

WHO UGANDA COUNTRY OFFICE

ANNUAL REPORT 2017



Cover photo: **Benjamin Sensasi**

Editorial Team: **Dr. Yonas Tegegn Woldemariam** - Chairman
Mr. Benjamin Sensasi - Editor
Ms. Naiz Mavura - Member
Mr. Joseph Mwoga - Member
Dr. Miriam Nanyunja - Member
Dr. Annet Kisakye - Member

Publication management, data visualization and infographics: **Allan Batte**

CONTENTS

8

Health Systems Cluster

Introduction	9
Achievements	9
i) Health Technologies and Commodities	9
ii) Health Promotion and Communication	10
iii) Public Health Informatics	10
iv) Health Information and Evidence	11
v) Laboratory	12
vi) Maternal and Newborn Health	13
vii) Family Planning	14
viii) Child Health	14
ix) Adolescent Health	15
x) Nutrition	16
xi) Gender and Human Rights	16
xii) Korea International Cooperation Agency (KOICA) MCH project	17
xiii) Library Services	17
xiv) injection Safety	18
Challenges	19
Way forward	19

42

Health Security and Emergencies Cluster

Introduction	43
Achievements	43
i) Immunization	43
ii) Emergency Response	44
Challenges	46
Way forward	46

22

Disease Prevention and Control Cluster

Introduction	23
Achievements	25
i) HIV/AIDS	25
ii) Tuberculosis	28
iii) Malaria	30
iv) Neglected Tropical Diseases	33
v) Non-Communicable Diseases (NCDs)	36
Challenges	37
Way forward	37

50

Country Support Unit Cluster

Introduction	51
Achievements	51
i) Leadership, Partnerships & coordination	51
ii) Promotion of WHO policies and guidelines	52
iii) Support to regional and global governing body meetings	52
iv) Financial Management	52
v) Program Implementation	53
vi) Human Resource Management ..	53
vii) Staff Development and Learning ..	54
viii) Travel, Logistics and Procurement	56
ix) Information and Communication Technology	56
Challenges	57

FOREWORD

One of the major highlights of 2017 was the outbreak of Marburg Virus Disease (MVD) in Kween and Kapchorwa districts, eastern Uganda. During the outbreak, two cases were confirmed, there was one probable case and 311 contacts were identified and followed up until they were declared free of MVD.

A number of lessons were learnt from this outbreak. The first was that government leadership and coordination of all response activities determines the speed and efficiency with which the disease is contained. We commend the Ministry of Health for the leadership and efficient coordination during the outbreak.

Secondly, quick notification by the government as guided by the International

Health Regulations (IHR) helped to quickly mobilize and deploy technical and logistical support needed in such situations. It is therefore important that countries regularly review and update all the core IHR competencies because they are critical to disease outbreak response.

Third is international collaboration which is also well articulated in the IHR. There were fears that the MVD could have spilled over to Kenya given the close interactions of people at the border and the fact that one of the confirmed cases went to Kenya in search of local medicines. The quick collaboration between Uganda and Kenya to deal with the threat was recorded as one of the best that countries ought to emulate during disease outbreaks that threaten global health.



In addition, disease outbreaks are the real test of the resilience of a country's health system. While Uganda's health system may have a lot to be done, it is commendable that the system was able to detect and respond in a timely manner to the MVD in eastern Uganda. The National and District Task Forces were able to deploy staff in record time to implement response activities according to protocols and Standard Operating procedures.

Finally, the outbreak reaffirmed WHO's readiness to support countries during emergencies and disease outbreaks. Our country office Rapid Response Team was on ground in Kween and Kapchorwa within less than 48 hours after notification by national authorities. This response time was important in kick-starting activities that

were the basis for later interventions by partners and stakeholders.

In this report, we report about our achievements during the MVD outbreak. We also highlight other important achievements in other areas of that were attained in 2017. We trust that you will enjoy reading this report which we hope gives an opportunity to discuss several health issues as we strive to achieve Universal Health Coverage in Uganda.

Dr. Yonas Tegegn Woldemariam
WHO Representative





WHO Country Office staff delivering solidarity packages to the families of people who died of Marburg Virus diseases in Kween district.

HEALTH SYSTEMS CLUSTER

Introduction

IN THE WHO COUNTRY COOPERATION STRATEGY FOR UGANDA 2016-2020, UNDER STRATEGIC PRIORITY TWO, WHO PLEDGED TO SUPPORT STRENGTHENING OF THE HEALTH SYSTEM FOR EFFECTIVE, EQUITABLE AND QUALITY HEALTH SERVICE DELIVERY. WHO ALSO UNDERTOOK TO SUPPORT NATIONAL EFFORT TO BUILD A RESILIENT HEALTH SYSTEM ABLE TO PROTECT HUMAN LIFE AND PRODUCE GOOD HEALTH OUTCOMES FOR ALL AT ALL TIMES THROUGH DELIVERY OF ESSENTIAL, QUALITY AND AFFORDABLE HEALTH SERVICES. IN 2017, UNDER THE HEALTH SYSTEMS CLUSTER THE WHO COUNTRY OFFICE ACHIEVED THE FOLLOWING TOWARDS ATTAINMENT OF THOSE GOALS.

Achievements

i) *Health Technologies and Commodities*

- Strengthened the oversight role and good governance of the National Drug Authority (NDA) through provision of technical support to the board of governors. This involved a capacity assessment using the WHO Global benchmarking tool which helped to identify progress made including existing regulatory strengths, as well as gaps and areas for improvement which now constitute the Institutional Development Plan (IDP).
- Revitalized the Rational Use of Medicines (RUM) unit in the Ministry of Health that is currently implementing activities in the country.
- Followed up implementation of the National Action Plan on Antimicrobial Resistance by providing antimicrobial stewardship, surveillance and convening steering group meetings for follow up on actions.
- Strengthened and provided leadership to the Medicines Procurement and Management Technical Working Group to access medicines and provide oversight on the implementation of the National Pharmaceutical Strategic Plan.
- Supported the country to successfully host the 40th International meeting of representatives of National Pharmacovigilance Centres.
- Participated in resource mobilization efforts for the mTRAC and other WHO and MoH activities.
- Supported the multi-stakeholder council of the Medicines Transparency Alliance (MeTA) and facilitated at the National MeTA Forum.

ii) *Health Promotion and Communication*

- Contributed to the control of the Marburg Virus Disease outbreak in Kween and Kapchorwa district through planning and implementation of risk communication activities. The activities included production of communication materials, training of the district and national risk communication implementers, partner mapping, community engagement and media coordination.
- The NCD Communication Strategy was finalized at a stakeholder meeting. The strategy that will be disseminated in 2018 provides key messages, communication channels, target audiences and roles of key stakeholders to address the rising burden of NCDs in the country.
- The National-wide campaign to distribute Long Lasting Insecticide-treated Nets (LLINs) was concluded with over 24 million nets distributed to over 37 million people. This campaign, together supplemental polio, measles immunization and sustained awareness on HIV/AIDS were heavily supported by well planned and executed health promotion interventions.
- Preparation for the implementation of the Community Health Extension Worker's (CHEWs) strategy were finalized in 2017 and the National policy, Strategy, Implementation Guidelines and training materials (Modules) were produced and approved by the national authorities. In 2018, the strategy will be piloted in 12 districts in northern

Uganda where the trained CHEWs will complement the current Village Health Teams in the delivery health services at individual, family and community levels.

- Visibility of WHO and its work at country level was high priority throughout 2017 and this was delivered through production and dissemination of regular bulletins, press releases, photographs, feature stories, mass media management and social media. The eight WHO commemorative days provided more opportunities to raise awareness on WHO and the several health themes highlighted during the year.

iii) *Public Health Informatics*

- Contributed to improved timeliness reporting by district of health data to the MoH under the Health Management Information System (HMIS) using HMIS 033b. This has achieved through enhanced and improved cascading of the mTrac system to the lower health facilities by the District Health Teams in all 122 districts of Uganda. Currently, 65 to 80 percent of the districts report using mTrac, on notifiable diseases, maternal and perinatal deaths, and tracer medicines 50 to 65% in 2017. The reason for under reporting especially in large districts such as Wakiso and Kampala was identified to be due to the ever increasing number of Private Health Providers that do not report consistently. In 2017, WHO provided funding to Wakiso and Kampala district for training and mentorship to address this problem.

- The Health Laboratory Information Management Systems (HLIMS) and the Central Public Health Laboratories (CPHL) were strengthened by finalizing the design and validation of laboratory data collection tools and reporting templates that are used at all levels of health laboratory services.
- The Ministry of Health together with WHO and partners finalized a costed-eHealth Policy and Strategy. This policy provides guidance on how to use Information and Communication Technology to improve the flow of information, through electronic means, to support the delivery of health services and the management of the health system. It also facilitates the achievement of the longer-term health goals such as universal access to care, health sector efficiency, and social transformation.

iv) **Health Information and Evidence**

- Supported the Ministry of Health to conduct quarterly Data Quality Assessments (DQAs) that informed decisions during the Health Sector Quarterly Performance Reviews, monitoring the Health Sector Development Plan and interventions in the various program areas. The assessments established the level of data quality in selected districts and health facilities; documented some of the critical issues affecting data quality and action plans developed for the facilities, district and district based partners. Districts and health facilities

for each DQA were selected based on poor performance over a given period considering low or inconsistent reporting and data quality.

- Contributed to the control of MVD in Kween and Kapchorwa districts by setting up of a Field Data Management Team (FDMT) that built capacity of district staff to collect and analyze outbreak data that was used to compile epidemiological situation reports and guided planning for logistics requisitions, prepositioning and human and financial resource.
- The population-based (household based) Preventive Chemotherapy (PC) coverage surveys were done in five of the forty nine districts that conducted



People donating blood - one of the activities supported by WHO.

Mass Drug Administration (MDAs) to verify achieved treatment coverage. The results provided precise estimates, overcoming many of the biases and errors that characterize reported coverage. Reasons for missing drug distribution and non-adherence to drug swallowing schedules were also highlighted.

- Supported an independent monitoring exercise to assess the quality of the Polio Supplemental Immunization Activities (SIAs) as well as to verify the administrative coverage figures submitted by the 73 districts in which the campaign was conducted. This exercise followed WHO guidelines

and provided strategic direction to mop-up teams in the districts.

- Supported government to formulate tools, budget and training of survey teams as well as report writing for the 2016 Demographic Health Survey (UDHS). The UDHS provides data needed to monitor and evaluate population and health programmes, giving a comprehensive overview on health, nutrition, maternal and child health issues every 5 years.

v) **Laboratory**

- Reviewed and developed nine national laboratory normative documents including the National Health



BENJAMIN SENSASI

Mothers waiting for antenatal services at Serere HealthCentre V.

- Laboratory Service-Policy (2016 - 2020), National Health Laboratory Services Strategic Plan (2016 - 2020), guidelines and training manuals.
- Supported strengthening of the laboratory quality management system through training and accreditation of 48 laboratory auditors in partnership with the African Science of Laboratory Medicine (ASLM) and Centers for Disease Control (CDC).
 - Strengthened monitoring of the annual biosafety and biosecurity at regional referral hospital laboratories using the principles of assessment, mitigation and corrective actions.
 - Supported the Ministry of health during the Marburg outbreak investigation and management in Kapchorwa and Kween districts in Eastern Uganda by collecting, packaging transporting, and tracking laboratory samples during the outbreak.
 - Facilitated the deployment of the mobile laboratory at Kapchorwa Hospital in which 13 (81.25%) Ugandans and 3 Kenyans (18.75%) were trained in the operations of a modern mobile laboratory in emergency situations.
 - Strengthened transportation and referral of highly pathogenic samples from regions (Moroto, Mbale, Mbarara and Kabale) using the National Hub Network for specialized quality laboratory services. Seventy one (71) health workers and Post Office staff were oriented on this issue. At the same time, WHO procured and distributed 300 triple packaging carrier boxes for highly infectious material category UN 2814 to priority districts.
 - Supported the National Laboratory Polio Containment Task Force to destroy materials of interest. The global deadline for destruction of the Sabin II polio virus and related materials of interest was the 31st July 2016. However, Uganda destroyed the materials on the 26th July 2016 witnessed by the task force members. At the function, 528 vials of Sabin 2 isolates, 45 original stool samples and 41 stool extracts that had been stored at the Extended Programme on Immunization Laboratory hosted at the Uganda Virus Research Institute were destroyed.
 - Built capacity of the Ministry of Health and the Uganda National Health Laboratory Services in case based laboratory diagnosis and surveillance of meningitis, case management and collection of Cerebral Spinal Fluid for laboratory diagnosis.
- vi) **Maternal and Newborn Health**
- The Road Map to implement the Maternal and Neonatal Health (MNH) Quality implementation guidelines were finalized. The WHO Quality of Care (QoC) Standards for Maternal and Neonatal Health and Health Facility Assessment Tools were also developed.
 - Financial resources for implementation of the MNH and QoC in 15 districts were mobilized following an entry

exercise and assessment of quality of health facilities in Hoima district which informed and guided the implementation.

- WHO supported implementation of the revised the National Maternal and Perinatal Death Surveillance and Response (MPDSR) guidelines in 17 districts and production of the 2017 MPDSR. This was based on the recommendations and feedback received from implementation of MPDSR activities in some districts.
- Finalized, produced and disseminated Essential Maternal and Newborn Care Guidelines for Uganda to implementing partners.

vii) **Family Planning**

- Trained 22 health workers on post-partum and post abortion family planning services provision using Medical Eligibility Criteria. In addition, service protocols and patient Flow charts for Post-Partum and Post Abortion Family Planning were produced and disseminated to 25 health facilities in 5 districts. They will be used to improve service delivery in health facilities throughout the country.
- Funded mentoring and support supervision activities on post-partum and post abortion family planning to 50 health facilities resulting in increased uptake of family planning by post-partum mothers and better recording whenever post-partum services are provided.

- Supported mentoring and support supervision visits to Male Action Groups in 4 districts using the updated guiding documents leading to more men seeking family planning services for themselves or their partners.

viii) **Child health**

- Trained 21 master trainers from Ethiopia, Malawi, Senegal, Uganda and Zambia on the new ICCM/TB/HIV guidelines. This was followed by an operational research study funded jointly by WHO and UNICEF to find out key issues to consider when rolling out the guidelines and design of the child health policy.
- Participated in writing the 2018-2021 proposal to the Global Fund to Fight Malaria, Tuberculosis and HIV/AIDS. The proposal now has a component on the Integrated Community Case Management (ICCM) to support the roll out of the new ICCM guidelines that integrate TB add HIV.
- Supported Ministry of health to conduct a training of trainers' course on Integrated Management of Childhood Illnesses (IMCI) for 20 master trainers which was also used to revise the national IMCI guidelines. The IMCI chart booklet and the decision to adopt clinical skills laboratory training as well as the IMCI distance learning approach resulted from this training. The finalization of the IMCI guidelines and the piloting of the distance learning model in Uganda benefited



Health workers in a happy moment with a patient at the Uganda - China Friendship hospital Naguru.

from the inter-country experience sharing and technical input from the WHO Regional Office.

ix) **Adolescent Health**

- WHO, UNICEF, UNFPA, UNAIDS, UN WOMEN and Makerere University School of Public Health supported a country-wide adolescent risk behavior study that generated country specific evidence to support adolescent programming in Uganda.
- Supported drafting of a new Adolescent Health Policy and an Adolescent Strategy for Uganda which are in line with the Sustainable Development

Goals (SDGs) on the health of adolescents. This was in line with the 2017 WHO Framework on accelerated action for adolescent health that guides development of evidence-based policies and strategies to support the implementation of adolescent health programs in countries.

- Developed the Framework for the Adolescent Girls in Uganda and a proposal on Total Market Approaches to increasing access to family planning services by adolescents. A consultative meeting with youth serving organizations on increasing access to Family Planning for young people was held as a follow up.

x) **Nutrition**

- Supported the Nutrition division in the ministry of health to carry out an analysis of the reporting trends of the nutrition indicators in the District Health Information System (DHIS2). This was a follow up activity to ensure sustainability of the nutrition surveillance that was started during the Accelerating Nutrition Improvement (ANI) project. The report of this exercise was used to guide targeted support supervision to improve reporting by the poor performing districts.
- Supported MoH to revise and include more nutrition indicators in the Health Management Information System (HMIS) intended to improve monitoring the decade of nutrition action.
- Together with other UN agencies (UNICEF and FAO) supported the engagement of Members of Parliament to gain their support and involvement in advocacy for nutrition. This resulted into the formation and launch of the Parliamentary Forum for Nutrition.

xi) **Gender and Human Rights**

- Supported the MoH to develop the National Plan of Action for Strengthening the Role of the Health System in the Prevention and Management of Gender Based Violence (GBV) and Violence against Children. In addition, WHO supported the MoH to finalize the training manual for health workers on Gender and Human Rights.

- Guided national and district authorities, and partners in the implementation of GBV in humanitarian settings especially in refugee camps.
- Supported the MoH to conduct district orientation meeting on GBV prevention and response activities in Masindi and Hoima districts. This resulted in agreements on the roles, responsibilities and a mechanisms on improved networking on GBV in the two districts.



xii) ***Korea International Cooperation Agency (KOICA) MCH project***

- Mobilized USD 1.6 million dollars from the Korea International Development Agency (KOICA) for the maternal and child health project in Iganga and Kamuli districts. The memorandum of understanding between WHO and KOICA was signed and implementation is scheduled for 2018.

xiii) ***Library Services***

- The Soroti Regional Referral Hospital library was refurbished and stocked with current books and health literature in addition to training staff in Library management. The library was also linked up on the electronic library system and HINARI all leading to improved access to health information and knowledge.



Ministry of Health and WHO staff interacting with members of the Village Health Team in Mukono District.

- The effectiveness of the Blue Trunk Library that has been implemented in Uganda for many years is due for assessment. In 2017, a proposal for the assessment was prepared and submitted for funding. The survey will inform decisions on the extension of the Blue Trunk library throughout the country.

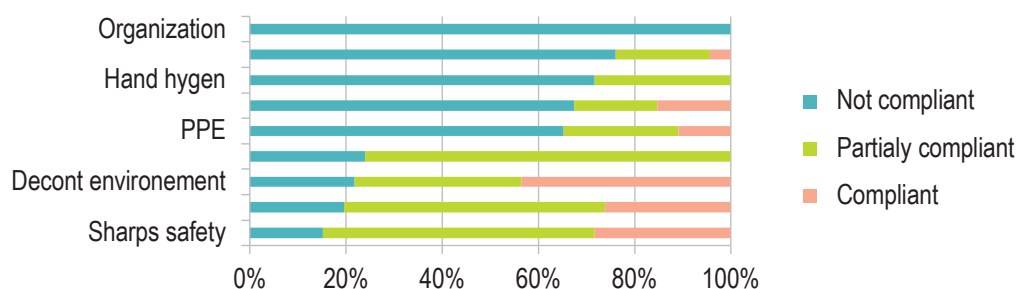
xiv) ***Injection Safety***

- The commodity quantification for the government sector was concluded in February, 2017 and aggregated into a national procurement plans by National Medical Stores. NMS is now able to forecast and procure adequate medicines and support thus eliminating stock out challenges.
- A new Uganda National Injection Safety policy was drafted following a review of global recommendations, injection safety studies, policies, and guidelines. The draft was presented to the national injection safety technical working group for input and the final draft will be reviewed by wider stakeholder groups in 2018.
- A total of 117 health workers drawn from 45 health facilities in Moyo (39) and Yumbe (78) districts were trained in comprehensive infection prevention and control. The “Do No HARM, Injection Safety in the Context of Infection Prevention Control Manual” was used for the training.
- Following the MVD outbreak in Kapchorwa and Kween districts, 46

health facilities were assessed to determine their capacity to respond to potential outbreaks. Overall, only 7% of the health facilities were compliant with IPC requirements, 30% were partially compliant while the rest 40% were non-compliant. Of the parameters assessed, organization of IPC, screening and isolation of patients, hand hygiene and decontamination of medical equipment had the worst scores while injection safety, decontamination of the environment and availability of IPC commodities had the best scores.

- A total of 595 health workers in Kween and Kapchorwa districts were trained in case management and infection prevention and control in hemorrhagic virus disease outbreaks. Forty two (42) health workers were trained as members of the Marburg Treatment Unit (MTU). As result, the two districts registered improvements in maintaining health worker and patient confidence while providing and seeking other health services during Marburg outbreaks.

Table 1: A summary of IPC scores in the districts of Kween and Kapchorwa



Challenges



- Lack of funding to fund most of the planned activities, changing donor interest and competing priorities making implementation of plans and strategies inadequate.
- Inadequate auditors to implement the strategy for certification and accreditation of the 100 laboratories earmarked by the country for quality improvement through the WHO Strengthening Laboratory Improvement Process toward Accreditation (SLIPTA).
- During disease outbreaks, laboratory services are not properly linked to the other response pillars which complicates data analysis and increases turnaround time for results on tested samples
- Inadequate human resources to implement planned activities in the WCO and in the Ministry of Health. This challenge becomes more pronounced during the frequent disease outbreaks.



Way forward

- WHO will support government to finalize important documents such as policies, strategies and frameworks that guide partners on how and where to channel the required technical and financial support.
- Capacity building in all areas of the health system is continuous and will be given more emphasis as the country moves towards Universal Health Coverage.
- Uganda being prone to disease outbreaks should be supported to build a resilient and robust health system capable of responding effectively and in time. WHO will put emphasis on laboratory services, materials child health, data management and community engagement among others.
- Monitoring and evaluation remains a weak link in health systems and WHO takes this component as one of the areas that need urgent and sustained support.







United Nations staff members cleaning Kalerwe market during UN Day 2017.

**DISEASE
PREVENTION
AND
CONTROL
CLUSTER**

Introduction

THE DISEASE PREVENTION AND CONTROL CLUSTER SCOPE OF WORK INCLUDES PREVENTION AND CONTROL OF COMMUNICABLE AND NON-COMMUNICABLE DISEASES. IT THUS COMPRISES OF THE HIV AND HEPATITIS, TUBERCULOSIS, MALARIA, NEGLECTED TROPICAL DISEASES, AND NON-COMMUNICABLE DISEASES PROGRAMME AREAS WHOSE MAIN ACHIEVEMENTS AND CHALLENGES IN 2017 AS WELL THE NEXT ACTIONS ARE HIGHLIGHTED IN THIS SECTION.

Uganda continues to have a high burden of HIV/AIDS as indicated by the national HIV prevalence among adults aged 15 to 64 years of 6.2%; 7.6% among females and 4.7% among males (PHIA 2017). The estimated number of persons living with HIV is still high at 1.2 million people aged 15 to 64 years. HIV prevalence is higher among women living in urban areas (9.8%) than those in rural areas (6.7%). The prevalence of HIV among children aged 0-14 years is 0.5% which corresponds to approximately 96,000 children living with HIV in Uganda.

Uganda is one of the 30 countries in the world with a high burden of TB and HIV. A national community based TB disease prevalence survey conducted from 2014 to 2016, estimated the prevalence and incidence of TB to be 253 and 202

per 100,000 population respectively. Uganda is also one of the countries where the threat of Drug resistant TB continues to be a major challenge. Indeed, 1.4% of new and 19% previously treated TB cases are estimated to have Multi-Drug Resistant (MDR) or Rifampicin Resistant (RR) TB. In addition, 46% of estimated MDR/RR-TB were notified of which approximately 54% were successfully treated in 2016.

Malaria remains the number one killer infectious disease in the country, accounting for 40% of visits to Outpatient Department in public health facilities. In 2017, more than 9.4 million confirmed cases of malaria and 5,111 deaths were reported (MOH/HMIS). A Uganda Malaria Reduction Strategic Plan (UMRSP, 2014 -2020) fully aligned with the Framework for Implementing WHO - Global Technical

Strategy (GTS) is being implemented. The progress made from 2009 to 2014, during which malaria prevalence reduced from 49% to 19% has stagnated in recent years (2014 – 2017). However, there has been a reduction in number of deaths due to malaria by 16.2%.

Uganda still has a high burden of Neglected Tropical Diseases (NTDs) affecting mainly the rural poor staying in remote underserved communities. The country is endemic for Onchocerciasis (river blindness), Lymphatic Filariasis

(elephantiasis and hydrocele), Trachoma, Schistosomiasis (Bilharzia), Soil Transmitted Helminthes (STH) (worms), Human African Trypanosomiasis (sleeping sickness), Leishmaniasis (Kalaazar), Buruli Ulcer Disease, Rabies, Tungiasis (Jiggers), and Plague, with co-endemicity of different NTDs in several districts. These diseases are associated with high levels of morbidity and disability, and affect the productivity of the affected poor populations making them poorer, thus propagating the vicious cycle of poverty and disease.



Health checks were some of the highlights in commemoration of World Health Day 2017.

Noncommunicable Diseases (NCDs) are a growing public health and development challenge in Uganda. Surveillance data shows that the burden of NCDs in Uganda is increasing exponentially leading to a dual burden of communicable and Noncommunicable diseases. The NCD STEPS risk factor survey indicated significant exposure to NCD risk factors in the population and a high burden of physiological risk factors; such as hypertension whose prevalence is 24.3%. Non-communicable diseases were identified as a priority both by WHO in its current Global Programme of Work, the WHO Country Cooperation Strategy (CCS) and the Government of Uganda Health Sector Development Plan (HSDP).

Achievements

i) *HIV/AIDS*

- WHO supported preparation and the national launch of the Presidential Fast Track Initiative (PFTI) to end HIV/AIDS as a public health threat by 2030. This is aimed at enhancing public awareness and male involvement in the fight against HIV/AIDS in the country. WHO support generated a roadmap that will guide implementation of the initiative at national, district and community levels.
- In line with 2015/16 WHO recommendations, additional testing approaches such as self-testing, use of lay providers and assisted partner notification were adapted. WHO supported the review and finalization of the national HIV Testing Services

Policy Guidelines. By end of 2017, the country had tested and provided results to 69% of all persons estimated to be infected with HIV (the first 90% of UNAIDS targets).

- The AIDS Control Programme (ACP) developed and validated an Integrated Mentorship Tool aimed at improving the quality of HIV services delivered by the healthcare workers. With WHO support, the tool was utilized in 37 districts to support health workers in the delivery of quality HIV/AIDS services. In addition, WHO supported efforts geared towards onsite mentorship for cohort monitoring for mother- baby pairs to 37 sites in seven districts of the Karamoja region.
- WHO offered technical assistance that helped the country set up the eMTCT National Validation Committee that will guide the process to elimination.
- As reflected in the graph [on the next page], Uganda has registered good progress in the uptake of Safe Male Circumcision over the years.
- Although the total number of young men that were circumcised during 2010-2015 fell below the target of 4.2 million, the program has created a firm foundation for routine provision of SMC services. This is demonstrated by the sharp rise in SMC numbers from 405,054 in 2016 to 698,412 in 2017 as indicated in the figure above.
- In 2017, WHO supported the review and update of guidelines for prevention of tetanus infection after circumcision

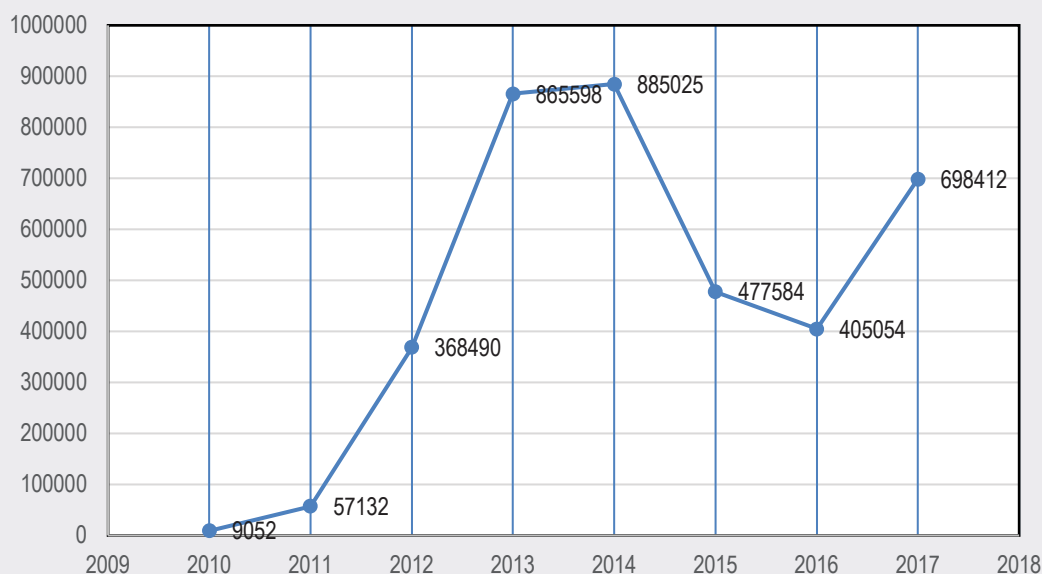
to match with WHO Global guidance. This went along with raising SMC awareness and organization of a surgical camp in Moroto district, Karamoja region where a total of 858 males were circumcised for HIV prevention. To strengthen the delivery SMC, 300 re-usable surgical kits were procured and distributed to 30 health facilities across the country.

- Uganda now has the necessary policy guidelines, training materials as well as monitoring and evaluation tools for systematic and successful implementation of PrEP. This resulted from WHO's support to the country that led to the adoption and preparation of materials for the step wise roll-out

of the use of ART for PrEP as another HIV prevention approach among populations most vulnerable to HIV infection.

- The consolidated guidelines for prevention and treatment of HIV in Uganda that were developed in 2016 were rolled-out in 2017. By the end of November 2017, more than 15,580 health workers had been trained and 992 health facilities reached out of the targeted 1,984 using the new guidelines. In addition, 65% of clients in pre-ART had been initiated on treatment and 85% of newly diagnosed HIV positive individuals had been enrolled on ART.

Trends of annual circumcisions for Uganda from 2010 to 2017





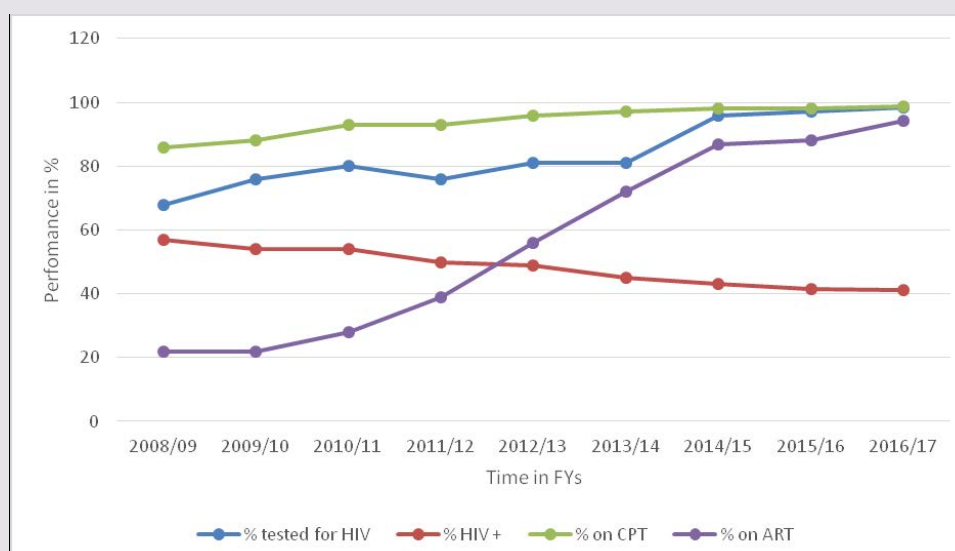
A health worker carrying out a malaria test during World Malaria Day 2017.

- WCO supported review of TB/HIV flip chart that is used by frontline health workers in making TB/HIV decisions for co-infected clients. Consequently, greater progress to improve the collaboration and integration of TB/HIV services registered higher performance with an increase in patient screening for TB of over 90% of HIV-positive TB patients initiated on antiretroviral therapy (ART) compared to 81% recorded in 2014.
- In collaboration with Central Public Health Laboratories (CPHL), WHO supported mentorship of 35 laboratories that had documented high sample rejection rates. Consequently, the hub system used for sample collection, transportation and referral is accessible by most of the ART centers. At the same time, the piloted viral load monitoring and reporting tools aimed at strengthening reporting against the third 90 of the cascade were evaluated.
- Site assessment for Open electronic medical record systems (Open EMRS) which helped to enhance health workers' capacity to access and use data from the DHIS2 platform and the Open EMRS was undertaken with WHO support. Information gathered from this assessment is being used to guide roll-out of Uganda EMR in 14 high volume sites in Karamoja region.

- WHO advised the National Technical Working Group that developed the protocol, design and implementation of the Uganda Population based HIV Impact Assessment (UPHIA) 2015/16). Preliminary results from the assessment indicated a fall in national HIV prevalence to 6% compared to 7.3% in 2011.
 - WHO technically guided the Prevention, Care, Treatment and Strategic Information Technical Working Group to produce the Annual HIV/AIDS Performance Report that was used to inform stakeholders at the Joint AIDS review.
 - The new HIV Testing and Screening recommendations; ratification of the Test and Treat approach; promotion of the increased use of ART in Pre-Exposure Prophylaxis; widening the reach of Viral load monitoring and adoption of new guidelines for mitigation of tetanus infections among males that access to circumcision services are some of the additional areas of work that benefitted from WHO's technical support during 2017.
- ii) **Tuberculosis**
- The TB Prevalence Survey was disseminated in 2017. The key findings were:
 - The prevalence of sputum smear-positive (S+) TB and bacteriologically confirmed (B+) TB among survey participants aged 15 years and older was 174/100,000 population, 14 (95%CI:111-160) and 401/100,000 population, (95%CI: 292-509), respectively.
 - The prevalence was higher among males than females. Among males, the prevalence of S+ TB and B+ TB stood at 314/100,000 population and 734/100,000 population, respectively. For females, prevalence stood at 70/100,000 population and 179 per 100,000 population, respectively.
 - The most affected age group for S+ TB was 35-44 years (294/100,000 population), while for B+ it was those aged 55-64 years (636/100,000 population). The prevalence of S+ is 169/100,000 population in rural areas vs. 191/100,000 population for urban areas, while the prevalence of B+ is 370/100,000 population in rural areas vs. 504/100,000 population in urban areas. After adjusting for all age groups and extra-pulmonary TB (as these were not
 - Overall, the prevalence of TB was found to be 253 (95% CI: 191–315), equivalent to 87,000 TB cases (95% CI: 65,000-110,000) per year.
 - The prevalence to notification ratio was found to be 1.2—higher for males (1.5) than for females (0.7)—and was highest in the 15-24 age group (1.7).

- Revised the national TB and leprosy strategic plan (2015/16-2019/20) in view of the TB prevalence survey findings and the WHO-End TB strategy.
- Successfully compiled and submitted in time, the joint TB/HIV Global Fund grant application for 2018-2020 leading to the award of 18M USD to cater for TB medicines and lab supplies (80% of the fund).
- Revised the algorithm for TB diagnosis and management in order to increase TB notifications. In addition, the country installed 15 New GeneXpert machines bringing the total number of TB diagnostic sites with this technology to 136 in the country.
- Revised the DR TB guidelines to cater for the introduction of Short MDR TB Treatment regimens. This will improve treatment completion for the estimated 700 MDR patients in the country.
- Expanded treatment initiation for TB patients:
 - At the end of 2017, there were 17 treatment centers for MDR (Rifampicin Resistant) TB in the country, up from 15 sites of 2016; In addition, 600 patients were already active on MDR Treatment
 - More than 300 health facilities in the country were implementing the DOT approach with support from the trained healthcare workers and the community
- Substantial progress in TB/HIV indicators over the years: The figure below demonstrates that substantial progress has been made in key TB/HIV indicators as captured by the TB Program over a 9-year period. Documented HIV status increased from 68% in 2008/2009 to 98.3% (target of 98%) in 2016/2017; TB/HIV co-infected patients on CPT increased from 86% in 2008/2009 to 98.8% (against a 99% target) and those on ART from 22% to 94.2% (target was 90%).

Trends in TB/HIV service uptake by FY, 2008/09 – 2016/17



iii) **Malaria**

- There is strengthened leadership, visibility and capacity of National Malaria Control Programme (NMCP) following WHO's support on malaria trend data analysis as well as production and dissemination of the weekly malaria status updates that are used at national and sub-national levels. NMCP now has capacity to lead, coordinate and strengthen partnership including through functional Thematic Working Groups (TWGs) routine monthly meetings and Roll Back Malaria Partnership Forum.
- In 2017, the Malaria Operational Plan (2017-2018) was developed during which WHO facilitated active engagement of NMCP with districts to operationalize the plan. This led to strengthened partnerships at all levels and increased resources from domestic and external sources.
- At the same time, the Country Strategy and Implementation Guidelines on Malaria Vector Control and Integrated Vector Management were developed and disseminated. As of December 2017, malaria deaths are reported to have decreased from 5,635 (2016) to 5,111. Additionally, there is increased capacity of the NMCP for malaria epidemic preparedness and response.
- WHO guided finalization of the National Therapeutic Efficacy Study 2017/18 Protocol that was submitted for IRB approval. Funding for implementation is expected from WHO and USAID.
- National, district and institutional training sessions, capacity building and procurement of materials for NMCP were all undertaken leading to improved generation of entomological data, surveillance and implementation of SME-OR.
- The Presidential launch of the Long Lasting Insecticide Treated Nets (LLINs) was done on 17th February 2017. WHO actively participated in the campaign through coordination and monitoring for universal coverage. A total of 24 million LLINs were distributed to 37 million people.
- Indoor Residual Spraying (IRS) campaign led by NMCP was re-introduced in 10 districts in northern Uganda. USAID-Abt Associates led the campaign in 14 new districts in Soroti sub region. WHO provided support to develop the Post-IRS Gains Sustainability Plan.
- Malaria plans in at least 50 districts were updated during regional reviews and planning consultative meetings intended to accelerate implementation of National Malaria Strategy (UMRSP, 2014-2020).
- WHO in collaboration with UNICEF finalized Uganda's Response to Malaria proposal (December 2017 to November 2022) that was submitted to UK-DFID for funding. The grant worth GBP 22 million will be implemented by UNICEF through Malaria Consortium in 23 districts and WHO to strengthen the central level activities.



EDMUND MWEBEMBEZI

The Rt. Honourable Prime Minister of Uganda Dr. Ruhakana Rugunda handing out LLINs at the launch of the LLIN distribution campaign in Gulu District - Northern Uganda.



WHO / UGANDA

- Advocacy activities that were successfully implemented included establishment of the parliamentary forum for malaria (UPFM), commemoration of the World Malaria Day 2017, and engagement with the inter religious council. These were geared towards increasing uptake of malaria interventions.
- WHO worked with NMCP, civil society organizations, NGOs, faith-based organization, the public and communities to plan the Malaria Indicator Survey and the implementation of the Mass Action Against Malaria (MAAM) in 2018. These interactions strengthened Roll Back Malaria Partnership in Uganda, coordination and leveraging of resources.
- By the end of 2017, 83% of the population had received LLIN. Sixty percent (60%) of the targeted population were protected by IRS. These interventions contributed to reducing of malaria deaths from 5,635 (2016) to 5,111 in 2017.

Figure 1: Reduction in Malaria deaths.

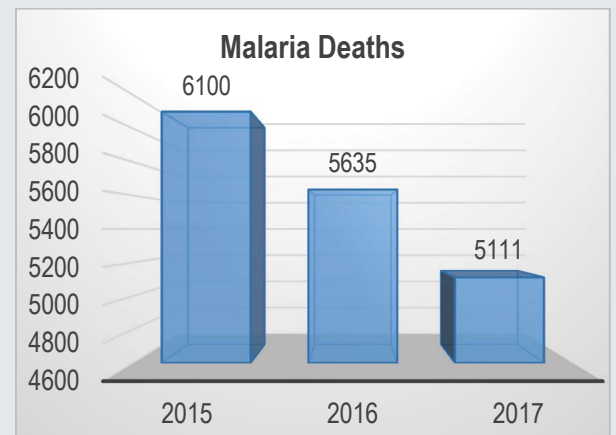
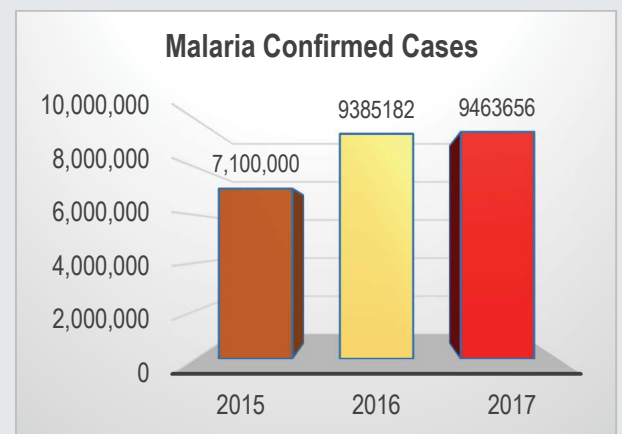
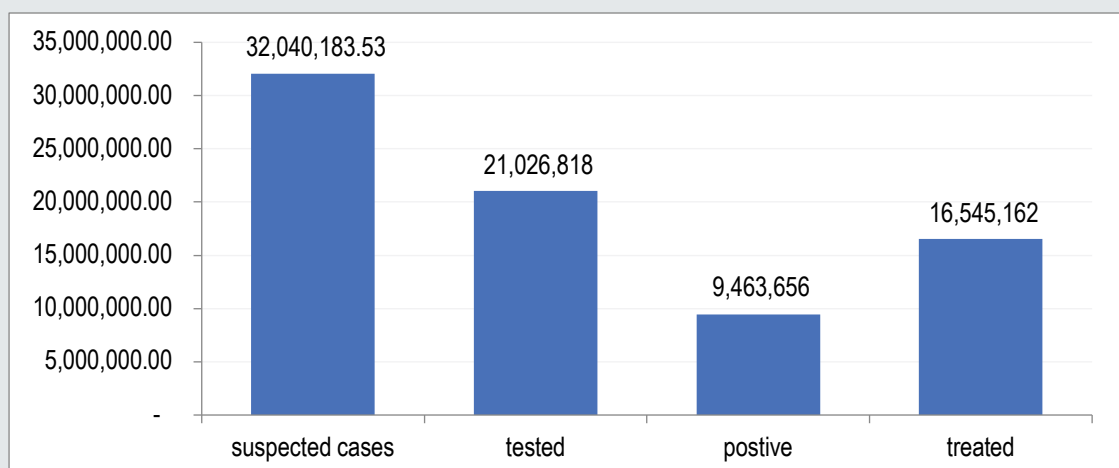


Figure 2: Increased confirmed malaria cases, Uganda (2015-2017)

Figure 3: Access of population at risk to malaria interventions including diagnosis and treatment.
Note: Testing rate of 66% and test positivity rate of 45%

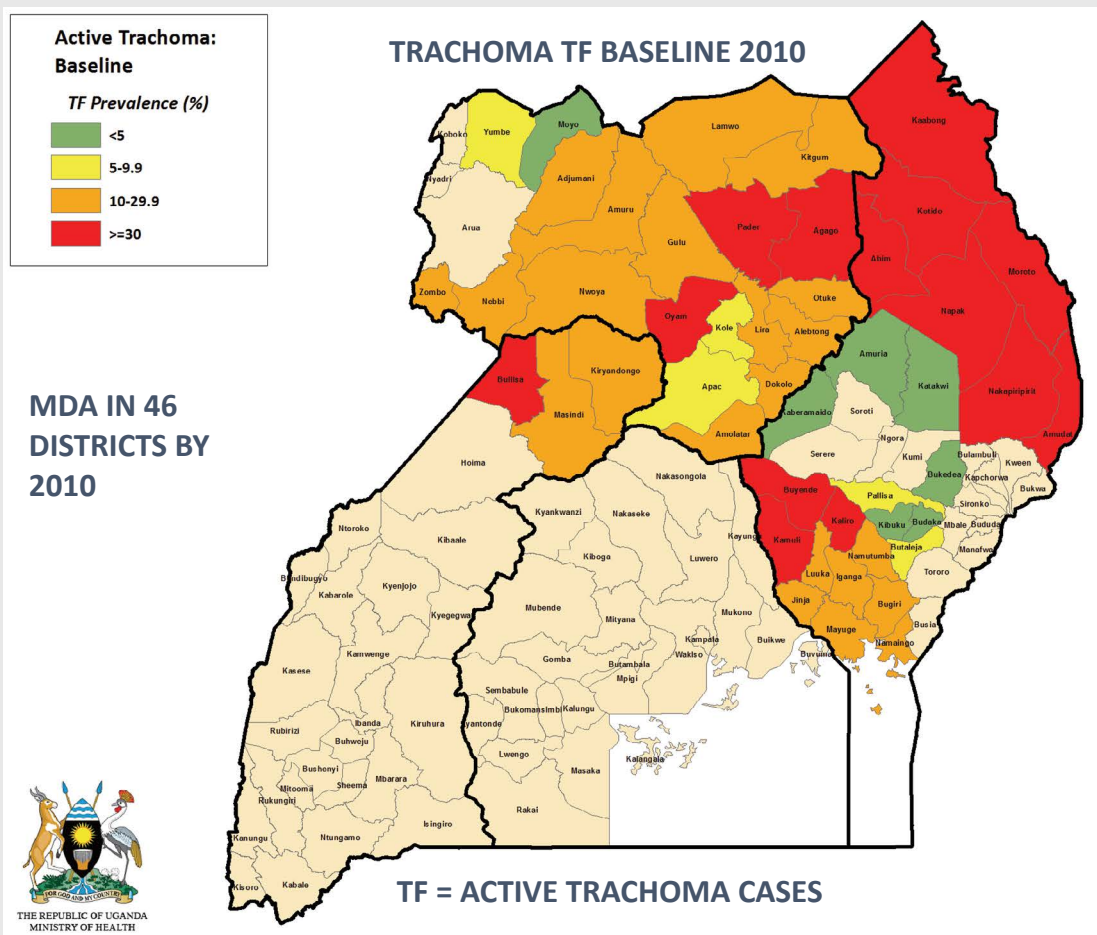
iv) **Neglected Tropical Diseases**

- In 2017, Uganda continued to make significant progress towards the elimination of trachoma, Lymphatic filariasis and Onchocerciasis by 2020. Forty of the 44 originally endemic districts for trachoma have achieved the elimination criteria; 46 of the LF endemic districts have achieved the elimination criteria, while 9 of the 16 endemic foci for river blindness have achieved elimination criteria, freeing over 3 million people from the risk of river blindness.
- There has been mixed progress in the Control of STH and Schistosomiasis with some districts making impressive progress while others still lag behind. For STH control, evidence shows that districts that are co-endemic with LF have achieved more success than those that are not. The STH prevalence in STH-LF co-endemic districts is close to zero, possibly due to additional deworming that is provided by the LF programme covering all people 5 years and above.
- Similarly, progress has been made in Schistosomiasis control in some districts, however regress has been observed in some districts with low programme reach, resulting in re-emergence of Schistosomiasis morbidity. A Schistosomiasis programme review with technical guidance from WHO was conducted and actions agreed upon to reverse this situation.
- HAT endemic districts in the West Nile region have made progress in r-Gambiense HAT elimination, with no indigenous HAT case reported in 2017. Only 2 imported cases were confirmed among refugees. However, the progress is slower in the r-Rhodesiense endemic districts in Eastern Uganda, where 13 cases were confirmed in Dokolo and Kaberamaido districts.
- WHO supported efforts to strengthen the Visceral Leishmaniasis (VL) control programme. A total of 114 cases were managed by the VL treatment center in Amudat in 2017, 32 of which were from Uganda while 82 were reported as originating from neighbouring Kenya. It is likely that there is under-reporting of cases in Uganda given that there is only one treatment center in the whole of Karamoja region.
- The country remained Guinea worm free for the 9th consecutive post-certification year. Guinea worm post-certification activities were supported, all rumors of suspected cases were investigated and Guinea worm ruled out. However, there is a threat of importation and/or re-introduction of Guinea worm from still endemic South Sudan given the influx of refugees into Uganda.
- At the annual Uganda Onchocerciasis Elimination Expert Advisory Committee (UOEEAC) that reviewed the progress of onchocerciasis elimination in Uganda, WHO presented the new

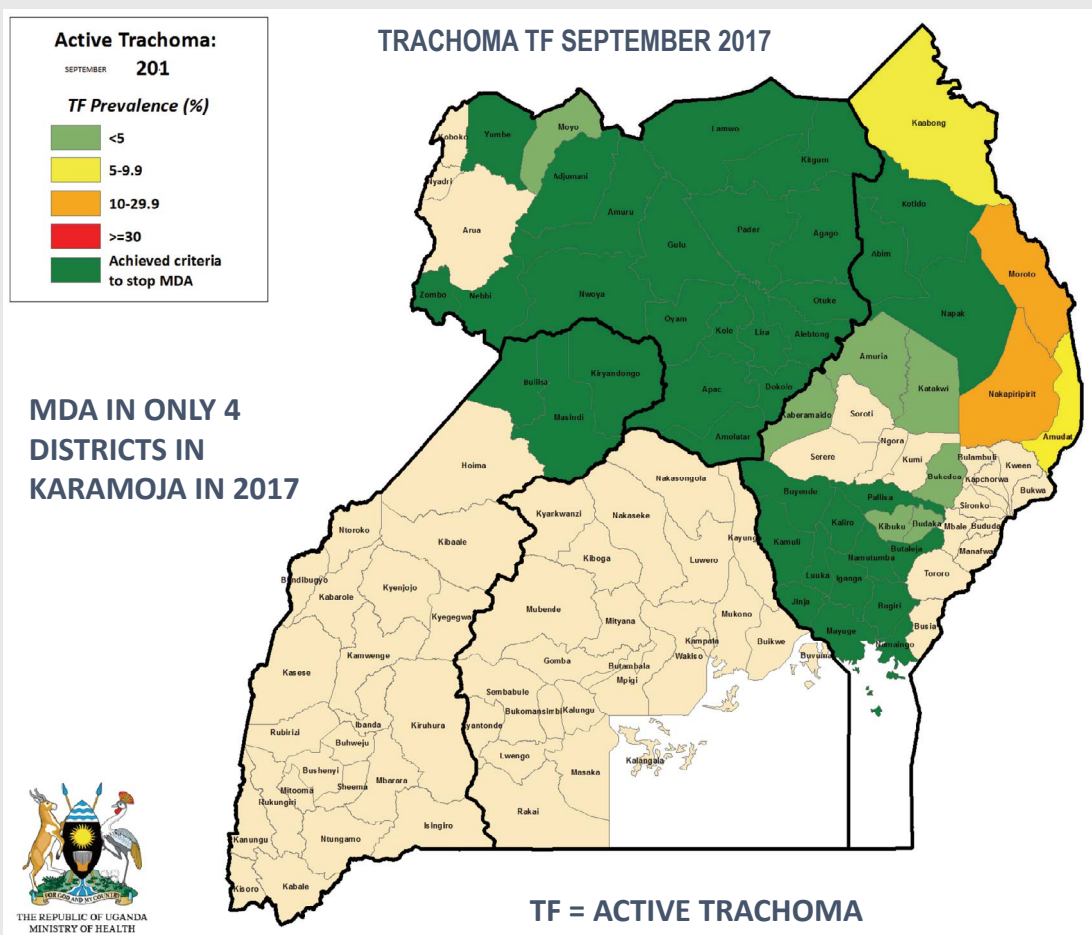
WHO guidelines for verification of elimination of onchocerciasis to the members. At the Schistosomiasis programme review meeting, among other contributions, WHO introduced the possibility of snail control in Uganda and also highlighted the need to integrate WASH interventions in the current interventions to reduce the current high risk of re-infection.

- WHO supported and built capacity of the NTD programme and partners to design and conduct NTD treatment coverage surveys using the WHO NTD

STAG recommended methodology. Results showed differences in survey and reported treatment coverage in different districts, with the biggest differences seen in coverage of Praziquantel for Schistosomiasis control. The programme reach was also low for Praziquantel in most of the districts surveyed. The findings and recommendations from the survey have been used by the programme and partners to inform improvements in implementation of Mass Drug Administration (MDA).



- To further build national capacity on NTD integrated epidemiological and impact assessment, WHO conducted a Regional Training Workshop on integrated monitoring and epidemiological assessment of MDA in GPELF, and introduced the new Filariasis Test Strip and integrated assessment of STH and Onchocerciasis. The training that was hosted in Entebbe, Uganda from 30th May to 2nd June 2017, brought together officers from seven countries.
- Data needed to report on the new VL surveillance indicators was not all being collected through HMIS/DHIS 2. To facilitate country reporting on the new surveillance indicators, WHO supported the Ministry of Health to review the HMIS reporting pertaining to VL and to develop an HMIS/DHIS 2 addendum for VL reporting for the Karamoja region. In addition, an individual tracker was developed for case-based reporting on the VL cases in DHIS 2. This will be rolled out in the Karamoja region in 2018.



- Given new evidence of Guinea Worm (GW) infection among animals, and the related threat to Guinea worm eradication, WHO supported the design and field implementation of the survey for Guinea Worm infection among dogs and domestic animals, integrated with a case search for Guinea worm among South Sudan refugee settlements. No case of GW infection in animals was found however, suspected cases were reported in the refugee settlements. These were followed up and found not to be true cases.
 - Furthermore, WHO and MoH jointly supported an inter-district meeting on Guinea worm post-certification surveillance where the guidelines for post certification surveillance were re-disseminated, one health approach to Guinea worm surveillance introduced to the districts in view of the threat of GW infection in animals, and agreement on cross border collaboration activities reached.
 - Cross-border transmission of diseases continued to pose challenges for NTD eradication, elimination and control. In an effort to enhance collaboration for disease control, WHO supported several cross-border meetings (Trachoma, HAT, GW), bringing together officers from different countries to plan together and strengthen collaboration in disease control and surveillance. Participating countries were Democratic Republic of Congo, Ethiopia, Kenya, South Sudan and Uganda.
 - WHO and other partners supported the Ministry of Health to finalize the Leishmaniasis Treatment Guidelines to be used to guide capacity building efforts in Karamoja region for Leishmaniasis control and contributing to Early Case Detection and Management.
- v) **Non-Communicable Diseases (NCDs)**
- *Information Education and Communication* materials on cancers of the cervix, breast and prostate were developed in an attempt to address the increasing demand for information on NCDs. Mass production and dissemination of the materials will be done in 2018.
 - The NCD multi-sectoral action plan (MSAP) based on the NCD Global Action Plan 2013-2020 was also finalized. The plan gives guidance and direction to implementing partners and stakeholders on the pertinent issues that should be addressed to prevent and control NCDs in the country. The plan also provides Monitoring and Evaluation guidance for the MSAP based on the NCD global monitoring framework. Costing of the MSAP will be facilitated by WHO and thereafter the plan will be approved by the Ministry of Health in 2018.
 - Several regulations for operationalization of the Tobacco Control Act 2015 including graphic health warnings on tobacco products, smoke free environment, display of 'No Smoking' signage and review and

harmonization of tobacco product taxes, among others, were developed with support from WHO and for its dissemination to communities. More support was on the, development and harmonization of The Tobacco Control Act 2015, Tobacco Control Policy and the Tobacco Control Strategic Plan.

- The Global HEARTS project is piloted in six countries globally including Uganda and Ethiopia in the WHO African Region. In 2017, the project was launched in Mpigi district where baseline facility capacity assessment was undertaken to determine capacity to manage Cardiovascular Diseases (CVDs) and diabetes. A trainers' manual and assessment tools were adapted and some health workers trained on the HEARTS technical package for prevention and control of CVDs and Diabetes.
- In 2017, WHO provided technical input into the World Vision proposal on Violence against Children based on the WHO INSPIRE technical package. The project will target boys through the “coaching of boys to men approach” to prevent their propensity to perpetrate violence and girls who have experienced violence at school, community and in homes.

Challenges

Despite marked progress highlighted above, challenges under this cluster include huge financing gaps to sustain WHO technical leadership and support. This is more pronounced in procurement of medicines and other essential commodities; over-reliance on donor resources for financing; and stock-out of commodities such as HIV testing kits and ARVs in the public sector facilities.

Human resources are inadequate in all programmes which adversely affects implementation of activities and sustainability. Related to this is the negative impact on government's ownership and leadership due to lack of technical officers to be fully in control.

Continued risk of cross-border transmission of disease by refugees and other migratory groups hampers the country's progress towards elimination of diseases. Suboptimal implementation

of interventions in several districts, poor access to clean water, sanitation and hygiene services as well poor environmental management all contribute to stagnation in achieving health for all.

Way forward

Continued advocacy, development of strategic documents, capacity building, mentorship, Support supervision and generation of strategic information for decision making will be high on the agenda under this cluster. Resource mobilization to support technical and administrative human resources will also be prioritized. Support to government to operationalize initiatives such as Mass Action Against Malaria will be another area of keen focus in addition to provision of technical support, dissemination of guidelines and tools and continuous data management improvements. WHO will continue to support efforts to strengthen cross-border as well a multi-sectoral collaboration for eradication, elimination and control of diseases.

HIV / AIDS

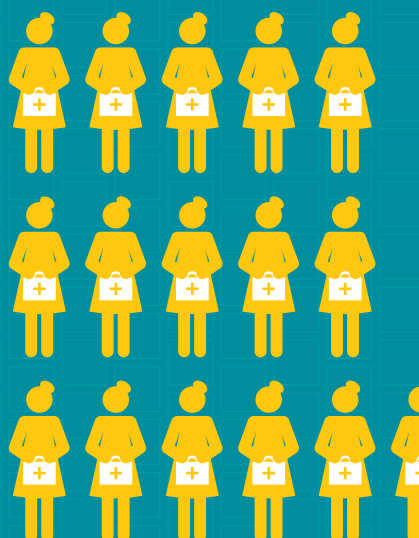
The SMC program has created a firm foundation for routine provision of services. This is demonstrated by the sharp rise in SMC numbers from **405,054** in 2016 to



POLICY GUIDELINES

By the end of November 2017, more than

15,580 health workers
had been trained and **992** health facilities
reached out of the targeted 1,984 using the
new guidelines.



TB

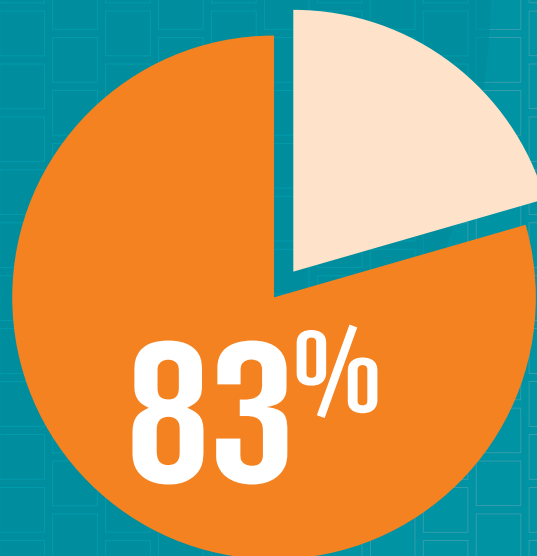
Documented HIV status increased from **68%** in 2008/2009 to **98.3%** (target of 98%) in 2016/2017; TB/HIV co-infected patients on CPT increased from **86%** in 2008/2009 to **98.8%** (against a 99% target) and those on ART from **22%** to **94.2%** (target was 90%).



MALARIA

By the end of 2017, **83%** of the population had received LLIN. Sixty percent (**60%**) of the targeted population were protected by IRS. These interventions contributed to reducing of malaria deaths from **5,635** (2016) to **5,111** in 2017.

5,111







**HEALTH
SECURITY
AND
EMERGENCIES
CLUSTER**

Introduction

WHO IS COMMITTED TO SUPPORTING THE GOVERNMENT OF UGANDA BUILDING A RESILIENT HEALTH SYSTEM CAPABLE OF RESPONDING TO HEALTH EMERGENCIES WITH PARTICULAR EMPHASIS PUT ON BUILDING CORE CAPACITIES TO PREVENT, DETECT, REPORT, ASSESS AND RESPOND TO PUBLIC HEALTH EMERGENCIES. IN 2017, WHO AND PARTNER SUPPORT CONTRIBUTED TO THE FOLLOWING ACHIEVEMENTS.

Achievements

i) *Immunization*

- The routine immunization coverage in 16 districts improved from 45% to 76% in 16 through implementation of Reach Every Community micro plans.
- The immunity profile of the under five children was increased in 6,441,282 children using the bOPV. According to the independent monitoring results, the coverage at household level by finger marking was 90% while by history it was 94%.
- Uganda now has an updated polio preparedness and response plan that will enable it to rapidly respond to any Wild Polio Virus (WPV) or Vaccine Derived Poliovirus (VDPV) importation.
- At the National level, Uganda achieved a non-polio AFP rate of 3.09/100,000 of children 0 - 14 years and all districts were able to detect and investigate at least one Acute Flaccid Paralysis (AFP) case.
- The Integrated Post Introduction Evaluation following introduction of new vaccines and technologies i.e. HPV in 2016, bOPV on 17th April 2016 and IPV on 29th April 2017 into routine immunization schedule and a new technology, the Fridge Tag, to improve cold chain performance guided formulation of recommendations to inform future new vaccine introduction processes.

- A pilot study on controlled temperature chain delivery of Gardasil was conducted in two districts to generate evidence from health workers on the experience and impact of delivering the HPV vaccine using this method. The study generated information that will be used to shape WHO's guidance to countries on the appropriate use of CTC in HPV vaccination programs.
 - Over seven million (7,141,530) persons aged 1 – 29 years were protected against serotype A of meningococcal meningitis using MenAfriVac® vaccine (Men A) in 39 high risk districts in northern Uganda. The immunization coverage survey found that 29 (74%) of the districts achieved a coverage of > 95%.
 - Development of an immunization Financial Sustainability Plan 2016/2017 to 2020/21 following Uganda National Immunization Technical Advisory Group (UNITAG)'s recommendation clearly showed a big resource gap for the immunization program and a need for intensive resource mobilization as new vaccines are introduced into the routine immunization program.
- ii) **Emergency Response**
- Cholera preparedness and response among refugees was enhanced using the revised cholera prevention and control guidelines. This preparedness involved active surveillance, outbreak investigation, sample transfer and prepositioning of 5 cholera kits and 15 malaria kits in the refugee hosting districts.
 - Over two hundred thousand (2,822) Village Health Team members were equipped with knowledge and tools to implement community based disease surveillance in refugee settlements.
 - Thirty (30) health workers in Moyo, Adjumani, Arua, Kamwenge and Hoima districts were equipped with skills and knowledge in Infection Prevention and Control during outbreak investigations. In addition, preposition of essential materials including 2 cholera investigation kits, 5 cholera logistics modules, 5 cholera laboratory kits, 8 binocular microscopes for TB diagnosis and 30 cholera treatment beds was done.
 - Provision of support to MoH to strengthen surveillance against Bird Flu – H5N8 following suspicious deaths of domestic and wild birds in Kalangala and Masaka districts. Overall, 20,537 domestic birds (3 turkeys, 9167 chicken and 11367 ducks) and 1155 wild birds died on seven landing sites.
 - In 2017, there was quick detection and response to Marburg Virus Disease outbreak in Kapchorwa and Kween districts. The outbreak was controlled within 42 days with only 03 confirmed cases and a Case Fatality Rate of 100%.
 - Strengthened surveillance, case management, WASH and community engagement in response to a cholera outbreak in Kasese district bordering the Democratic Republic of Congo. The outbreak that was precipitated by heavy rains, poor access to clean and



WHO staff members making sure that all eligible children receive the life saving polio vaccine during Sub-National Immunisation Days in Kabale district.



A WHO staff checking on a family during a health campaign in Northern Uganda.

- safe water, low latrine coverage (37%), and poor sanitation practices had 250 cases, 4 deaths and a CRF of 2%.
- Containment of the Congo Crimean Hemorrhagic Fever (CCHF) that was confirmed in Nakaseke district leading to 2 cases and no deaths. Laboratory tests by the veterinary team suggested high animal prevalence for CCHF.
 - WHO was notified about Rift Valley Fever outbreak in Kiboga district, central Uganda. Five cases were confirmed including four deaths (CFR: 80%). There was no evidence of human to human transmission or linkage between the cases.
 - The National Action Plan for Health security was drafted following a multi-sectoral Joint External Evaluation (JEE) exercise using the core International Health Regulation 19 technical areas. The evaluation revealed that Uganda had demonstrated capacity of 20%, developed capacity of 40% and limited capacity of 30% of the JEE core capacity indicators.
 - Uganda hosted the Global Health Security Agenda Ministerial Conference in October 2017 that was attended by 400 delegates from 55 countries. The conference defined a new road map to address the global health security challenges.
- ### Challenges
- There are increasing cases of MDR – TB especially in refugee communities due to poor detection, drug stock-outs and non-adherence to treatment regimens by some patients.
 - There are lapses in infection prevention and control in the health facilities due to inadequate training of some health workers and lack of required equipment and supplies.
 - Reporting in the Health Management Information System is not well harmonized pointing to poor skills among health workers which in turn leads to inaccuracies in some reported data.
 - Disease surveillance is not yet prioritized as lifesaving intervention in some places leading to outbreaks that would otherwise be detected and contained early.
 - Health system functionality in some refugee hosting districts especially new sites is weak leading to poor services delivery.

Way forward

WHO will expand its support to refugee emergency situations to include all technical programs. The Ministry of Health will also be supported to build skills in effective coordination of partners, governance, leadership and management at district and regional levels especially in emergency situations. WHO will advocate to partners for greater integration of refugee response into the district health system and plans. In addition, the Ministry of health will be supported to widely disseminate the National Refugee Response Plan to raise funding for implementation of activities. At the same time, the MoH and districts will be supported to attend to quality of care issues in health facilities located in refugee settlements and to scale up Infection Prevention and Control practices among the front line health workers.

IMMUNIZATION



The immunity profile of the under five children was increased in

6,441,282

children using the bOPV.

The routine immunization

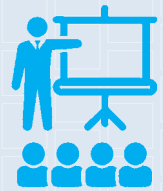
coverage in 16 districts

improved from **45%** to **76%**

in 16 through implementation of

Reach Every Community micro plans.

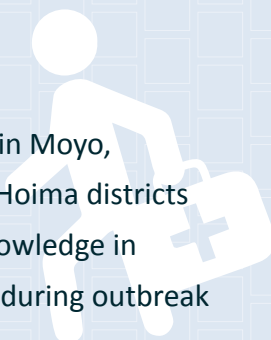
EMERGENCY RESPONSE



2,822 Village Health Team members

were equipped with knowledge and tools to implement community based disease surveillance in refugee settlements.

Thirty **(30)** health workers in Moyo, Adjumani, Arua, Kamwenge and Hoima districts were equipped with skills and knowledge in Infection Prevention and Control during outbreak investigations.







EDMUND MWEBEMBEZI

The Rt. Honourable Prime Minister Dr. Ruhakana Rugunda greeting the director Programme Management Dr. Joseph Kahore during the high level ministerial meeting on Global Health Security Agenda held at Munyonyo Kampala.

**COUNTRY
SUPPORT
UNIT
CLUSTER**

Introduction

WHO PRESENCE AT COUNTRY LEVEL WAS ENHANCED THROUGH IMPLEMENTATION OF THE COUNTRY COOPERATION STRATEGY (CCS) THAT IS WELL ALIGNED TO THE NATIONAL DEVELOPMENT PLAN II AND THE HEALTH SECTOR DEVELOPMENT PLAN 2015/16-2019/20 WHICH ARE ANCHORED ON UGANDA VISION 2040. ACHIEVEMENTS DURING THE YEAR OF IMPLEMENTATION REFLECT THE WHO GPW 12 AT COUNTRY LEVEL, THEREFORE ACHIEVING GREATER RELEVANCE OF WHO'S TECHNICAL SUPPORT TO THE COUNTRY.

The Country Support Unit provides all administrative support to all WHO technical programmes and clusters. There is a total of 20 administration staff (CSU staff, Admin assistants from program units, Drivers, office attendants) led by the Operations Officer. The CSU monitors implementation of program activities and guides technical staff based on the WHO financial rules and regulations. It also shares updates of status of various reports such as donor reports, encumbrances, Direct Financial Cooperation (DFC) and Direct Implementation (DI).

Achievements

- i) ***Leadership, Partnerships & coordination***
 - WCO continued to provide leadership in health and to maintain representation

on Several MoH led coordination structures such as the Health Policy Advisory Committee (HPAC) and technical working groups in the sector. WHO is the co-chair to the Communicable Diseases, Medicines Procurement and Management Technical Working Groups and the Task force on Emergency Preparedness and Response. WCO is still the secretariat to the Health Development Partners Group. WCO is fully engaged in the UN Development Assistance Framework supporting government and maintains ex-official membership on the GFATM Country Coordination Mechanism as well as the oversight committees. WCO hosts some of these coordination structures' meetings and is actively engaged. WHO maintained its leadership of

the Health Outcome in the UNDAF, and facilitated monthly HDP meetings to support development of the health sector, and regular technical briefs on pertinent health issues.

- WCO also actively participated in the annual health sector joint review activities and after supported the evaluation of the effectiveness of the review.

ii) *Promotion of WHO policies and guidelines*

- WHO continued to promote and disseminate WHO policies and guidelines through high level advocacy engagements and provision of technical support in various technical matters.

iii) *Support to regional and global governing body meetings*

- WCO supported the preparation of the country delegations to meaningfully participate in the 70th session of the World Health Assembly and the 65th session of the WHO Regional Committee for Africa. This was through preparation of briefing notes on various agenda items for the country's delegations.

iv) *Financial Management*

Budget Allocation and Delivery Rate

Table 2: Budget allocation and implementation for 2016-17

Biennium	Allocated PB	Total funds received	Total funds budgeted	% Available against Allocated PB	Utilization (Encumbrance & Expenditure)	% Budget Implementation against Total Available funds
2016-17	28,607,146	27,953,503	26,519,666	98%	24,996,543	89%

- The total Programme Budget (PB) allocation in the biennium 2016-2017 was USD 28,607,146. The total funds received were USD 27,953,503 representing 98% of

PB allocation. USD 26,519,666 was Award budgeted in the work plans and USD 24,996,543 was spent. The implementation rate against total funds available was 89%.

- From the funds received i.e. USD 27,953,503, 85.40% of the funds were received for specific purposes (USD 23,871,576) while 14.60% were flexible (USD 4,081,927). The specific funds were received from 31 donors. The top 5 donors who funded the country office during 2016-17 were: Bill and Melinda Gates (42.73%), GAVI Alliance (29.08%), UNICEF (13.35%), DFID (9.43%) and CDC (5.41%). Their total contribution was USD 17,386,779 which is 72.83% of the funds received during this biennium.
- v) **Program Implementation**
 - The program activities were implemented mainly through DIs, DFCs, Letters of Agreement (LOA), Technical Service Agreements (TSA), Agreement for Performance of Work (APW) and Special Service Agreements (SSA). Accountability of funds by the implementing partners and receipt of deliverables by the consultants were the major challenges.
- vi) **Human Resource Management**
 - The total number of staff by 31st December, 2017 was 45 (including 3 male temporary staff). The total number of men were 28 (62.22%) while women were 17 (37.78%). Table 3 below shows composition of staff by gender and status (local/International staff).

Table 3: Staff composition by gender and status (local/International staff)

Description	Male		Female		Total
	National	International	National	International	
No. of Staff as at 1 Jan 2017 (including temporary staff)	28	2	17	1	48
New Staff		1			1
Retirement*		1			(1)
Reassignment	1		1		(2)
Resignation	1				(1)
Termination					
Deceased					
No of staff as at 31 Dec 2017	26	2	16	1	45
% per category	57.78%	4.44%	35.56%	2.22%	100.00%
Total % (Male and Female)	62.22%		37.78%		100.00%

**Ad-interim WR completed his assignment in January 2017.*

In addition to the 45 staff above, there are 12 persons recruited on Short Term Service Agreement (SSA). They are based at the country office (3 persons), at the Uganda Virus Research Institute (UVRI) (6 persons) and at the Ministry of Health (3 persons).

Table 4: Composition of SSAs as at 31 December 2017

Description	Male	Female	Total	Location
SSA/NCD		1	1	WCO
SSA/Injection Safety		1	1	WCO
SSA/Strategic Partnership Portal	1		1	WCO
SSA/EPI POLIO LAB Entebbe			6	UVRI
SSA/Malaria Program	2	1	3	MoH
Total	2		12	

- Between November 2016 and January 2017, the country office was managed by two WHO Representatives in the different periods. Dr. Abdoulie Jack supported the WCO from Mid-April 2017 to Mid-January 2018. He was preceded by Dr. Tarande Manzila who supported the WCO from Nov 2016 to Mid-April 2017.
 - The WCO has a high need for technical skills to fill up various vacant positions in order to enable the office function in its full capacity. Availability of funds was a major challenge that withheld the recruitment process. Alternatively, the WCO continued to use SSAs and other consultants to support implementation of activities together with support from technical units in AFRO and Headquarters. During 2017, two staff were reassigned to other countries and one staff resign from the WCO.
- vii) **Staff Development and Learning**
- Staff participated and benefited from various trainings organized by either WHO AFRO, HQ, WHO through iLearn Portal or other recognized institutions.



BENJAMIN SENSASI

The Minister of State for Primary Health Care Hon. Sarah Opendi interacting with the Case Management Team during the MUD outbreak in Kween District.



BENJAMIN SENSASI

The WHO country office in Kampala.

Table 522: WCO staff participation in various trainings in 2017

UNIT	NO. OF STAFF	TRAINING	VENUE	Date
CSU	1	FICSA Workshop on General Service Salary Survey Methodology II (Harare, Zimbabwe)	Harare	Nov 2017
CSU	2	Mainstreaming Gender, Human Rights Based Approach and Sustainable Development Goals (SDGs) in UN Operations (Entebbe, Uganda)	Entebbe	Sept 2017
CSU	1	Writing Minutes	iLearn	Sept 2017
	8	Road Safety, 4x4 Driving & Preventive vehicle maintenance	WCO premise	7-11 June 2017

- In addition to staff participation in various trainings, all WCO staff completed the Mandatory Training certificates in December 2017 and possess valid certificates. These training are: Basic Security In the Field II (BSITF), Advanced Security In the Field (ASITF) and a UN Course on Prevention of Sexual Harassment, Sexual Harassment and Abuse of Authority.

viii) **Travel, Logistics and Procurement**

- The WCO developed Long Term Agreements (LTA) for car hire and supply of stationary. More LTAs will be developed and completed during 2018. The use of LTAs served time and shortened procurement processes. UN agencies in Uganda piggyback on LTAs developed by sister agencies as well as on LTAs developed under

the umbrella of ONE UN. The WCO has a Local Procurement Committee in place. The combination of LPC members is in line with the new and standard Terms of Reference.

ix) **Information and Communication Technology**

- The WCO has adequate network availability. All servers are well monitored and they operate efficiently. The five network printers were installed in 2017 bringing numerous benefits to the staff and the office such as improving health of staff, reduction in the use of papers, reduction in the maintenance cost of desk printers and increased operation efficiency.
- A plan for promoting green environment is being developed. The objective is to achieve a paperless working environment and improve operational efficiency of the country office.

Challenges

- Delay to account for funds by the implementing partners and late receipt of deliverables from consultants.
- Lack of funds to recruit staff for vacant positions in the country office.
- Absence of a substantive WHO Representative for a long period of time that affected planning and implementation of program activities.



World Health Organization

WHO Uganda Country Office

Plot 60 Prince Charles Drive, Kololo

P. O. Box 24578 Kampala - Uganda

Tel: +256 414 335500 [Reception]

Website: <http://www.afro.who.int/countries/uganda>

Twitter: @WHOUganda

Facebook: World Health Organization Uganda

Flickr: WHO Uganda