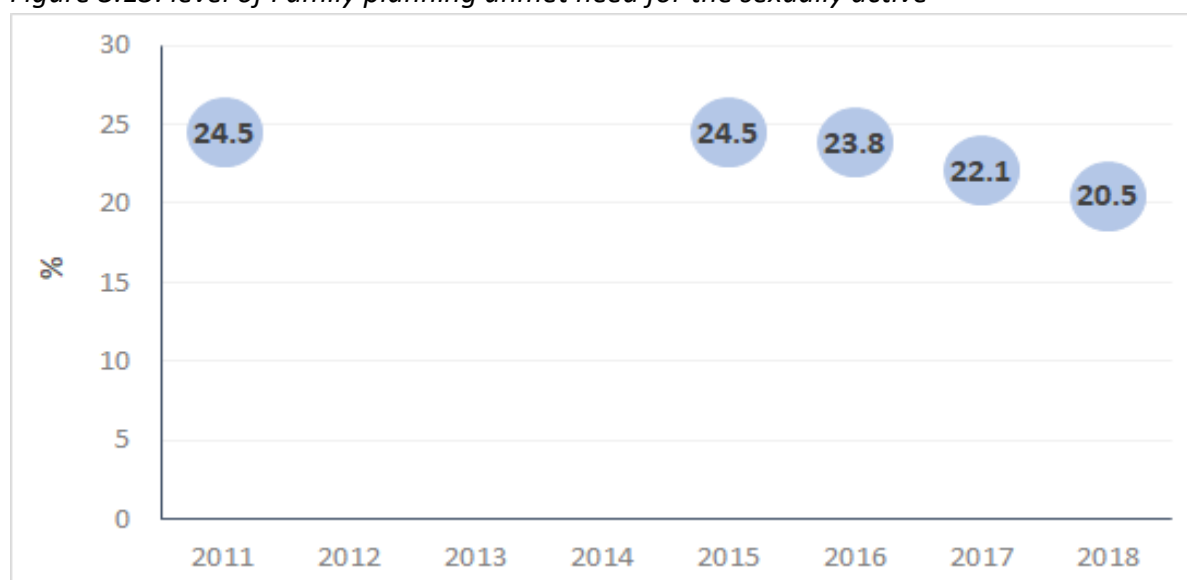


Figure 3.13 below gives a summary of trends observed in Uganda in the level of Family planning unmet need for the sexually active and among the married. The percentage of Sexually active and among married with unmet need has been reducing since 2015 from 24.5% to 20.5% in 2018.

Figure 3.13: level of Family planning unmet need for the sexually active



Couple Years of Protection (CYP) procured (RH Inter-switch)

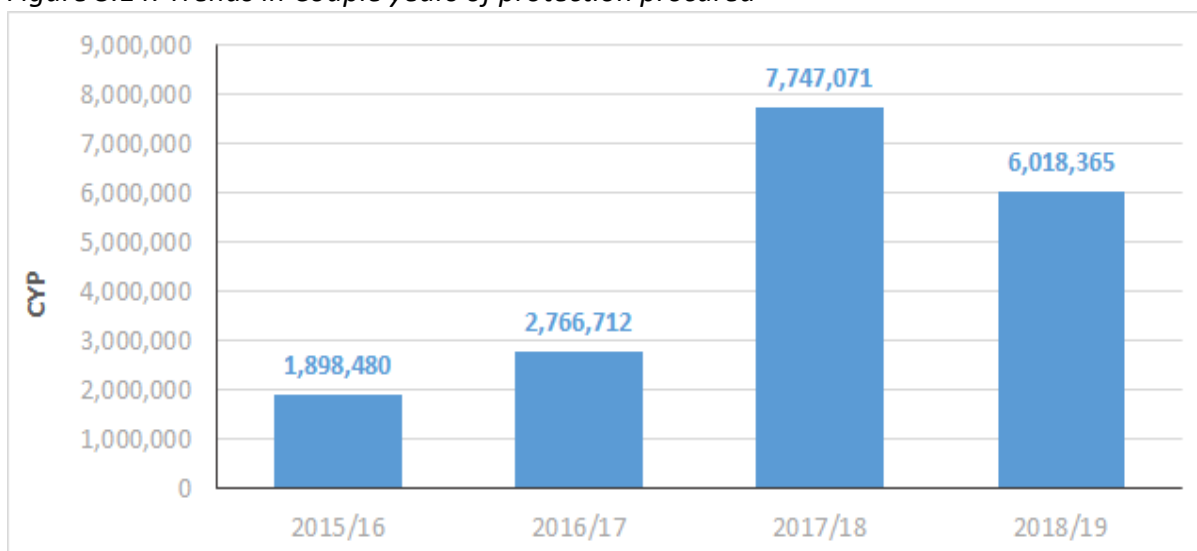
Table 3.4 below gives a number methods that have been used by couples for protection. Condom use has greatly increased under the male from 148,001 couples in FY2015/16 to over 1.5 million couples in FY2018/19. IUDs have consistently dominated the methods of choice with over a million of couples opting for them since 2015 to date.

Table 3.4: Couples years of protection by type Supplied

Method	Conversion Factor	CYP 2015/16	CYP 2016/17	CYP 2017/18	CYP 2018/19
Condoms – Female	0.008333	22,500.0	0.0	7,083.3	6,666.7
Condoms - Male	0.008333	148,001	150,000	837,370	1,529,690
Implants (pieces)	3.8	0	382,098	4,033,411	1,856,057
Injectable (doses)	0.25	509,650	1,587,500	1,287,750	1,165,900
IUDs (pieces)	4.6	1,058,000	0	1,154,600	1,277,880
Orals - Combined	0.066667	143,998	626,475	388,000	166,667
Orals - Emergency	0.05	12,405	0	19,080	7,560
Orals - Progestin Only	0.066667	3,926	20,640	19,776	7,944

Total CYP		1,898,480	2,766,712	7,747,071	6,018,365
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Figure 3.14: Trends in Couple years of protection procured



Trends in Funding and Sources for Contraceptives

Table 3.5 below gives a summary of key funding stakeholders for contraceptive commodities in Uganda since 2015. USAID and UNFPA have continued to demonstrate their commitment to making available contraceptive commodities with a combined contribution averaging over 95% of the annual budget.

Table 3.5: key funding stakeholders for contraceptive commodities in Uganda since 2015

SOURCE	CYP 2015/16	CYP 2016/17	CYP 2017/18	CYP 2018/19
<i>Others</i>	0	0	\$1,519,680	\$2,703,110
<i>IPPF</i>	\$8,506	0	0	0
<i>UNFPA</i>	\$2,942,918	\$4,490,167	\$6,069,155	\$4,951,271
<i>USAID</i>	\$1,753,303	\$5,212,113	\$10,756,546	\$6,939,479
Total	\$4,704,727	\$9,702,280	\$18,345,381	\$14,593,860

CYPs dispensed

Table 3.6 below gives a summary of trends observed in Uganda in the way commodities for CYPs are dispensed. Although it's evident that couples have a preference for long term methods as demonstrated with higher totals since 2015, the trends for the use of both short term and long term methods has been steadily increasing since 2015 to 2019 as shown by the improvement from 944,587 to over 1.3 million couples that use short term methods and 1.4 million to over 2.8 million couples using long term methods.

Table 3.6: way commodities for CYPs are dispensed

Method Dispensed	CYP 2015/16	CYP 2016/17	CYP 2017/18	CYP 2018/19	CYP 2019/2020
<i>Short Term (Condoms, ECPs, Oral Pills, Injectables)</i>	944,587	880,286	775,489	1,317,641	657,196
<i>Long Term (Implants, IUDs, Tubal Ligation & Vasectomy)</i>	1,437,411	1,993,027	2,321,623	2,873,463	2,915,813
TOTAL CYP	2,381,997	2,873,313	3,097,111	4,191,104	3,573,009

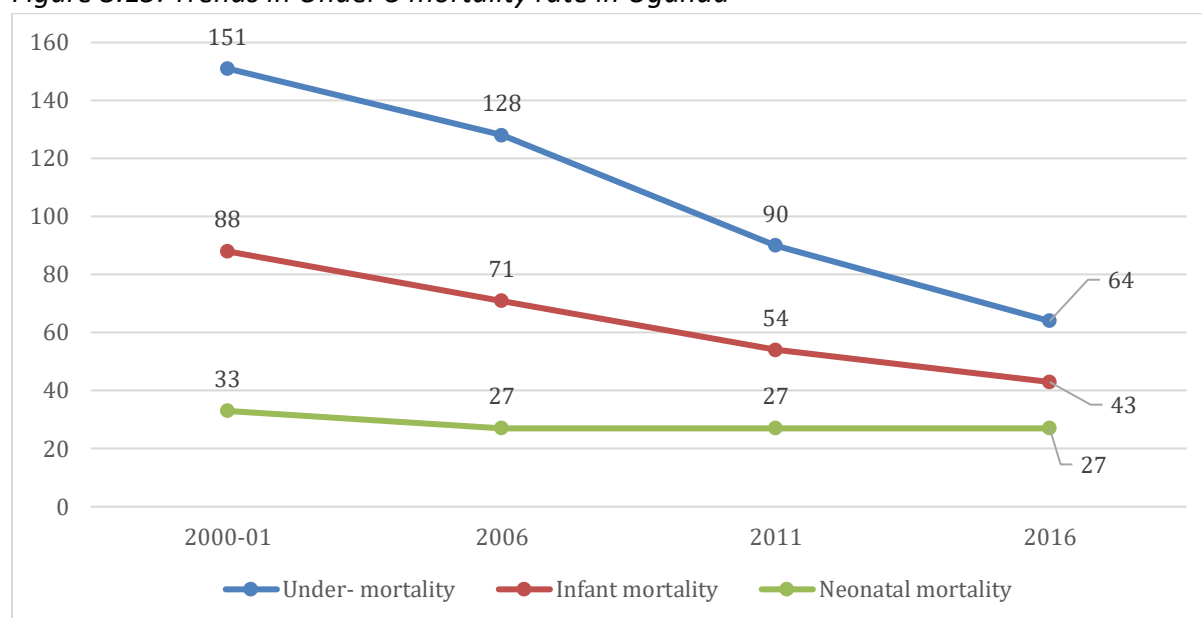
Source: DHIS2

3.2. Child Health

Under 5 mortality (Target by 2020;

In the 5-year period before the 2016 UDHS, the neonatal mortality rate was 27 deaths per 1,000 live births, implying that 1 in every 37 children die in the first month of life. The infant mortality rate in the same period was 43 deaths per 1,000 live births, meaning that 1 in 23 children die before his or her first birthday. The under-5 mortality rate of 64 deaths per 1,000 live births means that 1 in 16 children die before reaching age 5. Two-thirds (67%) of all deaths in the first 5 years of life take place between birth and the first birthday. Forty-two percent of deaths occur within the first month of life

Figure 3.15: Trends in Under 5 mortality rate in Uganda

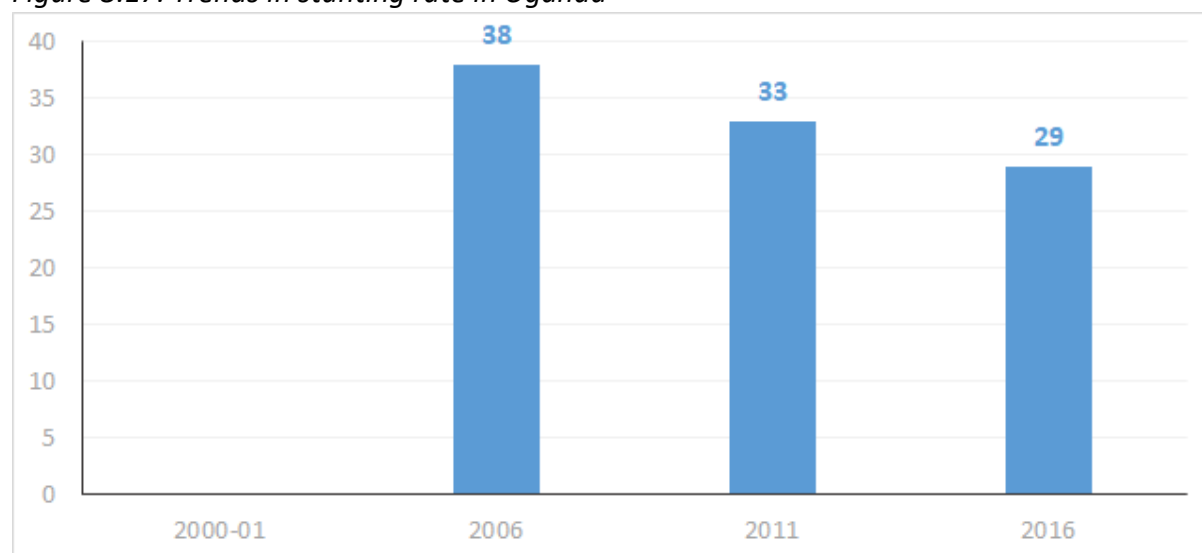


Source: UDHS

Stunting

WHO's member States endorsed global targets for improving maternal, infant and young child nutrition and that by 2025, there should be 40% reduction in the number of children under-5 who are stunted. Although there has been slow progress, the figure x below gives a summary of trends observed in Uganda in the way stunting has slowly reduced since 2006 from 38 to 29 stunted children in 2016.

Figure 3.17: Trends in stunting rate in Uganda

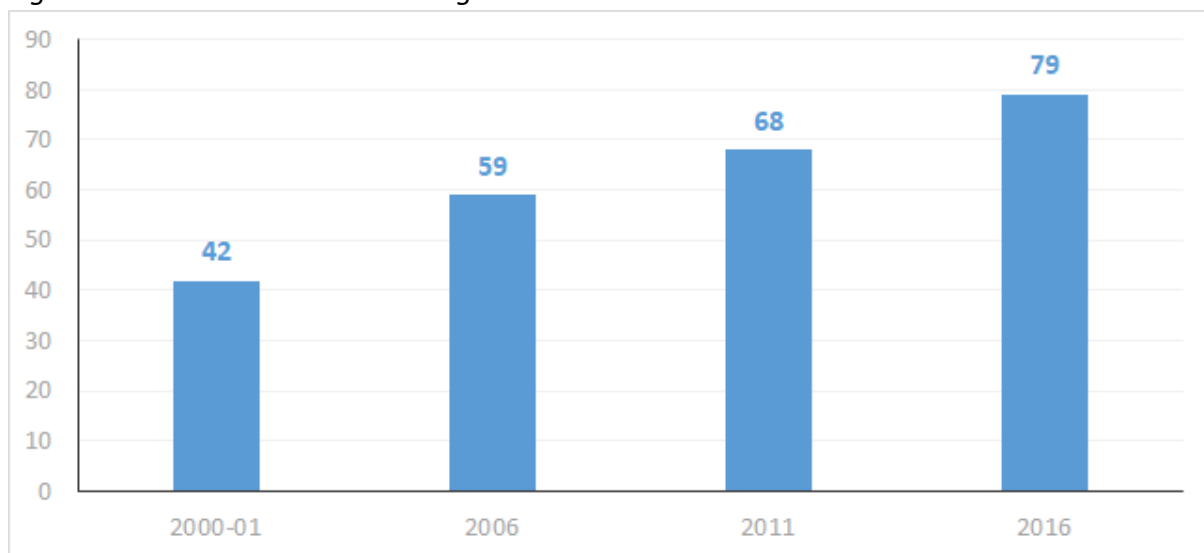


Source: UDHS

Immunization coverage (DPT3, measles) (DHIS2)

Three doses of DPT-containing vaccine, which protects against diphtheria, pertussis (whooping cough), and tetanus. Immunising children against vaccine-preventable diseases can greatly reduce childhood morbidity and mortality. Information on vaccination coverage was collected from the child's health card or the mother's direct report. Uganda's DPT-containing vaccine also protects against Hepatitis B (HepB) and Haemophilus influenzae Type b (Hib); it is known as DPT-HepB/Hib or the pentavalent vaccine.

Figure 3.18: Trends in DPT3 coverage

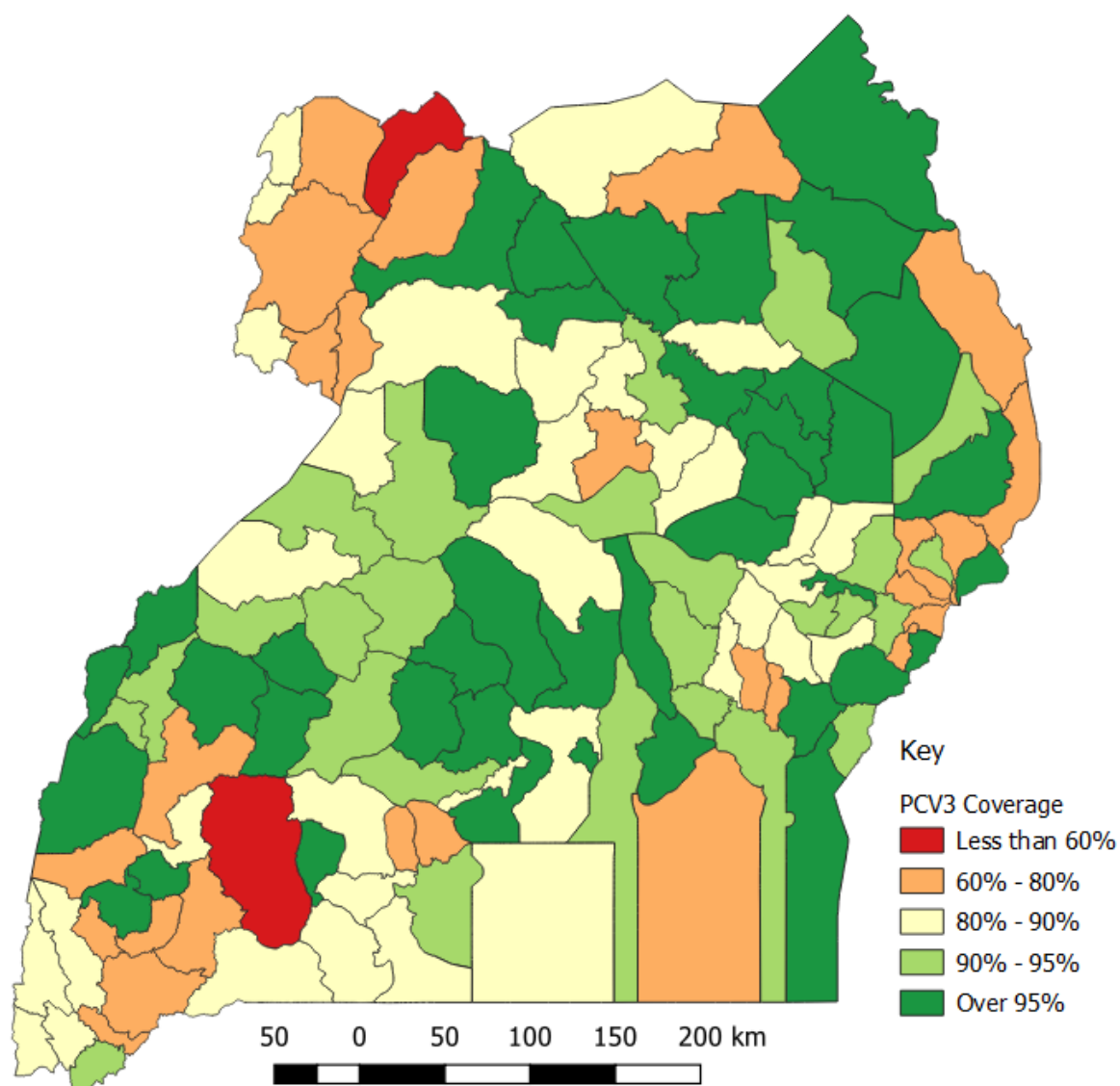


Source: UDHS

Over the year, there has been an increase in immunization coverage, Figure 3.18 above shows DPT3 coverage in Uganda over the years. Figure 3.19 below shows distribution of PCV3 coverage in Uganda in FY 2018/19.

The map below (Figure 3.19) shows the distribution of PCV3 coverage in Uganda for FY 2018/19. It can be observed that coverage in districts of west-Nile and southwest remains a significant challenge.

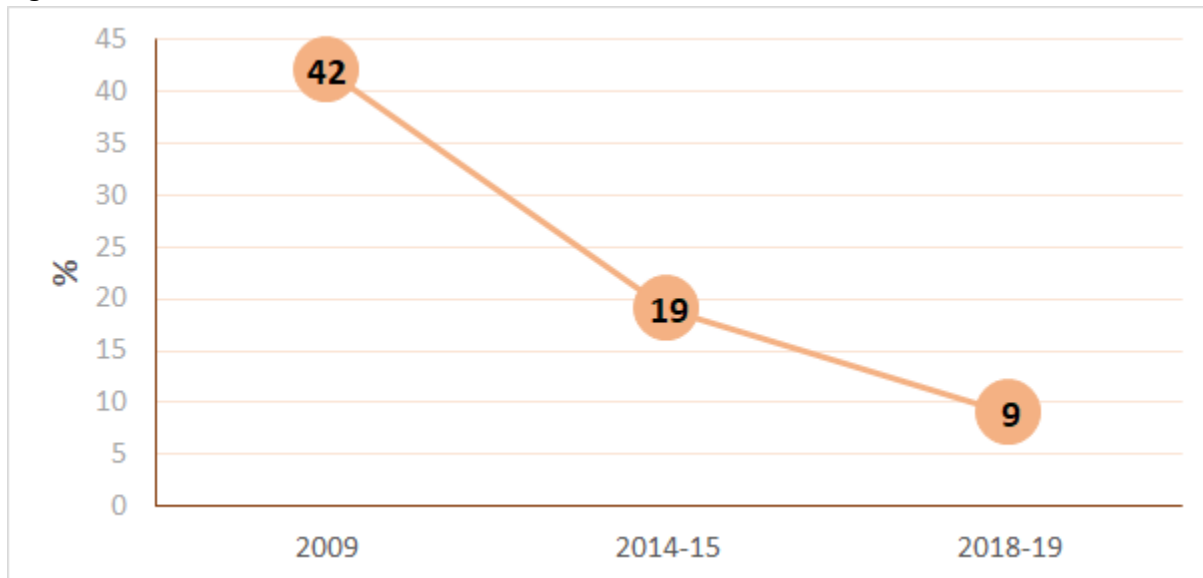
Figure 3.19: PCV3 Coverage in FY 2018/19



Incidence of common condition among under-5s

Figure 3.20 gives a summary of trends observed in Uganda in the Malaria prevalence since 2009. There has been a drastic reduction in malaria prevalence in Uganda as shown by the trend from 42% in 2009 to 9% in 2019.

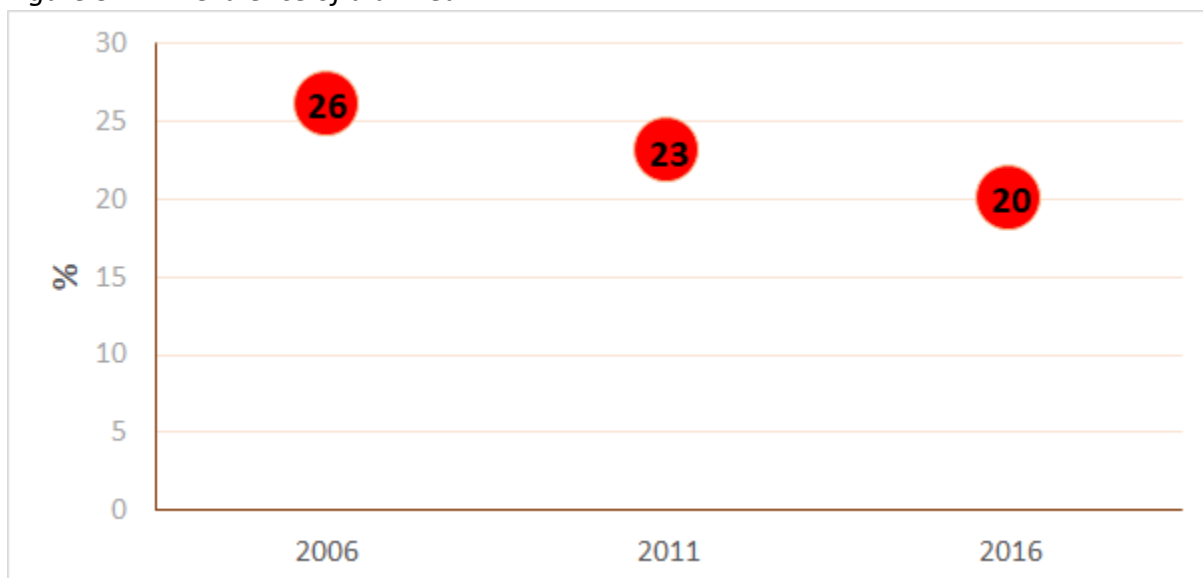
Figure 3.20: Malaria Prevalence



Source: MIS

Diarrheal diseases account for 1 in 9 or 9% of child deaths worldwide, making diarrhea the second leading cause of death among children under the age of five. Globally, from all causes of child deaths that occurs daily, diarrheal diseases accounts 15% more than 1600 children deaths under 5 years of age. Figure 3.21 below gives a summary of trends observed in Uganda in the Prevalence of Diarrhea, and findings show that there has been some reduction in the number of diarrhea cases annually from 26% in 2006 to 20% in 2016.

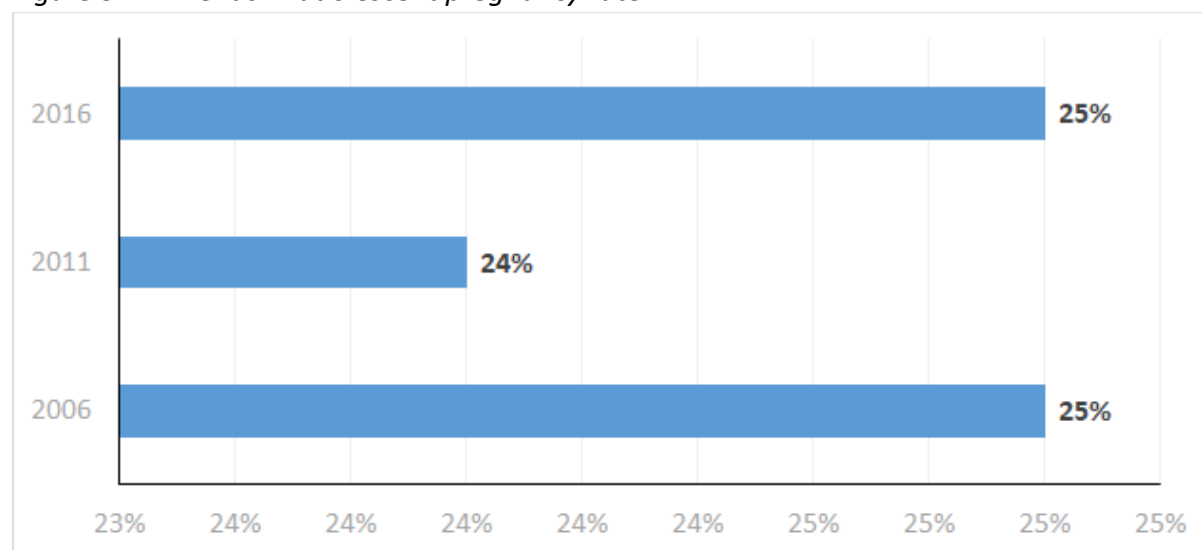
Figure 3.21: Prevalence of diarrhea



3.3. Adolescence

3.3.1 Adolescent pregnancy rate (UDHS) (Target by 2020; 14%)

Figure 3.22: Trends in adolescent pregnancy rate

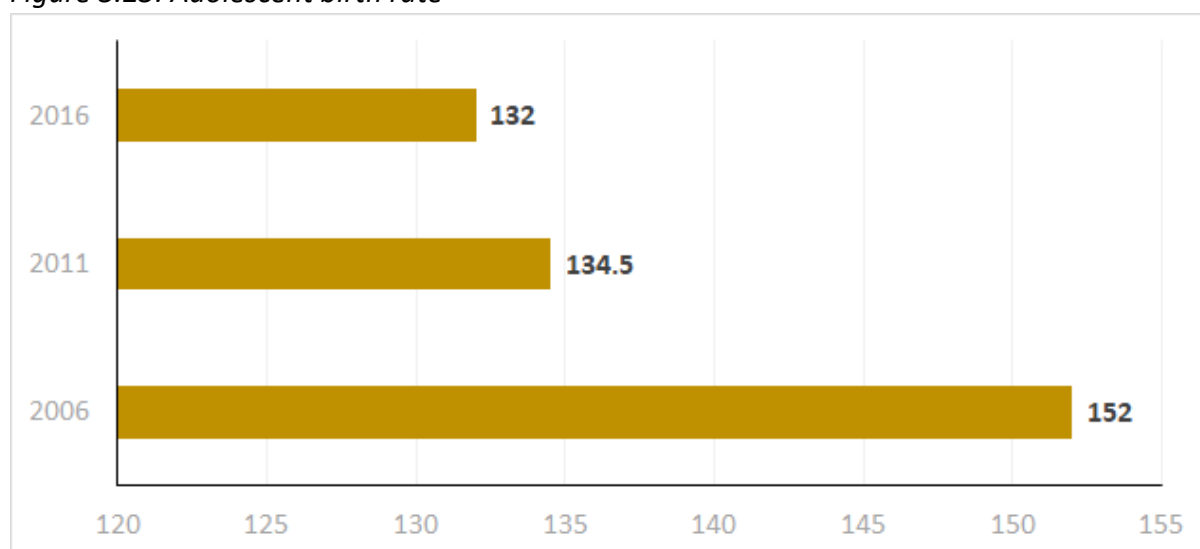


Between 2006 and 2011, Uganda observed a slight reduction in adolescent pregnancy rate (from 25% in 2006, to 24% in 2011), this however increased back to 25% between 2011 and 2016.

Adolescent birth rate per 1000 women 15-19 years (UDHS)

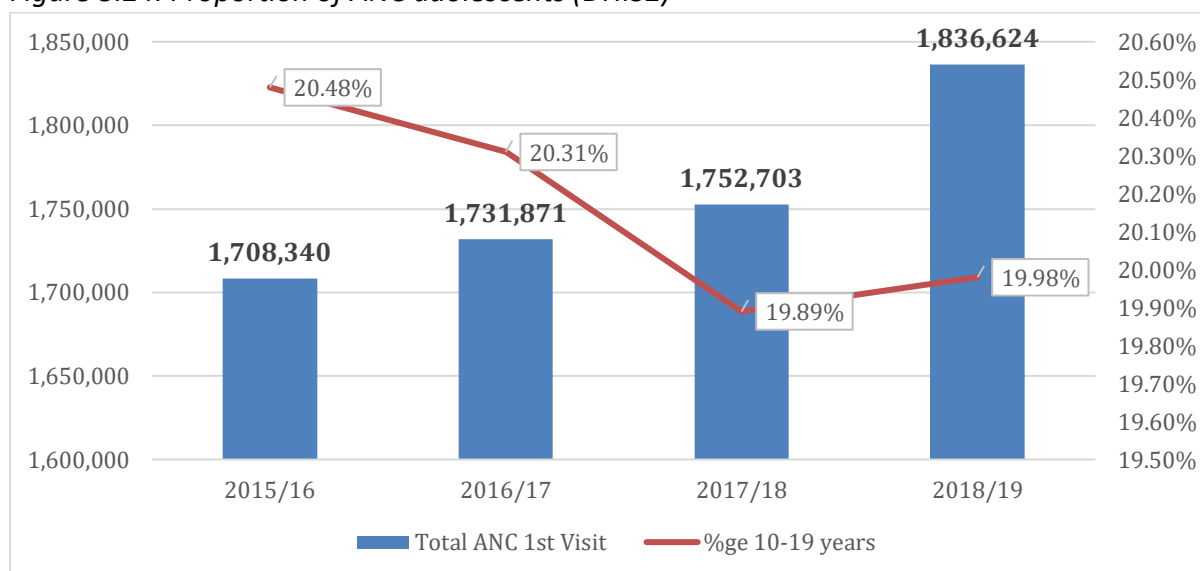
The Number of live births born to adolescent Women representing the age-specific fertility rate among 1000 women of the same age group (15-19 years) still remains high in the general population, has been declining steadily from 2011 but stagnated between 2011 and 2016.

Figure 3.23: Adolescent birth rate



The number of adolescents accessing ANC1 services continue to rise with 1.8 million accessing ANC services in 2015/16 and 1.8 million accessing ANC 1 services in 2018/19. The adolescents continue to constitute just about 20% of all women accessing ANC 1 service.

Figure 3.24: Proportion of ANC adolescents (DHIS2)



3.4. Maternal health

Functionality of HC IV is critical for provision of emergency care to pregnant women in Uganda. Figure 3.25 below gives trends in functionality of HC IV in Uganda. The

ability of HC IV to provide C-Section services was about 70% from the first quarter of 2019 to April-June 2020.

Figure 3.25: Functionality of HC IV (c-section + BT) (DHIS2)

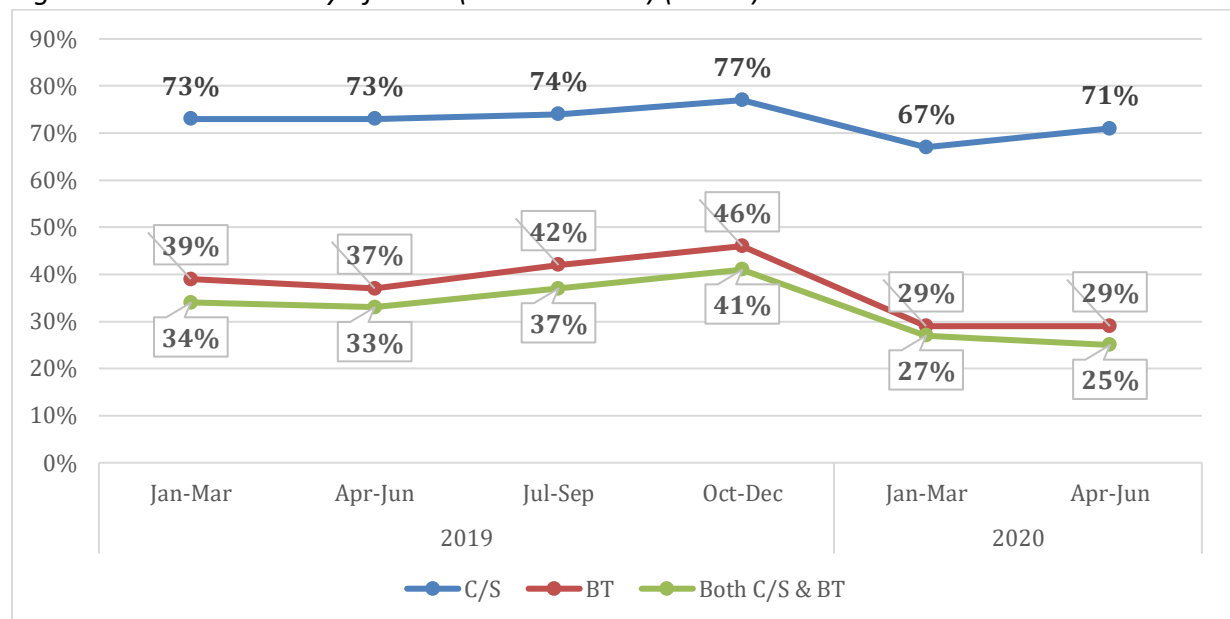
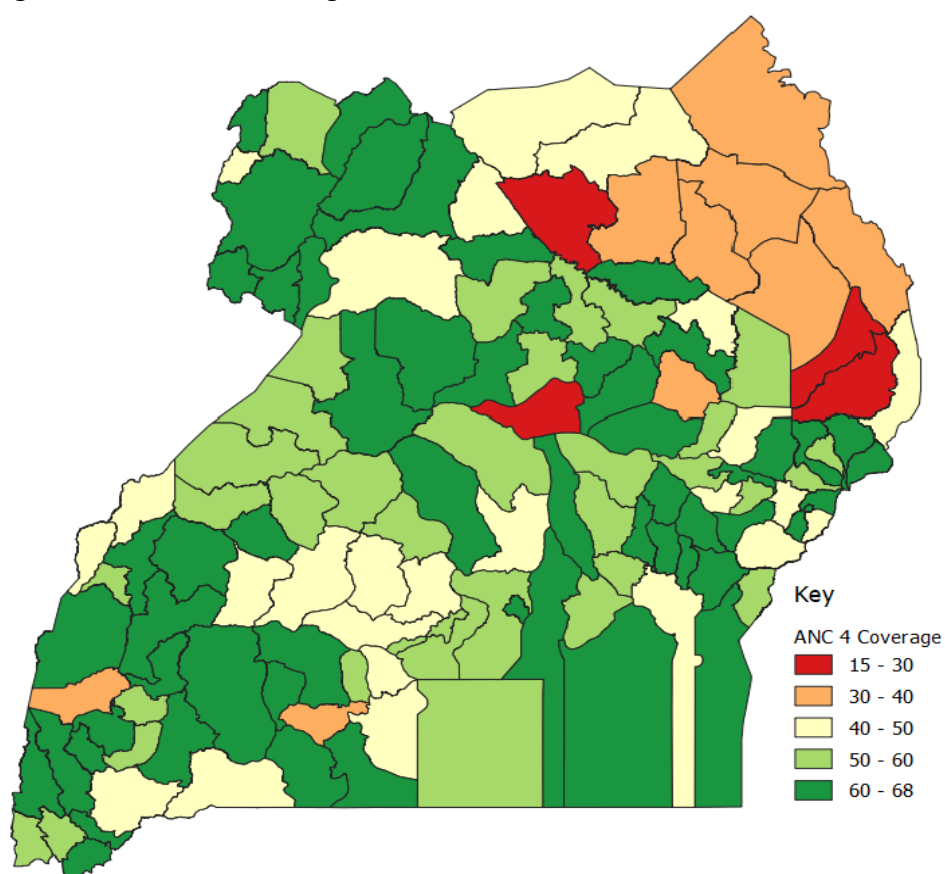


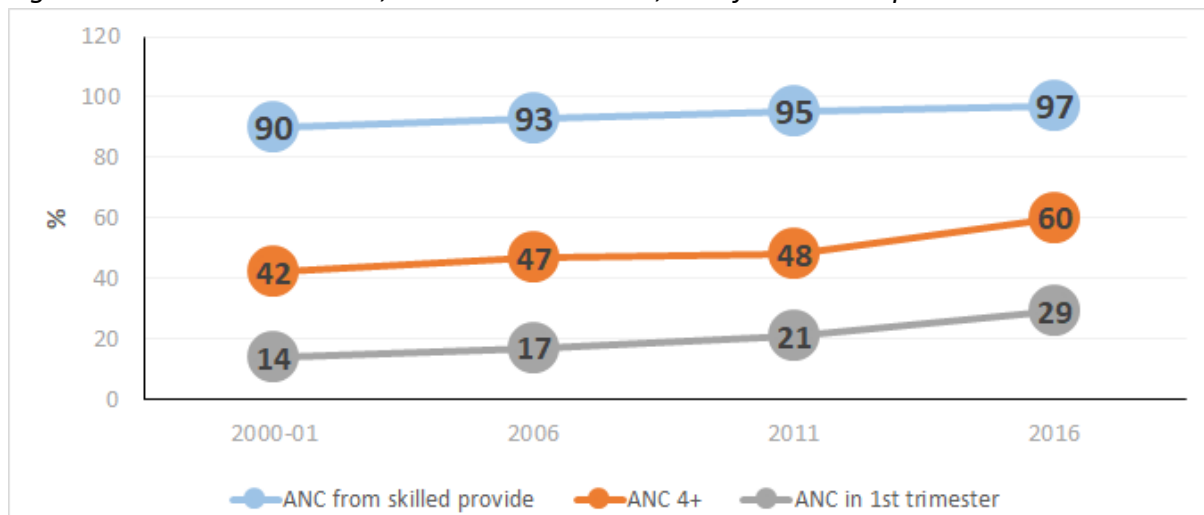
Figure 3.16 below shows distribution of ANC coverage by district. We can observe that coverage in the Karamoja, Teso and Parts of Acholi regions of Uganda remain lower relatively than the rest of the country.

Figure 3.26: ANC 4 coverage FY2018/19



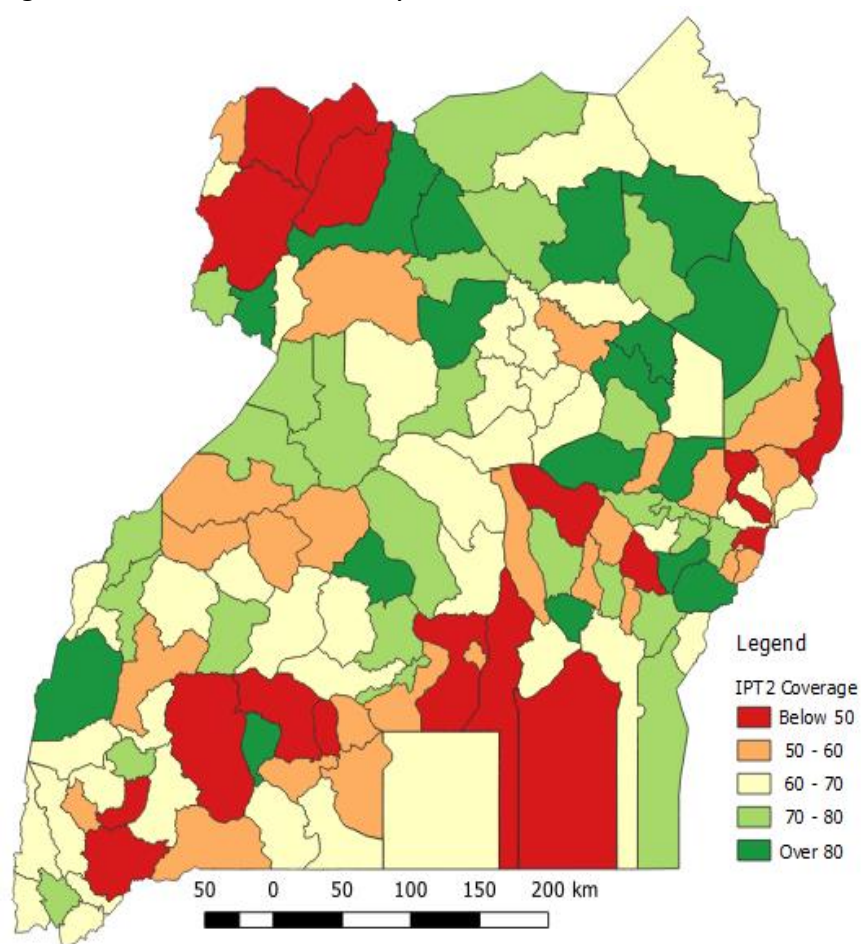
ANC access by pregnant women is important in ensuring favourable pregnancy outcomes for women. Figure 3.27 below shows trends in key ANC indicators. We can observe that since the year 2000, ANC 1 coverage has remained over the 90% mark even reaching 97% in 2016. Progress has been seen with ANC-1 attendance with in the first trimester of pregnancy rising from 42% in year 2000 to 60% in 2016. Challenges remain with attendance at least 4 ANC visits though some progress has also been registered here. In the year 2000 only 14% of mother who attended ANC-1 ended up attending atleast 4 ANC visits. By 2016, this number had risen to just 29%.

Figure 3.27: Trends in ANC4+, ANC in 1st trimester, ANC from skilled provider



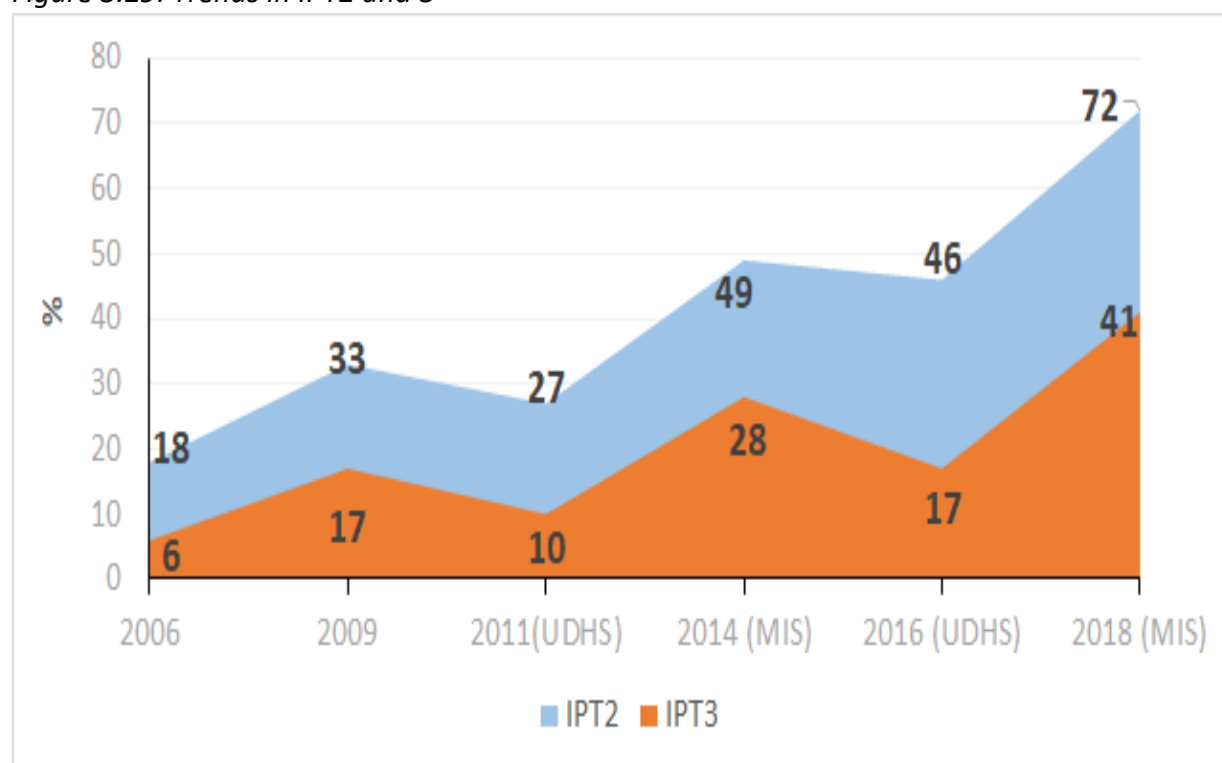
IPT coverage is important for protection of pregnant women against malaria. Figure 3.28 below gives a summary of IPT2 coverage for FY 2018/19. We can observe that coverage remains below 50% in Areas around west Nile and the lake Victoria basin. We also see low coverage in the Elgon region and the south western part of Uganda.

Figure 3.28: IPT2 distribution by district FY 2018/19



Overall Uganda has seen improvements in IPT coverage over time with IPT2 changing from 18% in 2006 to 72% in 2018. In the same period, IPT3 coverage moved from 6% to 41%. Figure 3.29 below shows trends in IPT coverage in Uganda.

Figure 3.29: Trends in IPT2 and 3



ITN use

Children and pregnant women are particularly vulnerable to malaria. Figure 3.30 below shows ITN usage by children under-5 years of age and pregnant women.

The percentage of children under age 5 who slept under an ITN increased from 33% in 2009, 43% in 2011, and 74% in 2014-15 before falling to 62% in 2016 and 60% in 2018. A similar trend is observed among pregnant women, with an increase from 44% in 2009, 47% in 2011, and 75% in 2014-15 followed by a decrease to 64% in 2016 and 65% in 2018.

Figure 3.30: trends in the use of ITNs by pregnant women and children under 5

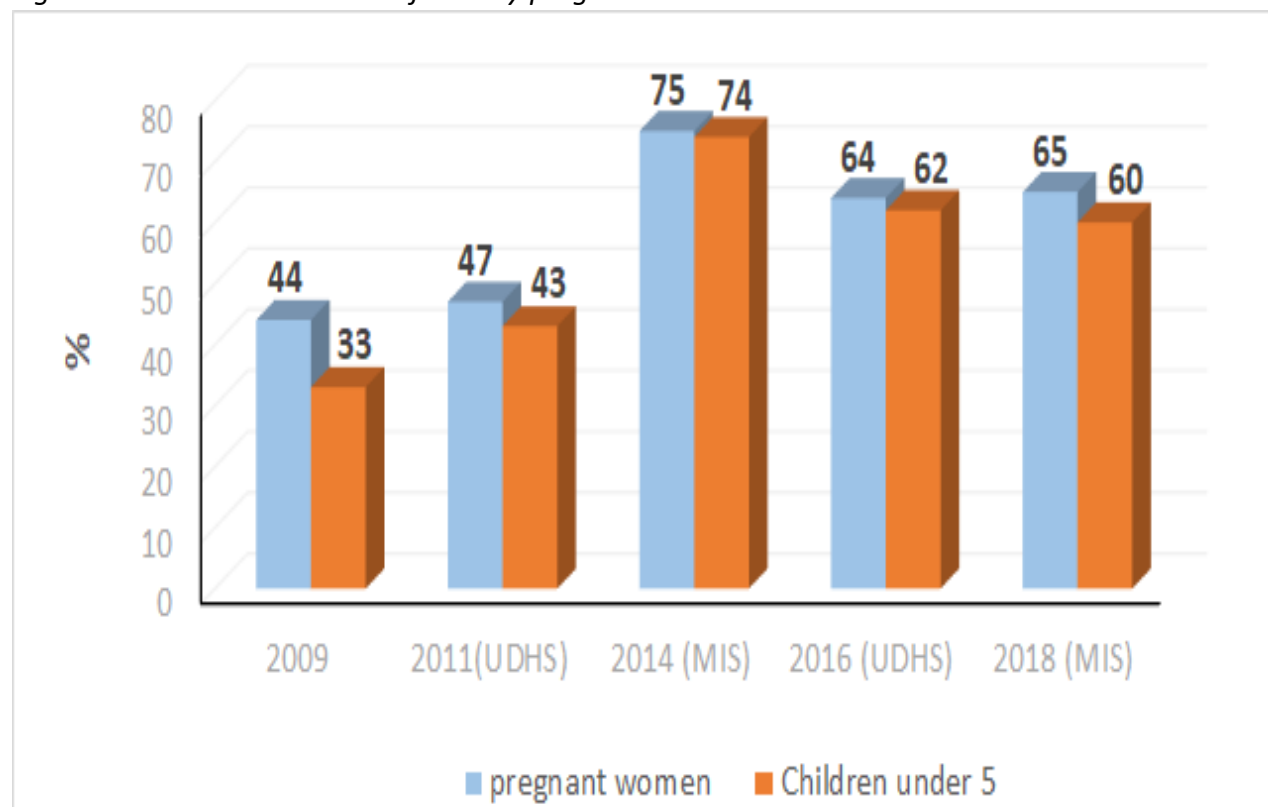
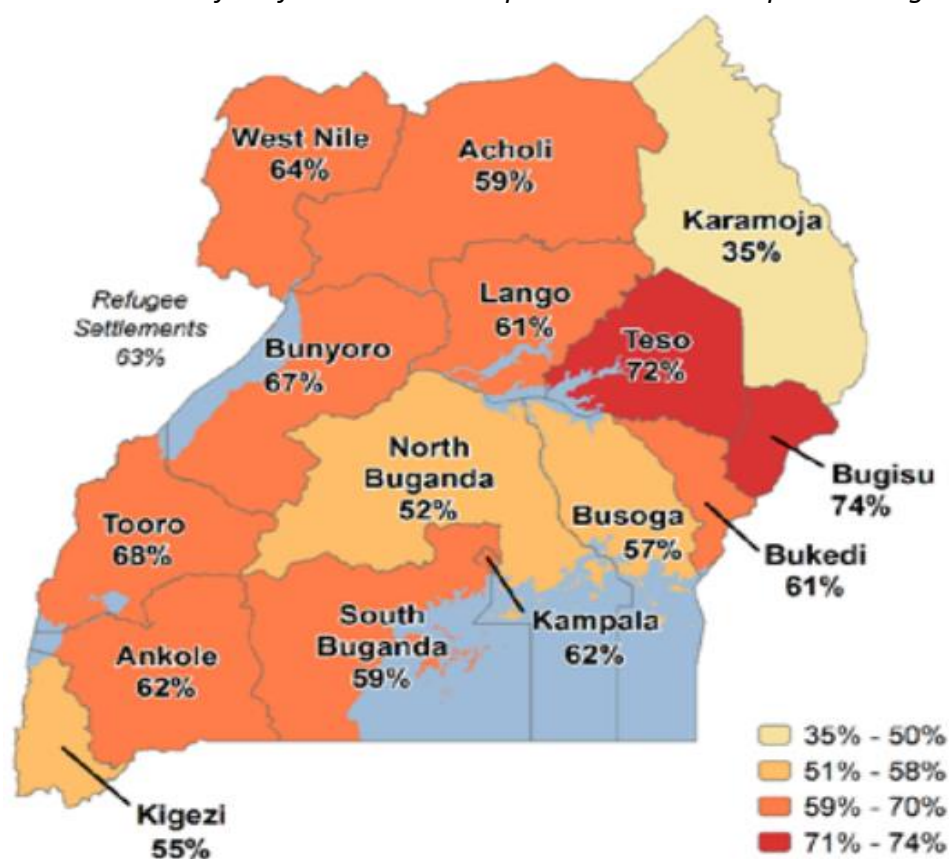


Figure 3.31 below shows distribution of percentage of children who slept on ITN by region. Teso and Bugisu region registered the lowest levels of ITN use in 2018.

Figure 3.31: Distribution of % of children who slept Under an ITN the previous night

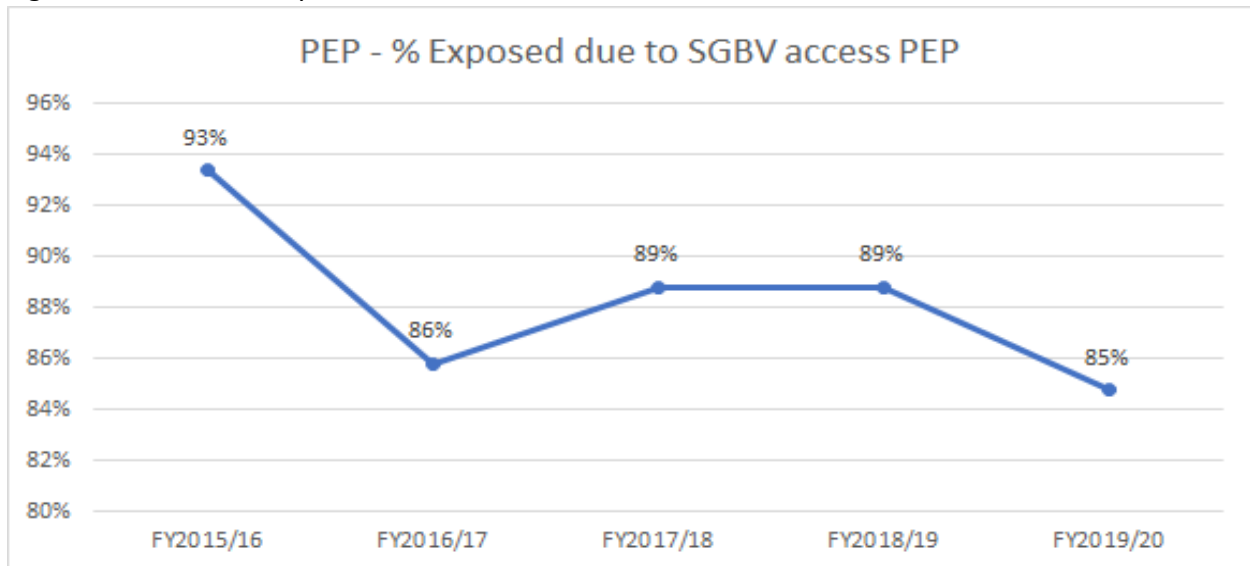


Source: MIS 2018

PEP - % Exposed due to SGBV access PEP

Figure 3.32 below shows trends in the use of PEP following exposure due to SGBV. Since FY2015/16, percentage use of PEP following SGBV has reduced from 93% to 85% in FY2019/2020. The reduction shows a worrying trend for a critical service.

Figure 3.32: PEP - % exposed due to SGBV access to PEP



4.0 HIV/AIDS, STIS AND TB: PROGRESS TOWARDS TARGETS

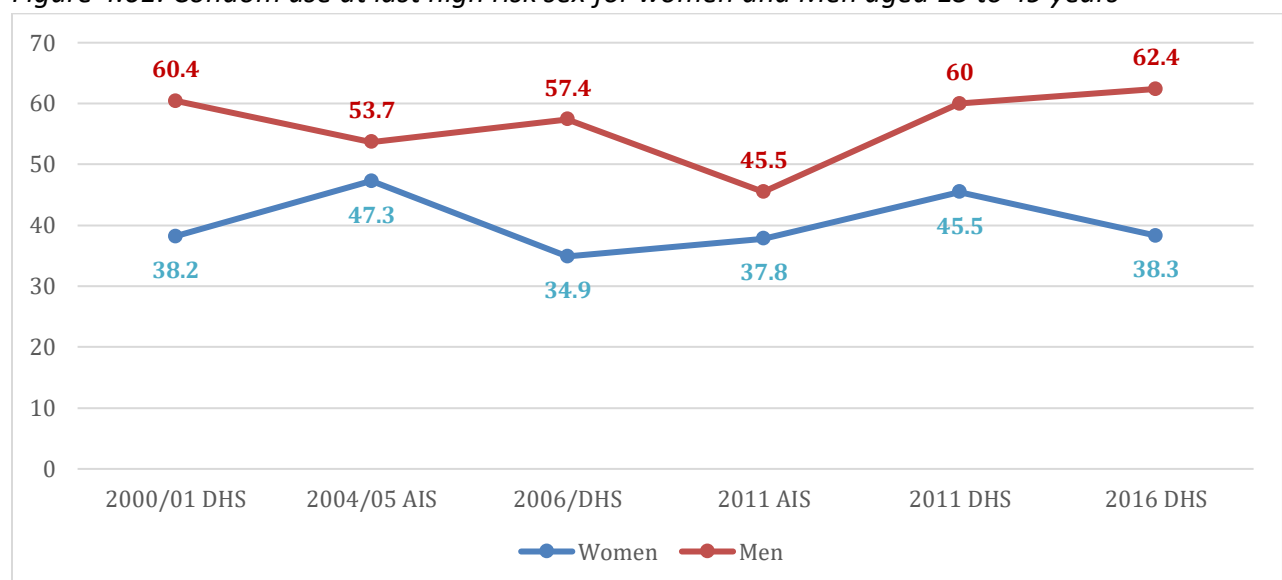
4.1. HIV Prevention and screening

Condom Use at last risk sex (with a non-marital, non-cohabiting partner)

Figure 4.01 below shows the trends in the use of condoms during risky sex by women and men aged 15 to 49 years. We observe that for men, the percentage using condoms during risky sex was 60.4% in 2000. This then reduced to 54% in 2004, and then back up to 57% in 2006. It fell to 45.5% in 2011 according to the AIDS indicator survey although the DHS put it at 60%. In the 2016 DHS, it was reported to have gone up to 62%.

Overall lower condom use is observed among women. However, a similar trends over the years is observed for condom use for risky sex.

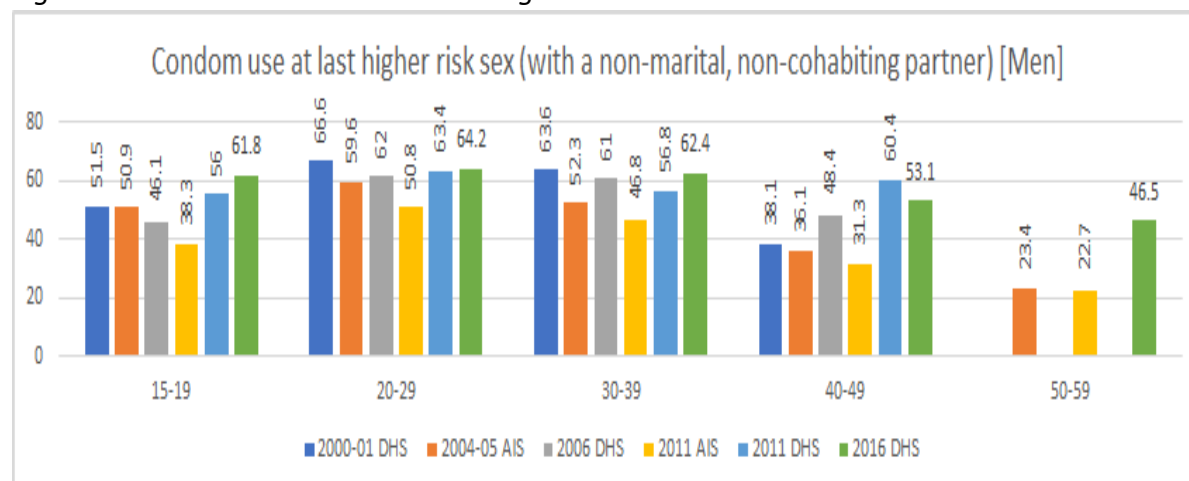
Figure 4.01: Condom use at last high risk sex for women and Men aged 15 to 49 years



Trends in Condom Use behaviour by Age group

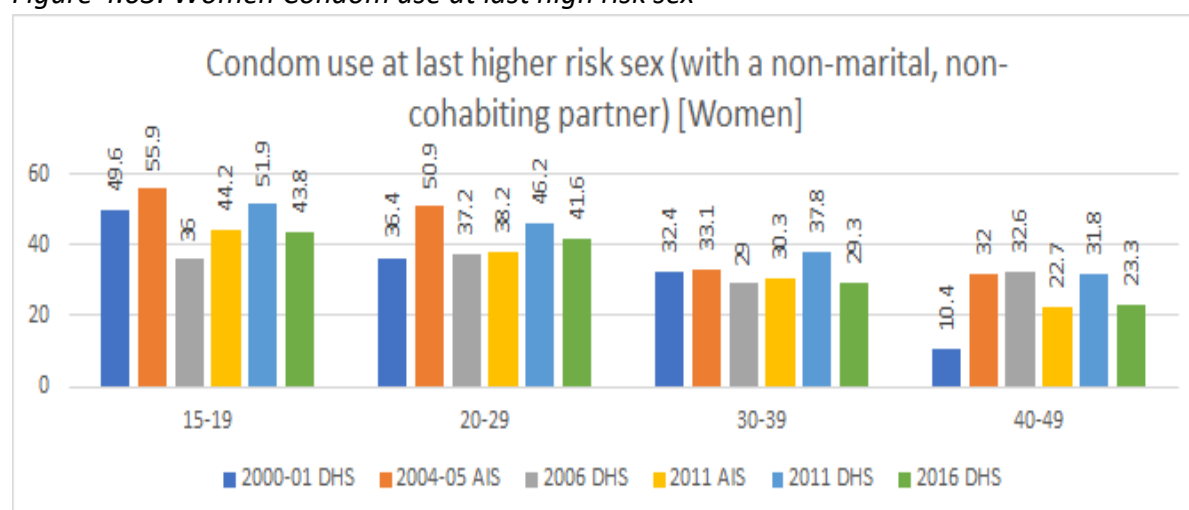
Over the years, we observe that condom use among men was highest in the age groups 20 to 29 years and 30 to 39 years. There was low usage in the 15 to 19 years and the 40-49 year age groups. The lowest usage among men was observed among men aged 50 to 59 years. Figure 4.02 shows trends in condom use at last high risk sex for men.

Figure 4.02: Men Condom use at last high risk sex



Condom usage for women remains a challenge in Uganda. The trends in condom usage for women remain noticeably lower than the usage among men. Figure 4.03 below shows trends in condom usage at last high risk sex for women. We observe that unlike the men, we observe significant condom usage among the 15 to 19 years and 20 to 29 years age groups. Usage then goes down for the 30 to the 39 year age group and the lowest usage of condoms for the high risk sex among women was among those aged between 40 and 49 years.

Figure 4.03: Women Condom use at last high risk sex

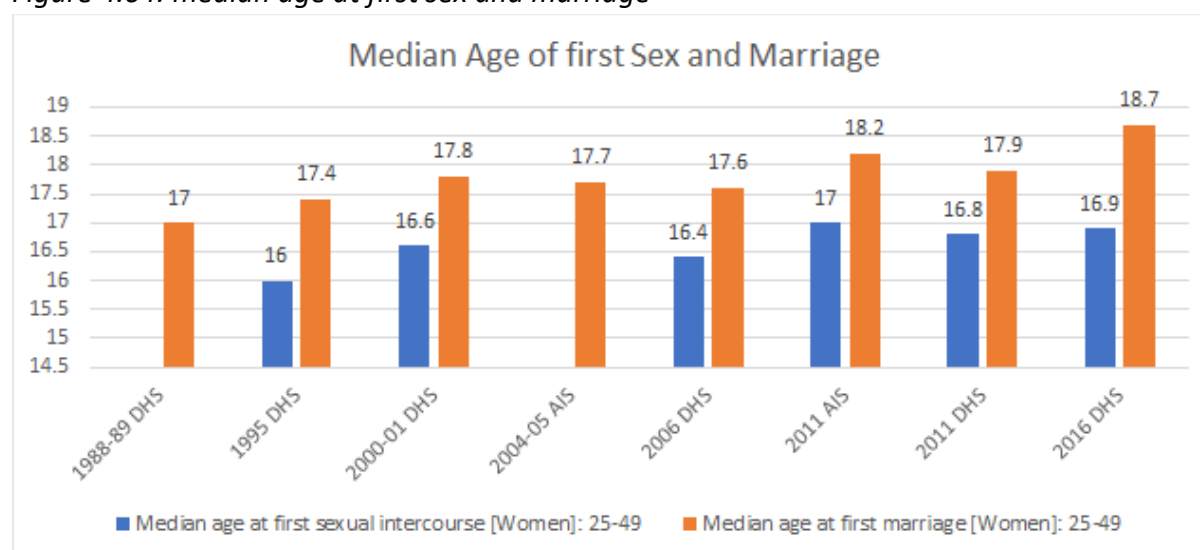


Sexual Debut

Sexual debut is an important indicator for fertility and sexually transmitted disease infection in a population. Figure 4.04 below shows trends in age at first sex for women in Uganda and age at first marriage.

The median age at first marriage for women has increase slightly from 17 in 1989 to 18.7 in 2016. The median age at first sex has also increased slightly from 16 years in 1995 to 16.9 years in 2016.

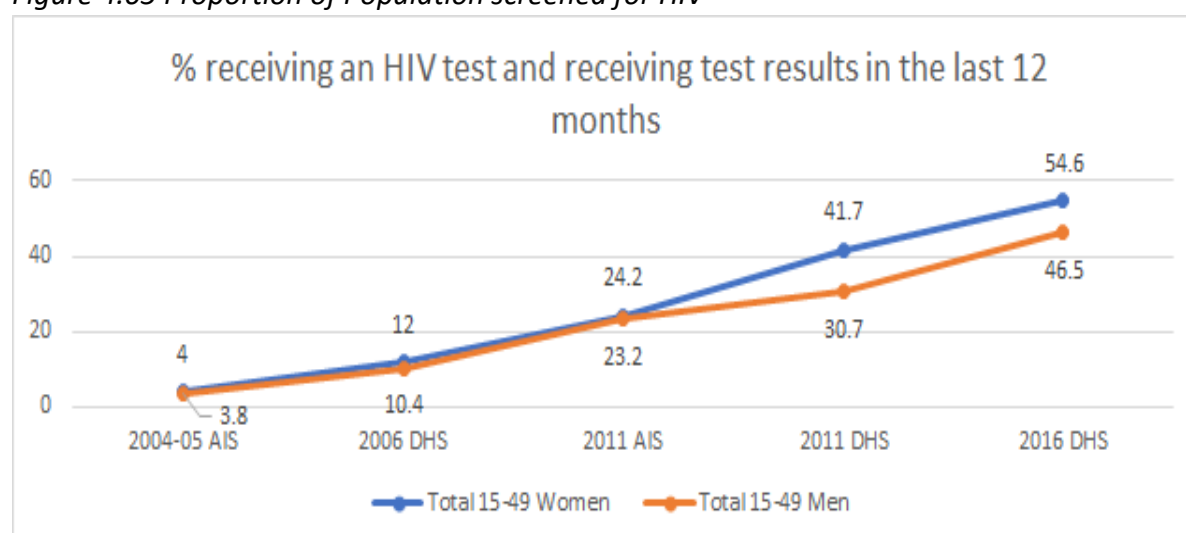
Figure 4.04: median age at first sex and marriage



Proportion of Population screened for HIV

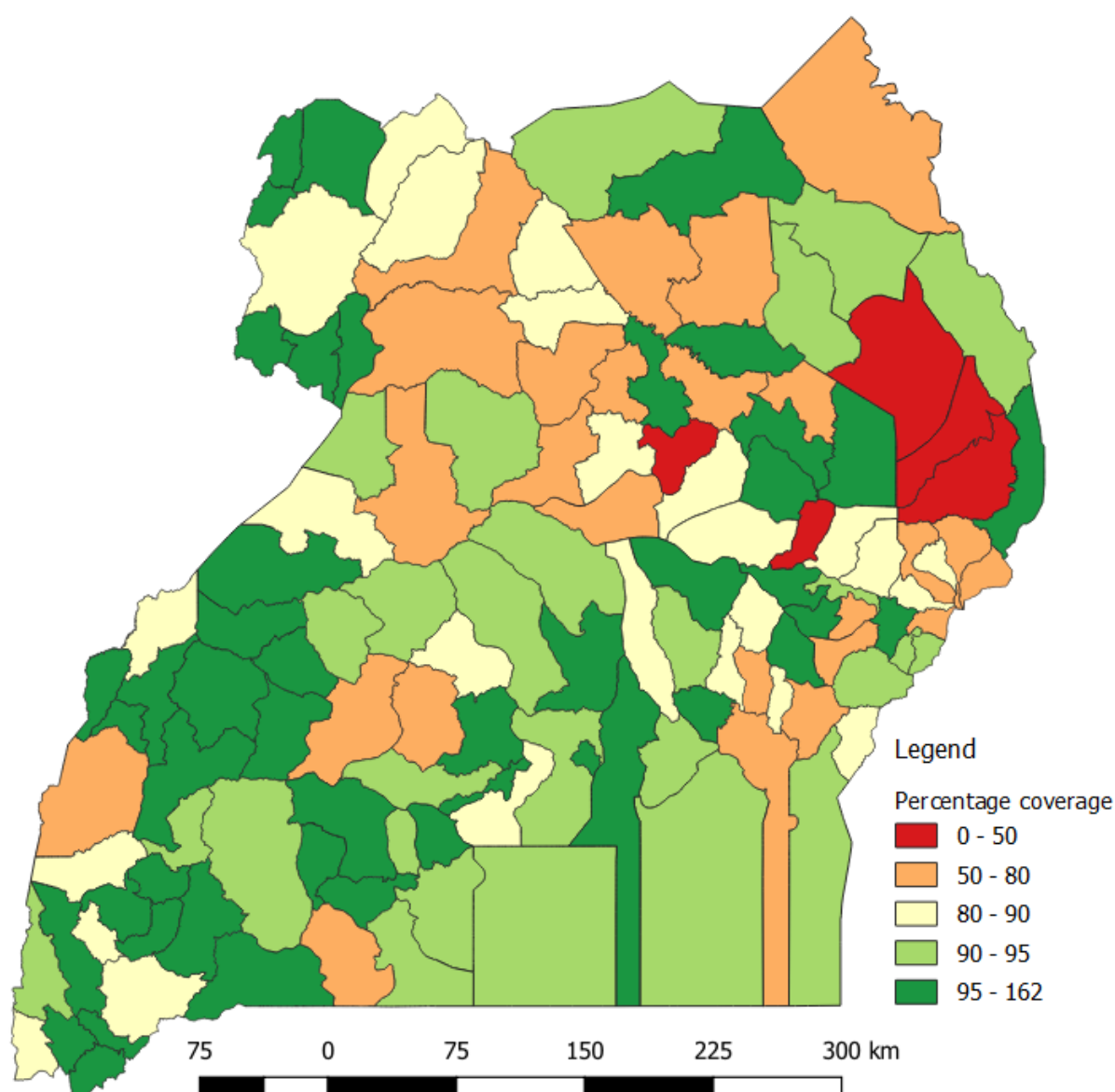
Figure 4.05 shows trends in percentage of the population receiving and HIV test and receiving test results in the last 12 months. We observe similar trends for men and women with 4% of women 2004/05 and 3.8% of men the same year. This then increased gradually to 54.6% for women in 2016 and 46.5% for men the same year.

Figure 4.05 Proportion of Population screened for HIV



The distribution of HIV positive women initiated on ART coverage for the FY 2018/19 is shown in Figure 4.06 below. We observe that Teso and Acholi have the lowest coverages for this period.

Figure 4.06: HIV+ pregnant women initiated on ART Coverage (2018/19)

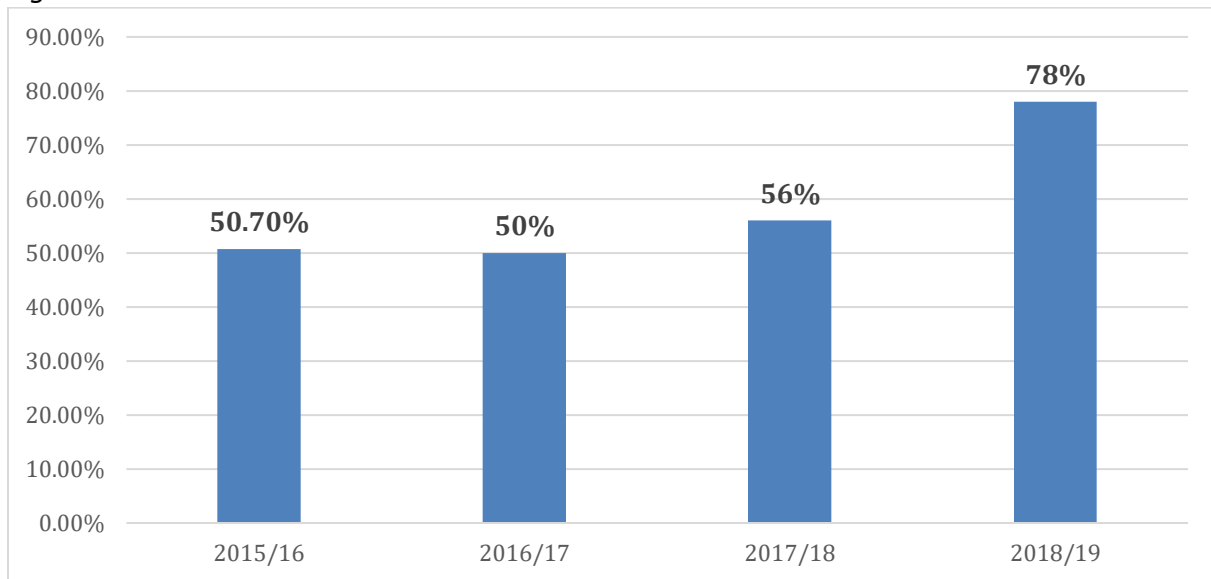


4.3. TB screening and treatment

The Ministry of Health intended to reduce the incidence of TB by 5% by 2019/20. To achieve this, MoH must ensure a high TB case detection rate as well as a high TB treatment success rate.

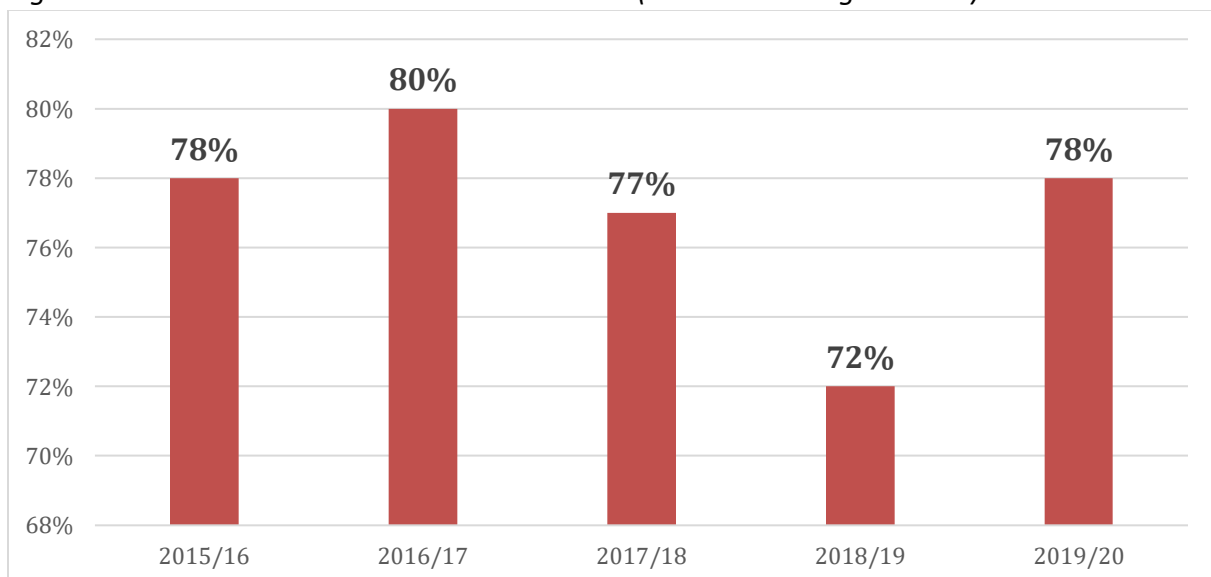
TB Case Detection Rate (HSDP 2020 Target is 84%)

Figure 4.07: TB case detection rate



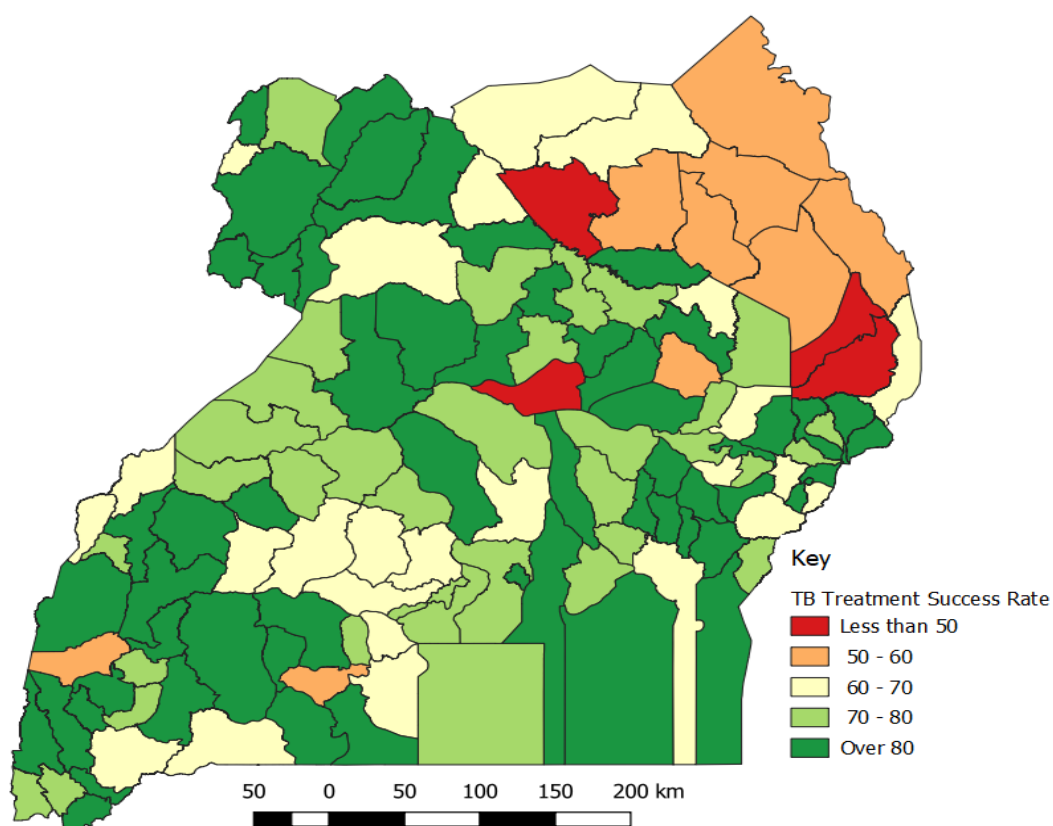
Uganda is one of the 30 WHO-designated countries with a high burden of TB/HIV. TB detection is a very crucial step in its management and control. There has been a progressive increase in TB cases detected from 50.7% in FY 2015/16 to 78% in FY 2018/19. The case detection rate is however still below the HSDP 2020 target of 84%.

Figure 4.08: Trends in TB treatment success rate (HSDP 2020 Target is 90%)



The proportion of people who complete the management, the TB treatment success rate (TSR) been fluctuating over the last 4 years with in 72 – 80 %. The 2019/2020 TSR is still below 90%, the HSDP 2020 Target and WHO recommended TSR.

Figure 4.09: Distribution of TB treatment success rate (HSDP 2020 Target is 90%)

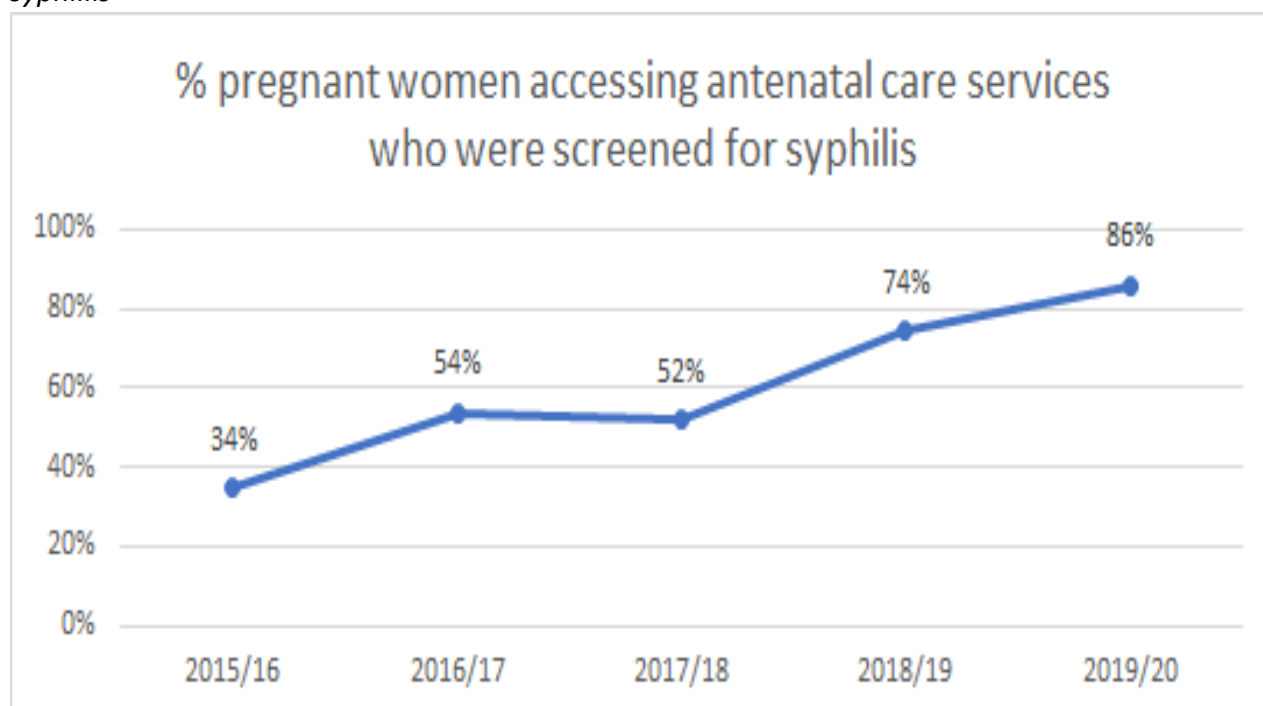


The TB treatment success rate was lowest (<50) in the four (4) districts; Amolatar , Nakapiripirit , Pader and Nabilatuk. The North- Eastern Region, Soroti , Lwengo and Rubirizi was generally below (50-60%) the National Average (78%).

4.4. STI screening and treatment

STI screening

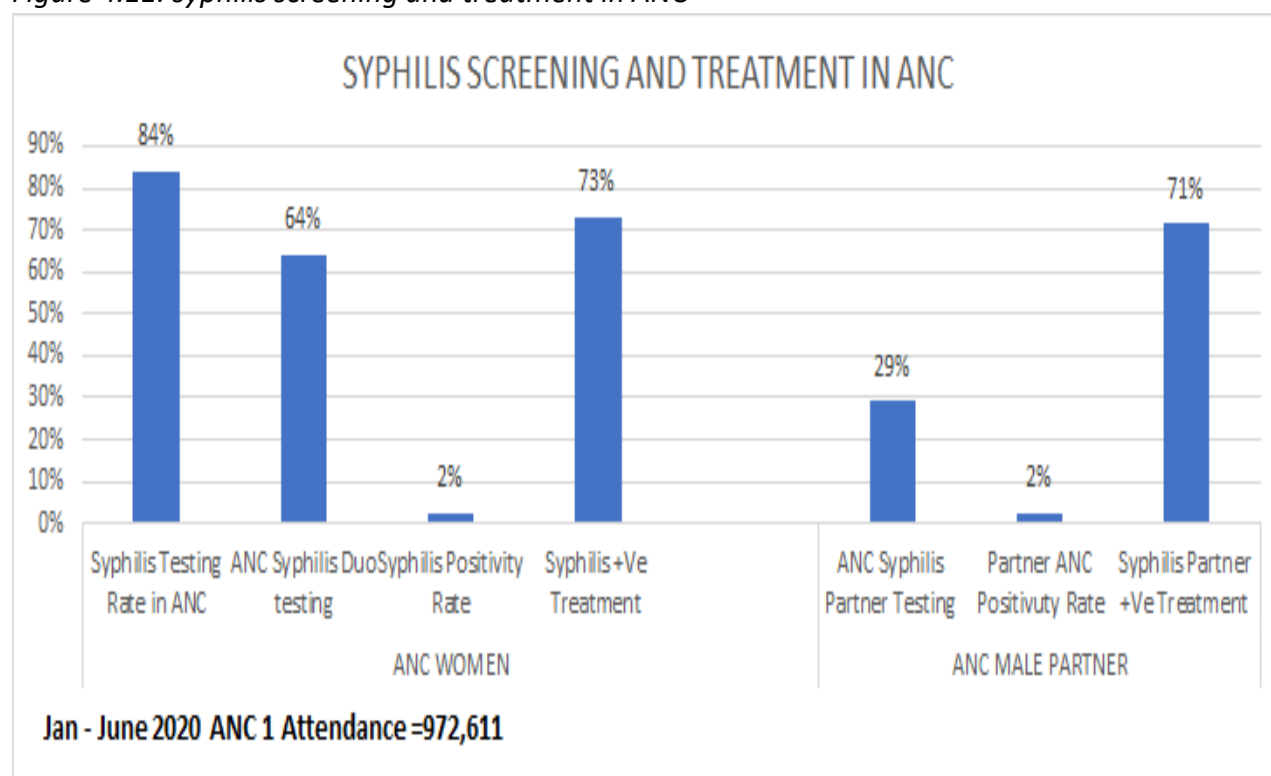
Figure 4.10: % pregnant women accessing antenatal care services who were screened for syphilis



Proportion of Screened and treated

Syphilis is one of the TORCHES (Congenital Infections) that are screened during the Antenatal visits. Syphilis contributes significantly to preventable morbidity and mortality in infants in Uganda. There has been a general increase in the percentage of mothers screened over the last 4 years with the highest increase between 2017/18 – 2018/19 (52 – 74%).

Figure 4.11: syphilis screening and treatment in ANC



The proportion of mothers attending ANC who are screened for syphilis in 2019/2020 was at 84%, 64% received Syphilis Duo testing (Including HIV), 2% were found to be positive and 73% of these were started on treatment. Increasing partner uptake of syphilis screening and treatment should decrease the risk of re-infection and protect subsequent pregnancies from syphilis re-infection. Only 29% of the partners of women attending ANC were screened, and 2 % were positive and 71% of these were started on treatment.

5.0 HEALTH FINANCING: PROGRESS TOWARDS TARGETS

5.1. Health

The Health System in Uganda continues to be financed by a multiplicity of stakeholders including; Government, Private Sector, Households and Health Development Partners (HDPs). There are two major modalities of financing the health sector and these include budget support and off-budget support.

During the period under review, service delivery in public facilities was mainly financed by Government, and grants/concessional loans from Development Partners. The Government of Uganda (GoU) also supported the PNFPs facilities with conditional grants worth **shs.28bn** of which 50% was earmarked for PHC Non-Wage and 50% for the medicines credit line under Joint Medical Stores.

BUDGET ALLOCATIONS

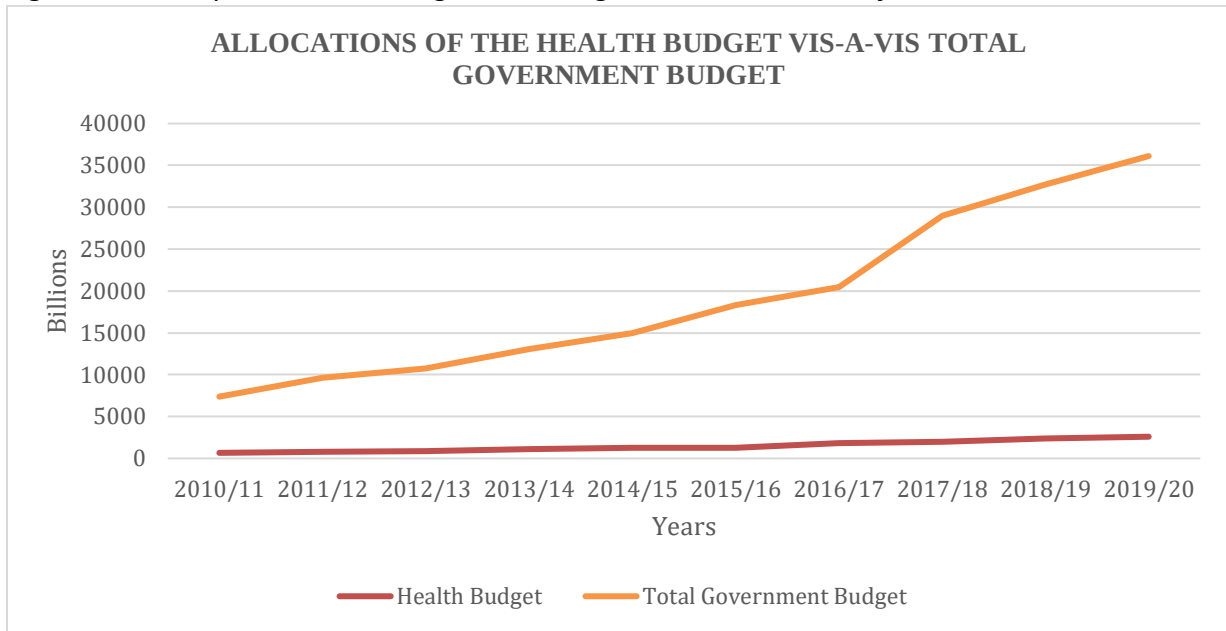
The health sector budget as a proportion of the National Budget remained at **7.2%** which was the same as the previous year. However, in nominal terms the health sector budget increased by **9.1% i.e** from Shs. **2,373** billion in FY 2018/19 to Shs. **2,589 billion** in FY 2019/20. This was majorly attributed to the enhancement of salaries for medical workers and increase in inflows from donor funding.

Table 5.1: Trends FOR growth & allocation of the health sector budget against the Total Government Budget

Year	Health Budget	Growth	Total Government Budget	Growth	Health as % of total budget
2010/11	660		7,377		8.9%
2011/12	799	21%	9,630	31%	8.3%
2012/13	829	4%	10,711	11%	7.7%
2013/14	1,128	36%	13,065	22%	8.6%
2014/15	1,281	14%	14,986	15%	8.5%
2015/16	1,271	-1%	18,311	22%	6.9%
2016/17	1,827	44%	20,431	12%	8.9%
2017/18	1,950	6.7%	29,000	42%	6.7%

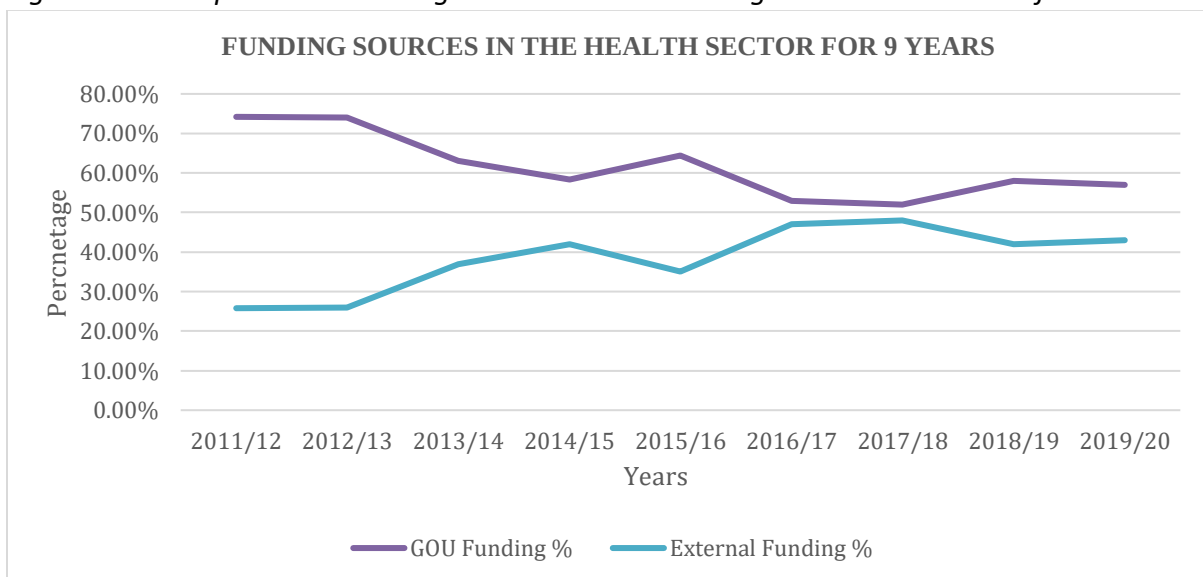
2018/19	2,373	18%	32,700	13%	7.2%
2019/20	2,589	9%	36,113	10%	7.2%

Figure 5.01: Graph Demonstrating the Funding in the Health Sector for 9 Years



GoU and External Financing Trends FY 2011/12 – 2019/20

Figure 5.02: Graph Demonstrating the SOURCE OF Funding in the Health Sector for 9 Years



From Table x and Figure x above, whereas the proportion of GoU contribution dropped to 57%, the nominal budget allocations have been steadily and significantly increasing. This demonstrates Government's commitment to prioritize the health sector in the medium term. It is therefore desirable to ensure that the increased funding translates into service delivery.

BUDGET PERFORMANCE

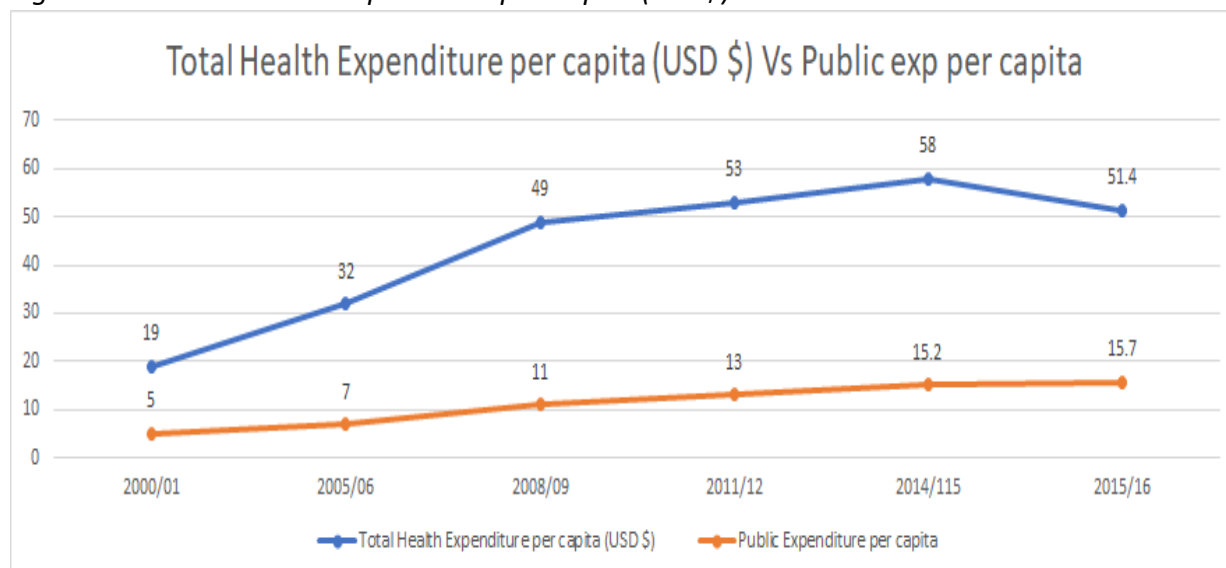
Overall Sector Performance

During the year under review, in addition to the Shs. 2.589 trillion allocated to the Health Sector, a supplementary budget amounting to 125 bn was granted mainly to handle Covid 19 pandemic responses. A total of Shs. 2.4 trillion representing 89 % of the total budget was released by MoFPED compared to 80 % in the previous year.

Compared to FY 2018/19, where all sector votes received about 100% of their budget except MoH Headquarters, FY 2019/20 was marked by low releases largely due to interruptions related to Covid 19. There was however remarkable increase in releases to MoH Headquarters at 77% compared to 60% in FY 2018/19 and 36% in FY 2017/18. This is due to improvement in release patterns for previously low performing externally financed projects like GAVI (from 9% in FY 2018/19 to 75% in FY 2019/20), Global Fund (from 61 % in FY 2018/19 to 74% in FY 2019/20) and URMCHIP (from 60% in FY 2018/19 to 100% in FY 2019/20).

The proportion of the budget spent increased from 56% in FY 2018/19 to 85% in FY 2019/20 due to increased releases from MOFPED and better absorption by the sector votes and donor funded projects. The overall budget absorption rate for the health sector stood at 96 % despite the Covid 19 pandemic restrictions. This good performance is largely attributed to remarkable performance of externally funded projects at 91% from 84% in the previous year.

Figure 5.03: Total Health Expenditure per Capita (USD\$)



Source: NHA 2018

Figure 5.04: % of Government Budget Commitment to Health

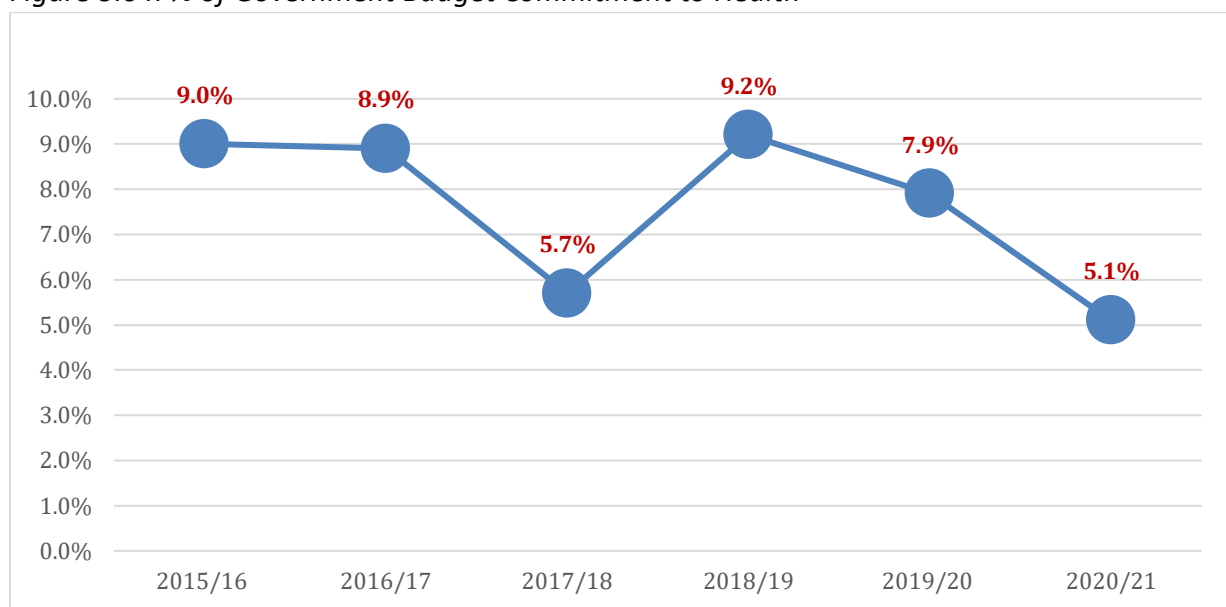
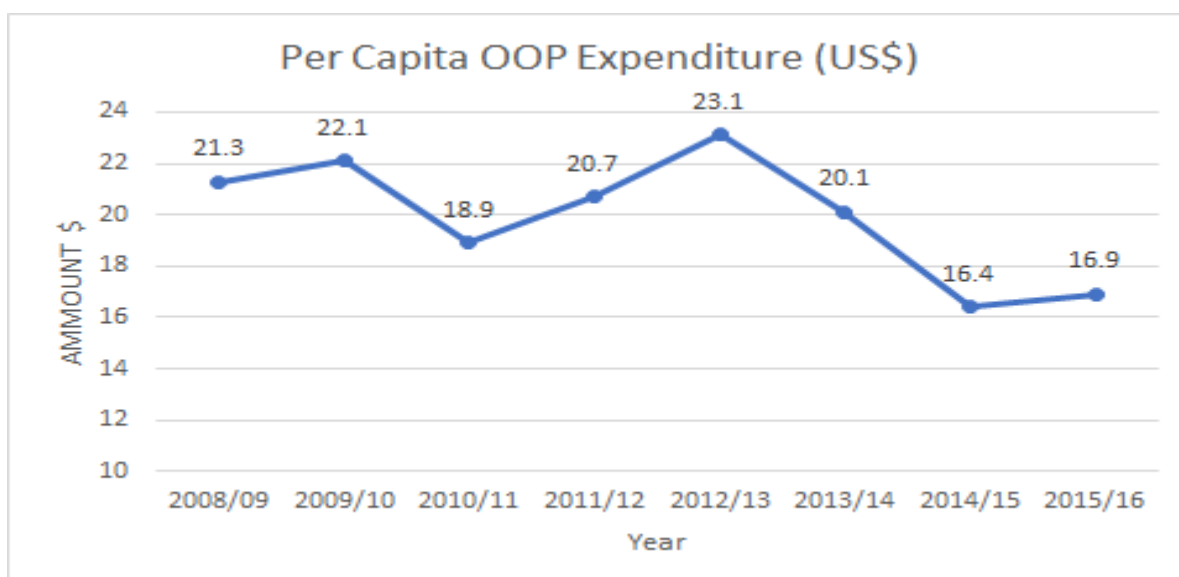


Figure 5.06: Per Capaita OOP Expenditure



Source: NHA 2018

Table: CHE, GDP, Annual Growth Rates and Share of Health on GDP, 2014/15 to 2015/16

	YEAR	FY2014/2015	FY2015/2016
Current Health Expenditure (UGX Millions)	Public	739,041	813,087
	Private	2,015,058	2,203,547
	Dev't Partners	2,112,746	2,157,424
	TOTAL	4,866,846	5,174,058
Share of Current Health Expenditure (%)	Public	15.20%	15.70%
	Private	41.40%	42.60%
	Dev't Partners	43.40%	41.70%
	TOTAL	100.00%	100.00%
Current Health Expenditure as a Share of GDP (%)	Public	0.94%	0.93%
	Private	2.56%	2.51%
	Dev't Partners	2.68%	2.45%
	TOTAL	6.20%	5.90%

Source: NHA 2018

6.0 PROGRESS ON UGANDA STRATEGIC COMMITMENTS IN RELATION TO THE EAC SECTORAL COUNCIL OF MINISTERS

As part of this review, we conducted key informant interviews to have an understanding of national-level stakeholders on the scorecard. A summary of the findings are below.

National Level Experiences in applying the RMNCAH scorecard

The users noted that the scorecard is implemented in the national DHIS2 system we observed that users

“.....the scorecard is implemented in our DHIS2 system. User departments are expected to access it for decision support.....” Staff member, MoH DHI

The implementation of the EAC scorecard is sustainable given that it is implemented within an existing national system.

The TWG within the ministry of health has given the different stakeholder an opportunity know about the score card as well as to benefit from the information it provides. However the lack of consistency in presentation of the scorecard has to some extent compromised its reach.

The scorecard is typically accessed directly through the DHIS2. This access has proved to be challenging with users requiring accounts and being knowledgeable in terms of use of DHIS2.

“....The scorecard indicators update automatically ...what we need is a mechanism to track the actions that are generated from the data.....” Staff member, Partner organisation

While we know of some presentations of the scorecards in the different meetings, there is evidence that some opportunities may have been missed to present the dashboard to a forum beyond the TWG.

“....scorecards are always mentioned in meetings on RMNCAH.....i am not very sure about the actions generated from the information.....”, health partner, Kampala

At the district level the main concern was around the need to include more indicators within the scorecard.

“....We would currently like to include many more indicators, but we are somewhat limited by the scorecard becoming too congested”, District health staff”, District staff

The scope of training of use of the information in the scorecard needs to be scaled beyond the district health teams and the associated partners. Administrative staff at the subnational level have expressed some gaps in ability to interpret the information in the scorecard.

“.....We are not well sensitized on how to interpret the score card.” District Administrative Staff

7.0 RECOMMENDATIONS AND WAY FORWARD

7.1 Conclusions

The Ministry of Health in Uganda has implemented the EAC scorecard at the national and subnational level. Overall, there is progress in the EAC scorecard and related indicators in Uganda. Some challenges with the implementation of the scorecard have been observed specifically around dissemination and use of the scorecard for decision support and policy formulation.

Forum like the different TWGs at the ministry of Health as well as the quarterly, semi-annual and annual review meetings should be leverage to further widen and deepen the reach of the scorecard.

7.2 Recommendation

- Develop strategy for deepening and widening the reach/dissemination of the scorecard
- Ensure frequent review and analysis of the scorecard for the purpose of generation of actions

ANNEX I: EAC SC INDICATOR MAPPING TOOL.

MAIN DATA SOURCES FOR THE EAC REGIONAL SCORECARD INDICATORS FOR YEAR 2018

	EAC integrated Scorecard Indicator	Uganda Indicator Status	Data source	Comments
1	Maternal Mortality Ratio	336	Udhs 2016	Per 100,000 live births
2	Under-five Mortality Rate	64	Udhs 2016	Per 1000 live births
3	Neonatal Mortality Rate	27	Udhs 2016	Per 1000 live births
4	Under 5 Stunting Rate	29%	Udhs 2016	
5	Antenatal care (4+ visits)	60%	Udhs 2016	
6	Health Facility Delivery Rate	73%	Udhs 2016	
7	Postnatal Care-mother (within 2 days)	54%	Udhs 2016	
8	Postnatal Care-baby (within 2 days)	56%	Udhs 2016	
9	DPT3/Pentavalent Coverage	79%	AHSPR, - DHIS2 2019	
10	Percent HIV+ pregnant women receiving ARVs for PMTCT	90.7%	AHSPR	This comprises the Pregnancy in ANC, in labour and in PNC
11	Contraceptive Prevalence Rate	34	PMA 2020, 2018	
12	Adolescent Pregnancy Rate	25	Udhs 2016	

13	Total Health Expenditure per Capita (\$USD)	53	NHA report 2015/16	Proportion of the National budget to the Health sector is approx. 6.9%
14	Density of Skilled Health Personnel (midwives, nurses and physicians) per 10,000 population)	16	HRH AUDIT REPORT, 2018	Per 10,000 population
15	Percentage of people living with HIV who know their status	66.2%	UPHIA, 2018	
16	Percentage of people currently receiving antiretroviral therapy. among those diagnosed with HIV	88.4%	UPHIA, 2018	
17	Proportion PLWHA screened for TB	30.8%	NTLP REPORT	
18	Percentage of pregnant women accessing antenatal care services who were screened for syphilis	86%	HIS, 2018	% Pregnant Women attending ANC tested for syphilis for first time during the Current pregnancy