Uganda Episcopal Conference

Catholic Secretariat

Uganda Catholic Medical Bureau

Minimum Health Care Package Delivery in Catholic Health Units of Lower Level

Comparative Survey 2003 and 2006

Kampala, August 2006
Erica Musch-Rossler RN, MSC Int. Health

Minimum Health Care Package
RCC Lower Level health Units
Comparative Survey 2003 and 2006

INDEX

LIST OF TABLES AND GRAPHS

Executive Summary

In 2003 Uganda Catholic Medical Bureau conducted a baseline survey about the implementation of the Minimum Health Care Package in the lower level health units.
The aim was to identify which elements, clusters and interventions of the MHCP were underprovided and to obtain a reference score for monitoring purposes in the future.
In June 2006 the same survey was conducted again with the aim to monitor whether the degree of completeness per level health unit and per cluster had changed and improved. This time the interviews were conducted by Diocesan staffs which were trained by the author in a 5-day workshop.

The questionnaire of 2003 was maintained with minimum adaptations and a few questions added. For comparative analytical purpose the same selected parameters were maintained and applied to the same range of HU. The total maximum attainable score remained 80 points for HU III and IV and 68 points for HU II. The 13 elements of the MHCP were grouped again in the same 5 major clusters (i) Communicable Diseases and Clinical Care; (ii) Child Health; (iii) Sexual and Reproductive Health & Rights; (iv) Public Health and (v) Special Care. The number of health units of the 2003 survey were maintained with the same division between HU of level II and HU of level III and IV: (i) 35 HU level II, (ii) 175 HU level III and (iii) 6 HU level IV. For the Comparative Descriptive Analysis a software programme for Microsoft (Analyse-it + General 1.65) with Box-whisker plots was used. The median and the Inter-quartile range were identified.

The results of the comparative survey shows that at both levels II and III the median increased to 70% and above (in 2003: 55% for level II and 68% for level III respectively), meaning that the compliance with the implementation of the Minimum Health Care Package has improved. The Comparative analysis of each cluster shows that at both levels significant improvement has been made in the cluster Sexual and Reproductive Health and Rights (at level II from 35% to 53% and at level III from 71% to 80%) and Public Health (at level II from 53% to 68% and at level III from 68% to79%).
The cluster Child Health remained at both levels with the highest degree of completeness (88%) and Special Care, although increased at both levels (level II from 25% to 38% and at level III from 25% to 50%), remained the weakest cluster. The cluster Sexual and Reproductive Health and Rights showed the highest inter-quartile range at level II (IQR 10.5) meaning a large variability in the observations.
The comparative analysis per Diocese revealed the degree of completeness of the overall performance of the MHCP and the degree of completeness per cluster. At level II only 1 Diocese remained below 50% (Lira), 6 Dioceses scored between 50-70% and 8 Dioceses scored a median degree of completeness of > 70% with the highest 96% (Fort Portal). Six Dioceses decreased their score (Lira, Gulu, Jinja, Masaka, Moroto and Tororo). At level III: 1 Diocese remained < 60% (Tororo) 2 Dioceses scored between 60%-70%; 13 Dioceses scored 71%-80% and 3 Dioceses scored a degree of completeness > 80% with the highest 86% (Kotido). The only Diocese that declined at both levels was Tororo.

The results are encouraging, for the input of UCMB and for the compliance by the Diocesan Coordinators and the staff of the respective health units. A comparative study as such shows clearly where progress has been made and where not, it identifies who did well and who did not and it elaborates on the issues and gaps that need to be further addressed and followed-up.

1. Introduction

In 2003 Uganda Catholic Medical Bureau initiated a baseline survey about the implementation of the Uganda Minimum Health Care Package in the RCC Lower Level Health Units. This baseline data generated a wealth of information and identified gaps and areas where further support, information and training were required in order to ensure an appropriate implementation of the essential package.
As an overall advisory body of the RC health facilities UCMB aims to improve quality of services for all users of catholic health units and service coverage of the respective population. Following the results of the survey in 2003 UCMB undertook specific actions to respond to the identified gaps in the service delivery, particularly in the field of Sexual & Reproductive Health & Rights and Special Care.
In 2006 the same survey was conducted again in all Lower level health units with the aim to identify if the degree of completeness per level health facility and per cluster had changed and improved. This report elaborates on the results of the second survey and provides the comparative descriptive analysis with the 2003 survey.

2. Background to the MHCP

The Poverty Eradication Action Plan (PEAP) constitutes the Development Framework for the Uganda National Policies, which means that (i) all activities implemented in Uganda have to be framed within this policy; (ii) all activities have to contribute to the PEAP implementation and the PEAP objectives and (iii) the Plan is based on 5 pillars including: (a) improve economic management; (b) enhance production, competitiveness and income; (c) improve security, conflict resolution & disaster management; (d) ensure good governance and (e) Human Development (education, Health, water supply, social development).
The 5th pillar (Human Development) includes the Health component and is the basis for the National Health Policy. The objectives are:

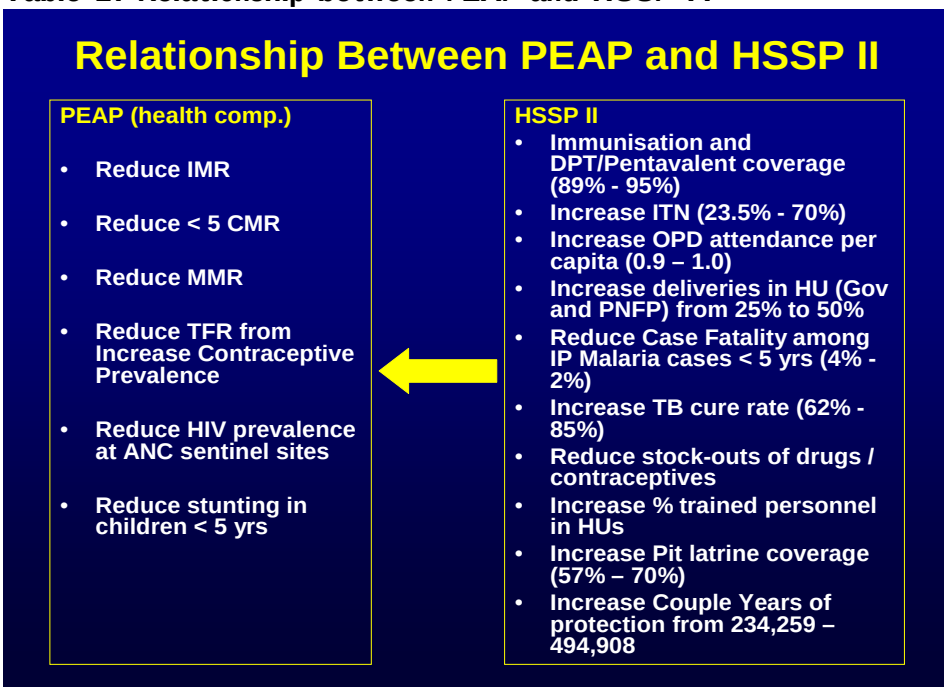
- Reduce IMR from 88 to 58/1000 live births
- Reduce , 5 CMR from 152 to 100/1000 live births
- Reduce MMR from 505 to 304/100.000 live births
- Reduce TFR from 6,9 to 5,4
- Increase Contraceptive Prevalence
- Reduce HIV prevalence at ANC sentinel sites from 6,2% to 5%
- Reduce stunting in children < 5 years from 38, 5% to 28%.

To reflect the National Health Policy the Health Sector Strategic Plan (HSSP) was developed. HSSP I covered the period of 2000/1-2004/5 and HSSP (II) covers the current period from 2005/6 to 2009/10.
The overall HSSP Goal is **efficient and equitable, high quality delivery services of the Minimum Health Care Package**. The HSSP has a commitment to achieving set of objectives and targets as described in table 1 below:

The current allocated resource envelope for the implementation of the Minimum Health Care Package has remained $9 per capita over the past 3 years, despite the fact that already in 2003 the Health Financing Strategy projected and estimated a need for $28 per capita to fully implement the MHCP and the WHO Commission for Microeconomics and Health had a medium term projection of $34 per capita (the latter associated with a greater coverage of ARVs.)[1] There is obviously still a long way to go to ensure a fully fledged implementation of the MHCP at all service levels.

[1] Implementation of the MHCP in RC Lower Level Health Units, 2003

Table 1: Relationship between PEAP and HSSP II



(UCMB, June 2006)

The RCC lower level health facilities is part of the total health service delivery and the national output and as such contribute consequently to the objectives of the PEAP. Improvement in the PEAP Pillars will eventually have an impact on the Millennium Development Goals. The 8 MDGs[2], agreed upon by World-Leaders of 189 states in September 2000 in a "millennium development declaration" are to be achieved by 2015 as a package to improve Human Development.[3]

3. Methodology

During the first MHCP survey in 2003, most interviews (60%) were conducted by the author and 40% was conducted by the respective Diocesan Coordinator.
This time, UCMB and the Diocesan Coordinators agreed during a Diocesan Technical Workshop to have the survey conducted by Diocesan members (medical or non-medical). The Diocesan Coordinators were made responsible for selecting candidates to be trained for implementing the survey in their respective dioceses. The following criteria for the participant were recommended:

- Ability and commitment for the job: able and willing to collect that data accurately and completely.
- Secondary school level/secondary school leavers
- Polite/discrete as they will mostly be interviewing older persons
- Real interest in the assignment

The training of 35 interviewers was conducted by the author in June 2006 in Kampala.

The questionnaire of 2003 was maintained and only slightly adapted and a few questions added. For comparative analytical purpose the same selected parameters were maintained and applied to the same range of HU. The total maximum attainable score remained 80 points for HU III and IV and 68 points for HU II. The 13 elements of the MHCP were grouped again in the

[2] Millennium Development Goals
[3] UCMB, June 2006

same 5 major clusters (i) Communicable Diseases and Clinical Care; (ii) Child Health; (iii) Sexual and Reproductive Health & Rights; (iv) Public Health and (v) Special Care.

The interviews were held in June with a target date for submission of the questionnaires on July 7th 2006. The returned questionnaires were computerized by UCMB (Ms. Monica Luwedde) in an Excel format, and forwarded to the author for analysis. For the comparative analysis, the number of health units of the 2003 survey were maintained with the same division between HU of level II and HU of level III and IV: (i) 35 HU level II, (ii) 175 HU level III and (iii) 6 HU level IV. For the Comparative Descriptive Analysis a software programme for Microsoft (Analyse-it + General 1.71) with Box-whisker plots was used. This was conducted by UCMB (Mr. Andrea Mandelli) and forwarded to the author.

For the comparative analysis, the number of health units of the 2003 survey were maintained with the same division between HU of level II and HU of level III and IV: (i) 35 HU level II, (ii) 175 HU level III and (iii) 6 HU level IV. For the Comparative Descriptive Analysis a software programme for Microsoft (Analyse-it + General 1.65) with Box-whisker plots was used.

4. Training of Interviewers

The Training was conducted in 2 groups from 5-19 June with 18 participants and 12-16 June with 17 participants respectively. In the first group 8 persons did not have experience with surveys and 4 persons were non-medical. In the second group 7 participants did not have experience with surveys and 3 were non-medical.

Table 2: Details on Training for Interviewers

Diocese	Number of LLHU	Persons trained	Diocese	Number of LLHU	Persons trained
Masaka	27	3	Lira	13	2
Kabale	24	2	Arua	12	2
Kampala	20	3	Kasana L	11	2
Mbarara	18	3	Gulu	8	1
Tororo	16	3	Lugazi	8	1
Hoima	15	2	Moroto	7	1
Fort Portal	14	2	Jinja	6	1
Soroti	14	2	Kotido	5	1
Kiyinda M	13	2	Nebbi	4	1
Kasese	3	1		**Total**	**35**

During 5-day training the following learning objectives were introduced:

Table 3: Learning Objectives of MHCP Survey

Goal
Participants will have the knowledge and skills to conduct the MHCP survey in their respective Diocesan lower level health facilities by using the prepared and discussed questionnaire.
Objective 1
Participants will understand the basic principles of monitoring/evaluation and indicators.
Objective 2
Participants will understand the basic principles of the Ministry of Health policy on the Minimum Health Care Package.
Objective 3
Participants will be familiar with the skills and attitude required for conducting a survey.
Objective 4
Participants will have participated in a practical session in order to learns and understand how to complete the questionnaire.

During the workshop emphasis was laid on the importance of understanding the need for data collection and using data as a tool for measuring performance as a routine activity and an unavoidable and serious responsibility of management[4]
After 3 days theoretical information the participants were able to participate in a practical session in a number of health facilities, courtesy of the Kampala Diocese. In groups of 4 the participants conducted the survey in 9 health units.

5. Level Health Facilities

The MoH guideline for allocation of service level for health facilities is related, amongst other, to funds for the Essential Drug Programme. The decision about the level services is the responsibility of the district health authorities. They have to inspect the HU and the activities conform the MHCP guidelines and have to allocate the level of services, depending on catchment area, proximity of other health units, output of services and staffing levels[5] However, it is anticipated that the criteria are not always implemented accordingly.

In 2003 the criteria for the level of the health facilities was determined by UCMB and was based on an agreement made with the PPP-desk[6] that each HU with one or more beds is to be considered a Health Unit level III.
This time the official registration certificate was the criteria for determining the level of the health facility. This resulted in a completely different picture as compared to the survey of 2003. In the 2006 survey 232 RC Lower Level HU participated, of which (i) 4 HU level IV, (ii) 139 HU level III and (iii) 88 HU level II. Eleven HU were newly registered. The total bed capacity is 2919 beds.

Table 4: Number of HU III and II and correspondent number of beds

Number of HU III	No Beds	Number of HU II	No Beds
26	0	38	0
11	1-5	23	1-5
24	6-10	15	6-10
40	11-20	10	11-20
34	21-50	2	> 20
8	> 50		
Total 143		Total 88	

Source data: UCMB

64 HU (28%) do not have any observation bed and are more or less considered as a dispensary, of these 38 HU are officially registered as HU II and 26 HU are registered as HU III.
All HU IV have more than 35 beds, the lowest 36 beds (Tororo) and the highest 100 beds (Kotido). Table 1 shows the bed allocation in HU III and II as provided in the 2006 interviews.
This data however demonstrates that the UCMB criteria for the allocation of level of health unit are not really applicable. It has to be queried whether a HU III with only one bed should be measured on a same level as a HU III with 64 beds, in particular if funding and allocation of drugs is related to the level status of a HU. This accounts obviously also for a HU II with 0 beds and a HU II with 50 beds.

In 2003 the MHCP report described the variety in standards as follows: *"The diversity in the standards of each specific level is considerable. There is a large number of well constructed, clean and well equipped health centers III, with good beds, bed sheets and mosquito nets, a bedside table, sanitation equipment for the very sick, accessible latrines and water facilities; then there are health units of a medium standard with less facilities but still at an acceptable level. Subsequently, it degrades to a shabby filthy deteriorating building where mattresses are*

[4] Quote UCMB
[5] Implementation of the MHCP in RC Lower Level Health Units, Musch, 2003
[6] Public-Private Partnership Desk

put on an examination table or a few beds are squeezed into a corner. These standards may all be categorized as a health centre III and may all charge a similar fee for in-patient services. Also for the Health Centre II there is a broad variety: from a luxury OPD with sparkling clean flush toilets right in the bush, to an unfinished construction and a one room squeezed OPD".

6. The Uganda National Minimum Health Care Package: the survey results

In line with the survey of 2003 and for comparability reasons the Minimum Health Care Package according to the HSSP I has been maintained. This package includes the following elements:

1. Control of Communicable Diseases: Malaria, STI/HIV/AIDS; Tuberculosis
2. Integrated Management of Childhood Illness
3. Sexual and Reproductive Health and Rights
4. Immunisation
5. Environmental Health
6. Health Education and Promotion
7. School Health
8. Epidemic &Disaster Prevention, Preparedness and Response
9. Improving Nutrition
10. Intervention against diseases targeted for Eradication
11. Strengthening Mental Health Services
12. Essential Clinical Care.
13. Outreach services

Before entering in the real assessment of the different elements of the package, the first question asked to the interviewee was whether the HU owned any written information about the Minimum Health Care Package services the HU should offer. 144/232 (62%) HU responded positive *(149/216 (69%).* They had either received information from the DDHS, Health Sub-District (HSD) or the Diocesan Health Office. From the ones responding negatively, 3/8 were newly registered HU.

6.1 Control of Communicable Diseases

The programme for Control of Communicable Diseases involves the most severe health problems in Uganda and includes: Malaria, STI/HIV/AIDS and Tuberculosis.
These diseases are among the most common causes of death and illness across the age profile as revealed by the Burden of Disease Study in 1995[7].

6.1.1 Malaria

A Malaria Control Strategic Plan 2001/2-2004/5 has been established in conjunction with the Malaria Consortium and the Department for International Development. The aim is to reduce the burden of malaria by the year 2005.
In June 2000 Uganda reviewed the malaria treatment policy and adopted an interim policy of Chloroquine + Sulfadoxine/Pyrimerhamine (CQ+SP) combination instead of Chloroquine monotherapy for the treatment of uncomplicated malaria. Studies on efficacy of CQ+SP in different sentinel sites in the country showed a relatively high mean clinical failure. Hence a new National Policy on Malaria Treatment was developed in 2005 and a decision was made to change the policy on malaria treatment from CQ+SP to Artemisinin based Combination Therapy. An effectiveness trial of this new therapy in Mbarara showed no clinical failure after 28 days of follow-up.[8]

The change of treatment from CQ+SP to the Artemisinin Based Combination Therapy is currently being introduced in the health units. In June the new drugs were about to be available

[7] Annual Health Sector Performance Report, MoH September 2002
[8] MoH, National Policy on Malaria Treatment, September 2005

and distributed by JMS. Workshops about the new treatment have been and/or are being conducted by the Health Sub-Districts.
209/232 HU (90 %) reported to have the Malaria Treatment Guidelines (185/216 (86%). However, since the new guidelines are actually being introduced, it is not quite sure whether this concerns the new guidelines or the old ones, as it is assumed that the former guidelines are still being used.
The 2003 report showed a variety of malaria treatment in a number of the HU, which was not always in line with the official guidelines, it may therefore be quite interesting to assess in a later stage in how far the new guidelines are seriously being implemented and whether the new treatment has contributed to an actual reduction in treatment failure.

Most HU ask patients to return for follow-up when required, that means when the patient realizes that (s)he is not getting better. If no improvement is found, a new blood slide will be taken and a possible change of drugs is prescribed. If necessary the patient will be admitted for observation. In general payment is made for the blood-slide and the prescribed second-line drugs. Only one HU (Fort Portal) mentioned: "they don't come".

Almost all HU provide malaria preventive activities which include: (i) health education, (ii) supply of treated mosquito nets (Kabale (15 HU) , Kiyinda (3 HU), Gulu (1 HU); (iii) spraying HU, (iv) prophylaxis to pregnant women and (v) theatre/drama about malaria (Kotido).
The Health Education messages include:

- *Use of treated mosquito nets*
- *Seeking early treatment*
- *Slashing bushes around the house*
- *Destroy mosquito breeding sites: stagnant water in broken bottles.*
- *Close windows and doors in the evening*
- *Signs and symptoms of malaria*
- *Proper use of drugs*
- *Use of boiled water (2)*

The use of treated mosquito nets is promoted in practically all health units, as being the most important preventive measure. However, unfortunately only 50 HU have actually bed-nets in their own facility.
None of the HU mentioned anymore the distribution of "home-pack"

Health education messages about malaria are, amongst others, provided during outreach services. The HU were asked if the communities, through the Parish Development Committees, followed up on the advices from the health education message. 167/232 HU (72%) confirmed that this happened (162/216 (75%).

Most HU aim to treat malaria patients themselves. In 2003 the reasons given for referral of a patient were when:

- *the patient is very sick, has convulsions, is vomiting and/or unconscious*
- *the patient does not respond to second line treatment*
- *the patient is very anaemic and needs transfusion*
- *when treatment fails*

149/232 HU (64%) reported to have referred malaria patients in the past month. The number varied from < 10 patients (117HU)., referrals of 11-19 patients (13 HU) and > 20 patients (6HU) with the highest number of 128 patients (Gulu).

6.1.2 STD/HIV/AIDS

The aim of the control of STD/HIV/AIDS programme is: prevent transmission of STDs and HIV infection, paying attention to gender perspectives; mitigate the impact of HIV/AIDS through the provision of care and support to those infected and affected, and to strengthen capacity for gender responsive planning, implementation, monitoring and evaluation of HIV/AIDS prevention and control at national, district and community levels. This involves a wide range of interventions for the prevention and control of the epidemic, which include: IEC/Public education, blood transfusion services, STD management; enhancement of infection control; care and support of PLWHA; PMTCT and VCT.

189/232 health units (82%) have the national guidelines for syndromic management of STIs. (152/216 (70%). Patients with STI's are in general treated at the HU; the numbers of referrals are few. 36 HU (48HU) referred < 10 patients in the past year and 5 HU (10HU) referred > 10 patients.
In 225/232 HU (97%) patients are asked to bring their partner for treatment (211/216 HU (98%).

182/232 HU (78%) provide counseling services (129/216(60%) for clients who want to know their HIV status and 75/232 HU (32%) conduct testing for HIV (35/216 (15%) This is a significant increase for these services. In the 182 HU providing counseling services 119/182 staff members (65%) had received training
The training was provided by: Taso, Mildmay, Aids Information Centre, GTZ, IRC, AVSI, Care Shado, Makerere Education Centre, Focal Office, Nkozi University, Institute of advanced leadership and/or by the District, the Nursing School, the Sub-District Hospital and the Dioceses.
Other preventive activities include: (i) health education including message of faithfulness, abstinence, condom use (ii) drama and (iii) Pastoral care.

In 2003 we asked health units in 11 Diocese whether they knew the Focal Point for HIV/AIDS of the Uganda Catholic Secretariat. The response then was rather disappointing as only (20/80 HU (25%) were aware about the Focal Point. This time the results were much better, 166/232 HU (72%) knew their Focal Point person. In general this is the Diocesan Coordinator.

Only 1 HU (Kotido) mentioned that it was providing ARV drugs to patient. As this was not specifically asked in the questionnaire it cannot be considered representative.

6.1.3 Tuberculosis and Leprosy Control

The aim of the National TB programme is: Prevention and control of Tuberculosis intensified and integrated in the health system.
For Tuberculosis the DOTS (Direct Observed Therapy Short Course) and for Leprosy the MDT (Multi-Drug Therapy) are the cost-effective interventions. The programme aims to expand on Community-Based DOTS, which entails that an appointed community member distributes and observes the intake of the drug on a daily basis.
Progress is being made in the elimination of Leprosy and integration of its management into PHC.

72/232 HU (31%) provide treatment for TB patients (50/216(23%) The number of patients remains relatively low. 12/72.HU had no patients at all 39/72 were treating 1-9 patients (26/50); 14/72 HU were treating 10-20 patients (8/50) and 7/72 had more than 20 patients (9/50) on treatment, of which the highest was 58 patients. (Masaka).

From the 72 HU treating TB patients 44 HU provided the DOTS treatment through community providers. It is anticipated that the other HU provided the drugs directly to the patients. From the 72 HU treating TB patients, 15 were HU II and 52 HU III and 5 HU IV.
Only 16.HU III provided DOTS drugs to HU II's (Kampala, Kabale, Masaka, Fort Portal, Mbarara, Moroto, Tororo and Nebbi) .

Microscopy for AAFB is conducted in 99/232 HU (43%) with laboratory services (90/216 (42%), of which 20/99 are at level HU II (8/90). Laboratory staff included: 3 lab technicians, 28 laboratory assistants, 10 laboratory attendants and 7 microscopists. Others (43) had not indicated the level of training.

From the 72 HU treating TB patients 45 HU mentioned that they followed up on contacts of TB patients, in collaboration with the community. For tracing of defaulters the HU mentioned that they:
(i) conducted home visiting, (ii) contacted the council health worker, (iii) informed village health workers or mobilizers.

Treatment of leprosy was reported in 10/232 HU (4%) in Hoima, Kampala, Kotido, Kasana Luweero and Lira. (4/216 (2%)

6.2 Integrated Management of Childhood Illness (IMCI)

The aim of IMCI programme is to reduce morbidity and mortality caused by common childhood illness in children under five year of age. The IMCI is an approach to provide health care to children in a holistic way and to integrate management of the major childhood disease symptoms and signs such as: fever, cough, fast breathing, diarrhoea and malnutrition. It involves also an assessment of the immunisation status of the child and for children below 2 years of age an assessment of the nutrition status.
The main interventions of IMCI are: immunization, growth monitoring, nutrition education, vitamin A distribution, CDD-ORT corner, case management of malaria and ARI

Immunization: *See further under Immunization*
.
Growth monitoring *is conducted in 198/232HU (85%) as a routine screening of children (183/216(85%)*

Vitamin A distribution *is provided during immunization sessions. 206/232 HU (89%) mentioned the distribution of Vitamin A.*

CDD-ORT corner *involves a tray with a jug (fresh) ORS and a few cups. It is covered and ready for use. In 200/232 HU (86%) an ORT- tray was prepared (169/216(78%).*

Nutrition education *see further under Nutrition.*

Case management of Malaria and ARI *according to the treatment guidelines*
209/232 HU (90%) had one Malaria guidelines (may be not the 2005 edition) and 219/232 (94%) had the National Treatment Guidelines.

6.3 Sexual and Reproductive Health and Rights

The aim of Sexual and Reproductive Health programme is to contribute to the improvement of the quality of life through increased utilization of Sexual and Reproductive Health Services, which include: (i) essential ante-natal and obstetric care; (ii) Family Planning; (iii) Adolescent

reproductive health (iv) violence against women. Effective implementation expected to contribute significantly to reduction of infant and under five mortality rates as well as maternal and peri-natal mortality and morbidity. Family Planning activities aim at reducing Total Fertility Rate (TFR) in addition to improved maternal and infant health.

6.3.1 Antenatal and obstetric care

To ensure safe pregnancy and delivery, improved management of complications of pregnancy and childbirth including spontaneous or induced abortion, and reduce the unacceptably high rates of maternal and peri-natal deaths through timely and effective emergency obstetric care provided at strategic and accessible locations

Assisted deliveries are one of the 3 performance indicators of the MoH. On national level the Performance Indicator for assisted deliveries has caused concern, as this was the only indicator showing a serious decline in FY 2001/2. (from 22.6% in FY 2000/2001 to 19% in FY 2001/2002)[9]

Antenatal services include: (i) registration of pregnant women on their first visit and providing an antenatal card; physical examination and blood pressure registration. (ii) Identification of high risk cases and advice on referral when required; (iii) provision of iron and folic acid tablets and tetanus vaccination; (iv) provision of intermittent presumptive treatment (IPT) and (v) a referral system for obstetric emergencies

199/232 HU (86%) are conducting antenatal services (172/216(80%) of these 155/199 (78%) have an enrolled or registered midwife, of these 26 are based at HU II.
46/199 HU (23%) are providing antenatal services without a qualified midwife (35/216(21%), of these are 35 HU II and 11 HU level III.
21/46 HU without a qualified midwife conduct only emergency deliveries and 25/46 HU conduct normal deliveries

The number of ANC visits varied, as in 2003, from 3 to 4157 (Kiyinda and Kotido). Whether this concerned only 1st visits and/or re-visits is not specified. The number of visits per pregnancy varied from 1-8 visits, with a majority between 3-4 visits per pregnancy.
200/232 HU (86%) provided Intermittent Presumptive Treatment (IPT) for malaria in pregnancy (173/216(80%).

In 2003 we asked 9 Dioceses whether they had knowledge about PMTCT[10]services and/or of they had referred women for PMTCT services within their respective district. Then only 38 HU responded positive and in a number of Dioceses the services were about to be provided. In the current survey 189/232 HU (82%) were familiar with PMTCT and 160/232 HU (69%) referred women when required.
In 43/232 HU (19%) the services were provided, this involved 15 Dioceses, except in Soroti, Moroto, Jinja and Lugazi.
Both Tororo and Masaka have > 5 HU were PMTCT services are included in the Sexual & Reproductive Health services. Others had 1-4 HU for the services...

Deliveries are conducted in 161/232 HU (69%) including HU II. (127/216 (59%). In 155/161 HU (96%) there is a qualified enrolled or registered midwife. 12 HU conduct deliveries without a qualified midwife, of these are 4 HU II.

[9] Joint Review Mission, October 2002.
[10] Prevention Mother to Child Transmission

The coverage of deliveries is somehow still not very clear to most of the in-charges of the HUs. The figures provided do not correspond and/or are unclear. From 64 HU mentioning that they knew their coverage for expected deliveries, 57/64 gave a percentage figure, of these only 27/57 were correct in line with the target number of expected deliveries and the actual number of deliveries conducted...
From a total of 113 HU the coverage was calculated, of these 103/113 HU (91%) reached a coverage rate of < 50% and 10/113 HU (8%) reached a coverage of > 50%, of which one was 100% (Arua) One HU reached a coverage of > 100%. (Kabale)

Health Units with midwifery staff provide obstetric care including: management of minor obstetric emergencies according to Life Saving Skill Guidelines; referral of obstetric emergencies & complications of the mother and/or new born baby; resuscitation of newborn baby; care of the newborn baby (BCG, OPV 0 & tetracycline eye ointment); post abortion care including MVA (Manual Vacuum Aspiration); Treatment of concurrent illness of the mother and regular maternal & peri-natal mortality review meetings

150/161 HU (93%) conducting deliveries are able to manage minor obstetric complications according to Life Saving Skills Guidelines. (99/127(78%), including parental administration of antibiotics.
121/165 HU mentioned that they were able to administer parental anti-convulsivants for pre-eclampsia or eclampsia, of these 10 HU did not have a qualified midwife and 2 were at HU level II.

157/161 HU (97%) are able to resuscitate a new-born baby (116/127(91%). Of these 130 HU have an ambu-bag for neonates and 139 HU have suction. From the 157 HU capable to resuscitate a newborn, 12 HU did not have a qualified midwife.
149/165 HU (90%) provide care for the new born baby, including BCG, OPV 0 and Tetracycline eye ointment, immediately at birth (119/127(94%).

Post abortion care including Manual Vacuum Aspiration (MVA) is conducted in 40/165 HU (24%) (38/127(30%). Only 16 HU owned an aspirator. In this survey we asked also if the HU were able to perform removal of retained products. 113 HU responded positive to this, including 6 HU without a qualified midwife and 52 HU responded negative, including 38 HU with a qualified enrolled or registered midwife.

73/165 (44%) conduct maternal & peri-natal mortality review meetings. (11/127(9%)
A few larger well established HU mentioned however that this was not applicable as no deaths had been reported. That means that the number is probably higher with HU that will conduct mortality review meetings when a death occurs.

181/232 HU (78%) conduct postnatal care (133/216(62%) This involves, weighing of the baby, examination of the baby and mother and administration of Vitamin A to the mother. Health education about breast-feeding... The services are often provided during immunization sessions.
We asked the in-charges if they "implemented the 12 steps of breastfeeding", this is a guideline explaining the best ways of successful breastfeeding. Only 98 HU responded positive to this question, indicating that they were not aware about this specific guideline of the 12 steps. However, it is assumed that breast feeding in general is promoted to mothers during postnatal care as the most appropriate means of nutrition for the new born baby.

113/181 HU (62%) conduct cervical examination (aided or unaided visual inspection) (59/127 (46%).

6.3.2 Family Planning

To provide information and services for appropriate modern family planning methods and reduce the wide gap between desired and actual use of family planning services.
Providing services of artificial (modern) family planning in a Catholic HU is a sensitive topic. Most of the HU comply and adhere to the Principles of the Church and do not provide the services. However 182/232 HU (78%) provide information about where people can obtain modern family planning services and refer clients to the appropriate institutions (181/216(84%).

135/232 HU (58%) provide Natural Family Planning (161/216(75%).

164/232 HU (71%) indicated that they had seen and/or referred women with gynaecological problems. The number of cases referred varied between 1-42 cases
26 HU level III indicated that they had not seen any women with gynaecological problems (Kabale 13, Hoima 2, Masaka 2, Nebbi 2).

6.3.3 Adolescent Reproductive Health

To promote sexual and reproductive health and rights of adolescent boys and girls, including sex education in and out of school, life skills against sexually transmitted infections, unwanted pregnancies and unhealthy lifestyles.
Components of ARH are included in the day-to-day activities of the HU. When a young girl comes with a suspected STI she will be treated accordingly, or when she is pregnant she will receive ANC services, but she will not always receive reproductive health and rights information. In particular the latter is not a topic easily being discussed.
HU providing school health to primary and, in particular, secondary schools, includes most components of ARH in their activities, albeit that family planning is conform the RC principles. Some in-charges mentioned that they enjoyed having discussions with the students of the school, because they were interested and asked a lot of questions, for others the subject of sexual education was not always easy to talk about. In the talks emphasis was laid on abstaining of sex.[11]

160/232 HU (68%) provide Adolescent Reproductive Health Services, including (natural) family planning advice and promotion of Healthy Lifestyle at schools (98/216(45%).

A number of HU referred young people to specific institutions or to district services. None of the HU mentioned the existence of an ARC services (youth club) from the RC Church
.

6.3.4 Violence against women

To promote and support agencies and organisations that work to reduce domestic violence, female genital mutilation and other forms of violence against women.

193/232 HU (83%) reported cases of Violence to women (177/216 (82%). The numbers varied from 1 – 150 cases (Tororo), with the majority between 1-5 cases. Most HU provide first aid treatment and refer cases to a higher level service when needed.

97/193 HU having reported cases of violence to women have informed the local authorities.

[11] MHCP Report 2003

6.4 Immunisation

The aim of immunisation is to control on a cost-effective way preventable childhood killer diseases. During the past year 2 new antigens: Hepatitis B and Haemophilus Influenza B, were added to the routine immunisation schedule. The immunisation programme is co-ordinated through UNEPI.

215/232 HU (93%) conduct Immunisation (186/216 (86%). Of these 69/215 HU (32%) provide immunization services on a daily basis, most others provide services 1-2 days per week and 6 HU provide vaccination once per month. 10 HU provide only vaccination services during the outreach activities.
Cold chain equipment is provided by the Health Sub-District, this includes a vaccine refrigerator on gas, a full spare gas bottle, vaccine carriers and ice packs In addition the district provides regularly the vaccines, vaccination syringes, yellow sharp containers and Vitamin A capsules.[12]
155/215 (72%) HU are fully equipped with a refrigerator (136/216 (73%) and 49/155 HU have only a vaccine carrier and collect vaccines for daily use from a nearby storage in a higher-level facility.

In 2003 less than 15 HU knew their accurate vaccination coverage (DPT 3 coverage). Unfortunately, this has not significantly improved.
173 HU knew their overall target population for children under one year of age (target population - average 4,3% (114 HU).

From 152 HU the coverage was calculated from the data provided (number of targeted children under one year of age and number of DTP 3 immunisations conducted). Of these 60/152 HU (40%) reached a coverage below 50%; 45/152 HU (30%) reached a coverage rate of 50-100% and 47/152 HU (30%) reached a coverage rate of > 100% with the highest 2254% (Kampala). Five HU reached coverage of > 1000% (Kampala, Kotido, Kiyinda and Kabale (2), in these cases target populations may need to be re-assessed.
Only 19/152 HU (12.5%) provided the correct coverage rate.

6.5 Environmental Health

The aim of the programme is to contribute to the attainment of a significant reduction in morbidity and mortality due to environmental health related conditions, such as low access to safe water and poor latrine coverage. The Govt. shall continue to manage health issues that relate to environmental and occupational hazards through enforcing appropriate legislation.

225/232 HU (97%) provide health education about Safe Water (131/216 HU (61%).
The messages included:

- *To boil drinking water (majority)*
- *Clean containers for water*
- *Keep water source clean.*
- *Purification of water*

Activities related to access of water include: (i) Meeting with the committee members (Kabale), (ii) sensitize the LC's about the need for springs (Mbarara), (iii) Lobby for drilled boreholes, construction of boreholes (Mbarara, Tororo), (iv) spring protection (Arua) (v) Inspection of water services (Gulu), Protection of springs and boreholes (Kasana) construction of shallow

[12] MHCP Report 2003

wells (Masaka), Cleaning of borehole surroundings (Jinja). The number of HU conducting the above mentioned activities were limited, most HU remained with Health Education only.

202/232 HU (87%) promote hygiene practices at household level (193/216 HU (89%). The message was not specified.
189/232 HU (82%) promote hygiene practices in public institutions and places such as markets, slaughter places and shops. (109/216 (50%). It is however, not clear whether this questions has been correctly understood. In the report of 2003 it was stated that many considered this the responsibility of the governmental health units.

6.6 Health Education and Promotion

The aim of Health Education and Promotion is to promote individual and community responsibility for better health and the major causes of morbidity and mortality and to publicize the HSSP. Intensify information, education and communication activities to improve health awareness, effect desired changes in knowledge, attitude and behavior (including health seeking behavior) directed towards the prevention and control of major health problems, and in promoting healthy lifestyles.

230/232 HU (99%) give health education at the facility and during outreaches. (205/216 (95%)
Health education sessions are provided to patients, mothers, pregnant women and clients. 111/230 HU have a fixed time schedule and 116/230 have a list of topics.
In 213/232 HU there is health education material available and visible in the health units. This was received from DDHS, HSD, Diocesan Health Office or self-made (Kotido)
Practically all health units give health education during consultations.
112/232 HU mentioned that they had received training in health education, predominantly during their professional nursing training school or for specific topics, such as Reproductive Health, sanitation and or immunization from the HSD, the Diocesan Office, UCMB and in-house training. Only one HU mentioned a Diploma of Health Education and Promotion (Lira).

6.7 School health

The aim of the School Health Programme is to provide comprehensive preventive and promotive health services to school going children, estimated at 45% of the national population. The programme aims to improve the health of the school children, reduce dropout rates and enhance performance at schools. Provision of health education, screening for and treating common ailments, improvement of environmental sanitation and personal hygiene and promotion of appropriate nutrition practices.

190/232 HU (82%) conduct school health activities (148/216(69%) including hygiene promotion. The number of schools being visited vary from 1- 28 schools, with the majority visiting between 1-5 schools (117) 6-10 schools (57) and > 10 schools are visited by 13 HU, with the highest a visit 2 times per year to 28 schools (Masaka). Most HU visit each school either once a month or once per term.

172/190 HU (91%) conduct supervision of adequate clean latrines and access to water at the schools (123/148 (83%) and 107/190 (56%) conduct regular medical examination for pupils. 57/190 HU (30%) provide eye care and detection of eyesight problems.
Promotion of a Healthy Lifestyle is provided in 178/190 HU (94%), this is also part of the Adolescent Reproductive Health services and 138/190 HU (73%) provide immunization sessions at school for young girls of 14 years and older (62/148 (42%).

Other activities include:

- *De-worming*
- *Nutrition education and talk about balanced diet*
- *Vit. A distribution*
- *Health parades (Kasese)*
- *Dental examination (Tororo)*
- *Pregnancy tests*
- *Inspection of hand washing (Nebbi)*

Training of teachers in first aid is conducted in 66/190 HU (35%) (30/148 (21%) and supply of first aid material to schools is provided by 91/190 HU (48%) (48/148 (33%)

6.8 Epidemic & Disaster Prevention, preparedness and Response

The aim of the programme is prevention, early detection and prompt response to health emergencies, including natural and man-made disasters, massive movements of populations (Internally Displaced Persons (IDPs) and refugees) and other diseases of public health importance in collaboration with relevant sectors and agencies.

201/232 HU (87%) send the weekly notifiable disease report to the HSD (189/216(88%) The potential epidemic diseases are: malaria, diarrhea, typhoid, measles, cholera (Tororo, Fort Portal and Kasese) and Meningitis (Gulu, Kotido, Hoima, Kiyinda M and Arua).

185/232 HU (80%) mentioned that they had sufficient stock of drugs in place for a sudden malaria outbreak (176/216 (82%). It is assumed, just as in the 2003 report, that this is based on the actual stock present. Only 62 HU mentioned that they kept a buffer stock for malaria in reserve.

6.9 Improving Nutrition

The aim of the programme is to contribute towards the improvement of the nutritional status of the population including promotion of household food security and healthier eating habits. Attention will be given to young children and pregnant and lactating mothers.
Education and other measures will be undertaken to protect the population against micronutrient deficiencies, obesity and other nutrition related diseases.

32/232 (14%) own demonstration gardens (38/216 (18%) and 57/213 HU (27%) hold demonstrations on preparation of nutritious meals (69/216 (32%)

Malnourished children are identified through: (i) growth monitoring and (ii) physical examination. This survey did not further assess whether the Road to Health card was properly used as was discussed in the report of 2003..
Number of cases for referral varied from 1-100, with the majority between 1 - 5 referrals (84HU)

63/232 HU mentioned that other organizations were working in the same district to improve the nutritional situation, 30 HU worked together with the other organizations in activities such as: (i) supplementary feeding, (ii) screening of children in order to trace malnourished children, (iii) Feeding and (iv) distribution of food.

6.10 Interventions against Diseases targeted for Eradication

The aim of the programme is to achieve the targets for eradication/elimination of targeted diseases including: Poliomyelitis, Guinea Worm, Onchocerciasis, Measles and Leprosy. The

Government of Uganda is a signatory to international resolutions committed to the elimination and eradication of some diseases.

225/232 HU (97%) are familiar with one or more diseases targeted for eradication. (178/216 (82%) and 214 HU have received information from the authorities about the diseases. Polio is by far the most well known disease targeted for eradication.
155/225 HU (69%) work with the Parish Development Committee (113/178 (52%) for surveillance and control measures.

6.11 Mental Health Services

The aim of the programme is to provide improved access to primary mental health services to the entire population and to ensure ready access to quality mental health referral services at district, regional and national levels.

163/232 HU (70%) have treated or referred mental health patients (98/216 (45%) The number of patients varied from 1 – 1462.
Over 500 patients were seen in 3 HU (Mbarara and Kasese) with the highest (1462) in Mbarara. The majority were between 1-5 patients (79 HU).

138/232 HU (60%) treat epileptic patients (105/216 (49%). In order to ensure that epileptic patients return the HU initiates that: (i) appointments are made, (ii) cooperation with village health worker, (iii) sensitization of care taker.
133/232 HU (57%) provide health education about mental health patients, messages include:

- *Do not discriminate or isolate mental health patients*
- *Early treatment, assistance and referral*
- *Avoid excessive alcohol and drug*
- *For epileptic patients: avoid fire places and climbing trees.*

6.12 Essential Clinical Care

The aim of the programme is to provide basic care for common illness, including non-communicable diseases and injuries.

6.12.1 Care of injuries and other common conditions including non-communicable diseases

The number of new OPD patients vary from 3 (Kabale) to 106 (Gulu) per day. From 191 HU the number of new OPD cases per day, based on 5 working days per week were calculated as follows:

Table 5: Total Number of New OPD cases per day in the HU surveyed

No of new OPD cases per day	*No of HU*
3 – 5	*13 HU (including 6 HU III)*
6 – 10	*35 HU*
11 – 20	*70 HU*
21 – 50	*66 HU*
> 50	*7 HU (including to HU II)*

The five most common diseases seen in the HU are: (i) malaria, (ii) Acute Respiratory Infections, (iii) diarrhoeal diseases (iv) worms and (v) STIs.

206/232 HU (89%) write a referral letter when a patient is referred to higher level service (178/216 (82%). Only 32 HU mentioned that they receive a feedback from the hospital or higher level facility about the referred case.

127/232 HU (55%) have access to transport for referring a patient (103/216 (48%), of these 65 are owned by the HU.

First Aid interventions are available in all health units, only 25/232 HU (11%) mentioned that they were not able to provide IV Fluids as first aid (24/216 (11%)
Control of bleeding, control of pain and dressing of wounds were confirmed more or less by all. 178/232 (77%) mentioned that they were able to suture wounds and 206/232 (89%) indicated that they were able to temporary immobilize fractures.
219/232 HU (94%) had the National Treatment Guidelines.

6.12.2 Palliative Care

To promote the development of services for the chronically and terminally ill persons in collaboration with organisations dedicated to this field.

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness. This include prevention and relief of suffering by means of early identification and effective assessment and treatment of pain and other problems, physical, psychosocial, and spiritual. It uses a multidisciplinary team approach to address the needs of patients and their families, including dignity in dying and bereavement support (WHO definition 2002)

74/232 HU (32%) indicated that they provided palliative care to patients with severe pain (68/216 (31%) such as AIDS patients (61), Cancer patients (39) and Sickle Cell patients (53).
37/232HU (16%) had received formal training about Palliative Care (25/216 (11%), of these 6 HU did not treat patients. Training was provided by (i) Hospice Mbarara and Hoima; (ii) Mildmay, (iii) Respective District Hospital.

6.12.3 Disabilities and rehabilitative health

To increase access to medical rehabilitation services in the districts for persons with disabilities and develop a referral claim for these services.

156/232 HU (67%) have seen patients with disabilities at the OPD, of these 105 HU mentioned Eye sight problems; 101 HU mentioned Hearing problems; 77 HU mentioned Skin problems (burns), 65 HU Locomotive problems, 32 HU mentioned amputees and 2 HU mentioned others such as Cleft Palate and a baby born without an anus.

The number of disabled patients seen at the HU varied from 1-100, of these the majority were between 1-10 patients (47 HU) between 11-25 patients (10 HU), the highest number of patients was 51 patients (Kotido) and 100 patients (Masaka).

131/232 HU (57%) referred disabled patients to the nearest hospital (102/216 (47%), number of patients varied from 1 – 33, with the highest in Kotido and the majority between 1-4 referrals.

44/156 HU (28%) mentioned that disabled person returned for follow-up services to their respective facility

.

6.12.4 Oral /Dental Care

To ensure availability of basic dental treatment services, with adequate supplies in district hospitals and upgraded health centers.

Practically all health units provide pain relief for dental and oral problems and health education about dental and oral care. Only 44/232 HU (19%) conducted tooth extraction (32/216 (15%), of these were 13 HU II, 27 HU level III and 4 HU level IV. Others referred patients with dental problems to the nearest appropriate facilities.

6.13 Outreaches

217/232 HU (94%) conduct outreach services (200/216 (93%). The number of outreach stations vary mostly between 1-15 stations. Two HU visit 33 stations (Tororo and Masaka) and one HU has 48 stations (Kabale).The majority, 144/200 HU (72%) visits between 3 to 6 stations
169/200 HU (85%) visit the outreach stations once a month (153/216 (77%) others go either once a week, twice per month or once or twice per year.

Outreach activities include predominantly: (i) immunization (213/217); (ii) health education (216/217); growth monitoring (204/217) and antenatal care (132/217).
Other activities include:

- *Home visiting - ("attend to bed ridden patients")*
- *Curative services*
- *De-worming*
- *School visits*
- *CBHC*
- *VCT services and PMTCT sensitization*
- *Nutritional support, distribution of food to children*
- *Eye Care*
- *Training and Supervision of CHWs and TBAs.*

140/217 HU (65%) conducting outreaches mentioned that in their outreach stations a health committee existed within the Parish Development Committee (81/200(41%) and 128 of 140 HU mentioned that they have regular contact with this committee. (77/81).

Others mentioned contacts with (i) Local Council Committee; (ii) immunization mobilizers, (iii) Community Health Workers /Village Health worker, (iv) Community Resource Person and (v) the Parish Priest or Catechist.

7. Comparative Descriptive Analysis of the results of 2003 and 2006 surveys.

In the 2003 survey the Minimum Health Care Package according to the HSSP I was used. The package included 13 elements and within each a number of interventions are supposed to be implemented. The current HSSP II (2005/6-2009/10) has increased to 22 the number of elements and these have been grouped into 4 clusters. However, for comparability reasons the analysis of the 2006 survey will be based on the expected standards/interventions of the 13 elements of the MHCP according to the HSSP I.

The selected parameters were derived from the interventions of the Minimum Health Care Package and corresponded, when implemented by the HU, to a positive score. At the end of the assessment this process attributed a total score to the HUs as summation of the points attained because of interventions implemented in line with health unit level.

The maximum attainable score for the implementation of the 13 elements totalled to 80 points for a health unit III and 68 points for a health unit II. An overview of the result for each individual health unit is shown in annex 2 and 3.

For analytical purpose the 13 elements of the MHCP were grouped into 5 major clusters as outlined below:

Table 6: Re-grouping of the 13 elements into 5 major clusters of interventions

	Control of communicable diseases and Clinical Care	**Child Health**	**Sexual and Reproductive Health and Rights**	**Public Health**	**Special Care**
	Malaria STI/HIV/AIDS TB & Leprosy Care of injuries Oral/Dental	Child Health Immunisation	Antenatal Care Obstetric Care Postnatal Care Family Planning Adolescent Reprod. Health	Violence against women Environmental Health School health Health Education Epidemics Nutrition Diseases Eradication Outreach	Mental Health Palliative Care Care for Disabled
HC II	17	8	16	19	8
HC III	21	8	24	19	8

For computer analysis the Box-whisker plots, a refined analysis tool was used[13]. Graphs with the Box-Whisker plots for each level HU and for each of the 5 clusters per level HU are attached in annex 3. The graphs form part of the tables described below.

[13] This tool provides information about the central location of a set of parameters (median) and the scatter/dispersion of the various observations of the parameters around the median. It provides in addition the inter-quartile range (IQR) (25% immediately above or 25% below the median value). The "whisker" extends to a certain value above and/or below the limit of the inter-quartile range. (UCMB)

7.1 Health Unit II

Table 7 below (+ graph in annex) shows that the median score has increased from 37.5 in 2003 (95% CI of median 32-42) to 47 in 2006 (95% CI of median 40-51). The inter-quartile range has increased from 12 to 16.5, indicating a much wider variability in the overall performance of the MHCP in the facilities in comparison with 2003. Both observations, above and below the inter-quartile range have moved upwards, meaning that an increased number have reached at 65 points (in 2003 only one far observation). There is one far observation (outlier) at 0 point, indicating that no data has been received from this facility. The median degree of completeness has increased from 54% in 2003 to 70% in 2006.

Table 7: Result of survey 2003 and Result of survey 2006 (HC II)

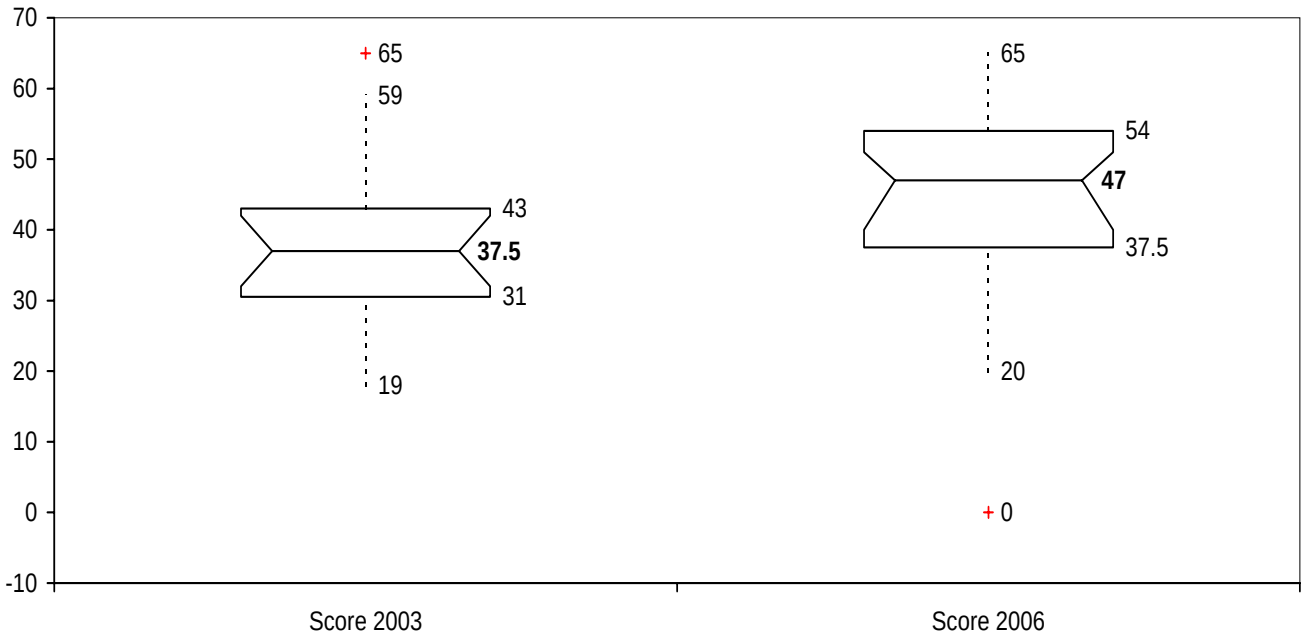
Health Unit II	points	
43 - 59	16	
37.5 - 43	**6.5**	**IQR - 12**
31 - 37.5	**5.5**	
19 - 31	12	

Median degree of completeness 37.5/68 = 55%

Health Unit II	points	
54 - 65	11	
47 - 54	**7**	**IQR - 16.5**
37.5 - 47	**9.5**	
20 - 37.5	17.5	

Median Degree of completeness 47/68 = 70%

Graph 1: Distribution of scores among the HU of level II (Box-Whisker plot)



	n	Mean	SD	SE	95% CI of Mean	Median	IQR	95% CI of Median
Score 2003	35	37.514	10.6643	1.8026	33.851 to 41.178	37.000	12.500	32.000 to 42.000
Score 2006	35	44.971	13.4547	2.2743	40.350 to 49.593	47.000	16.500	40.000 to 51.000

7.2 Health Unit III

Table 8 below shows that the median score has increased from 54 in 2003 (95% CI of median 51-55) to 60 points in 2006 (95% CI of median 58-61).
The inter-quartile range has narrowed from 16 points to 10.5, meaning that more health units are performing at a similar level. There is a wider variability in the lower inter-quartile range, but less than in 2003. Both observations, above as well as below the inter-quartile range have moved upwards, in particular the observation below the lower IQR has moved up 18 points (from 21-39). However, there are an increased number of far observations (outliers) below 39 points (13 HU)

Table 8: Result of survey 2003 and Result of survey 2006 (HC III)

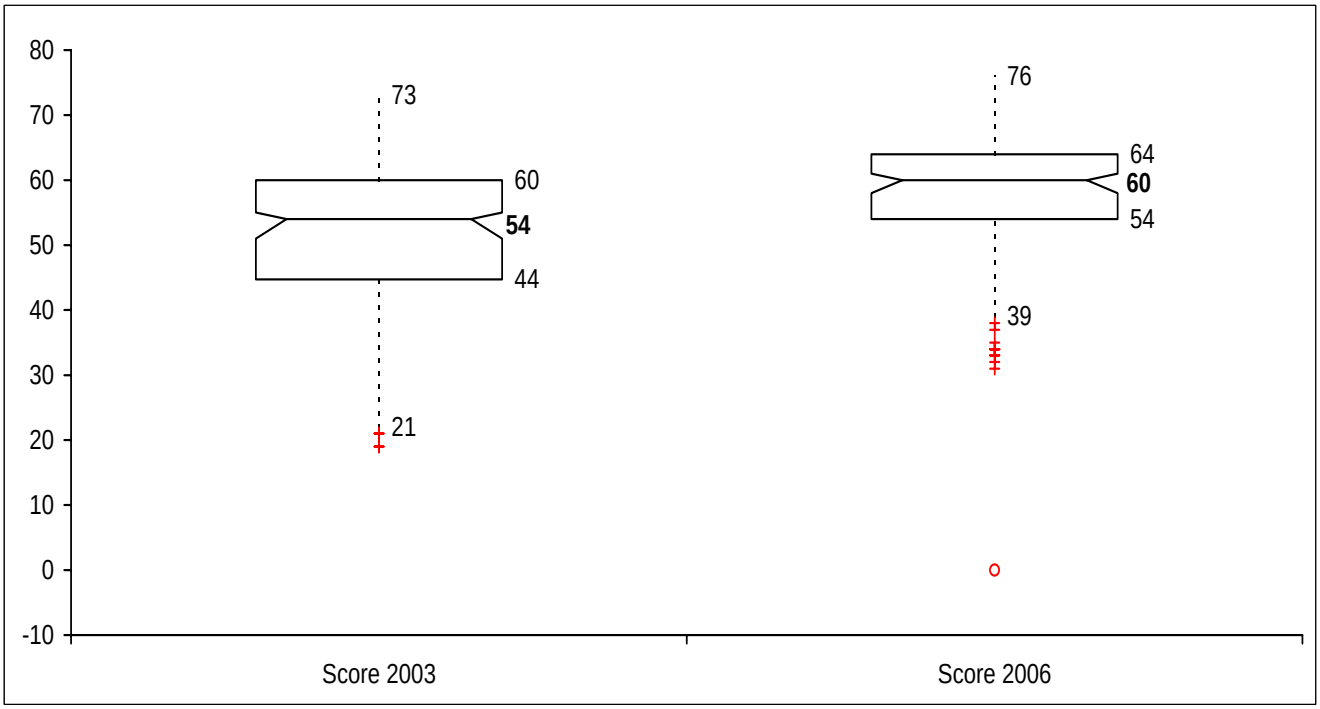
Health Unit III	Points	
60 - 73	13	
54 - 60	**6**	**IQR - 16**
44 - 54	**10**	
21 - 44	23	

Median Degree of completeness 54/80 = 68%

Health Unit III	Points	
64 - 76	12	
60 - 64	**4**	**IQR – 10**
54 - 60	**6**	
39 - 54	15	

Median Degree of completeness 60/80 = 75%

Graph 2: Distribution of scores among the HU of level III (Box-Whisker plot)



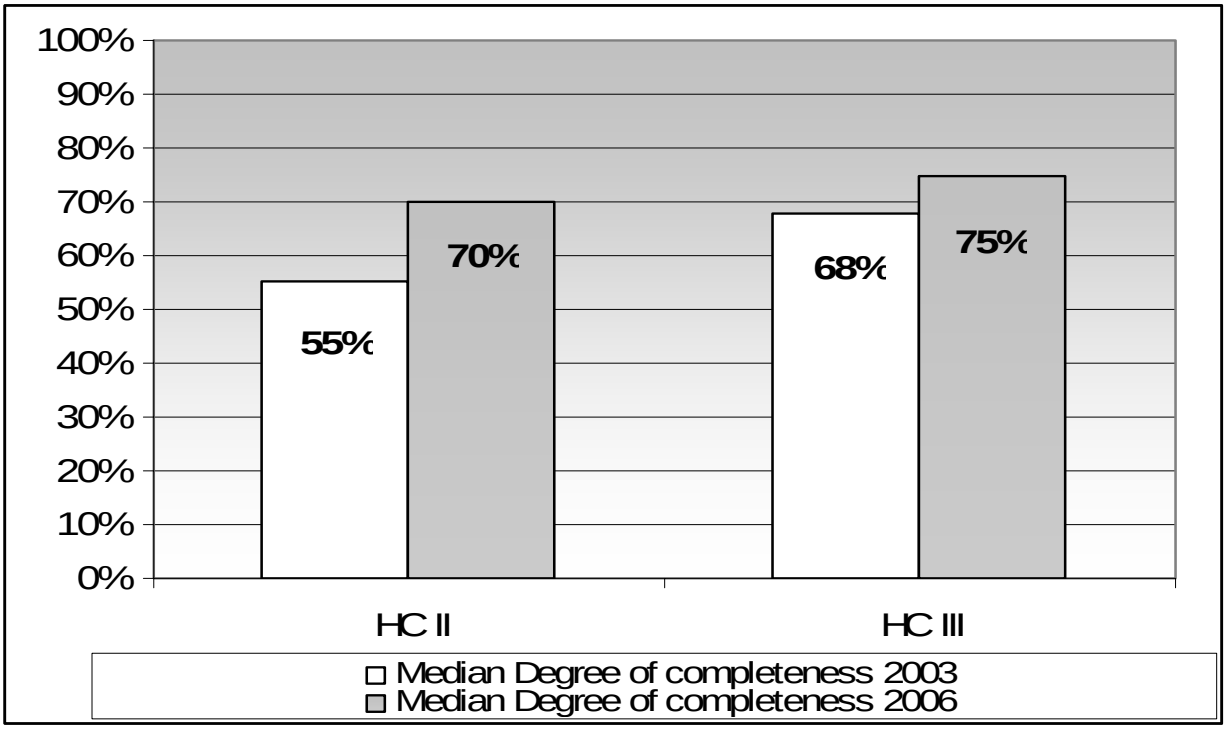
	n	Mean	SD	SE	95% CI of Mean	Median	IQR	95% CI of Median
Score 2003	180	51.317	11.8602	0.8840	49.572 to 53.061	54.000	15.250	51.000 to 55.000
Score 2006	180	57.558	10.6314	0.7902	55.999 to 59.117	60.000	10.000	58.000 to 61.000

7.3 Summary conclusion on the improvement in the implementation of the elements of the MHCP

For the RCC Lower Level Health Units Network the median degree of completeness in both HU of level II and HU of level III has significantly increased.

In the group of HU of level II it has increased from 55% to 70% while in the group of HC of level III in has increased from 71% in 2003 to 75% in 2006, as indicated in the below graph.

Graph 4: Improvement in the implementation of the MHCP Elements (HU level II and III)



7.4 Comparative analysis per cluster - HC II

The tables below show the parameters for HU level II in each of the five combined clusters, the left column represents the survey of 2003 and the right column the survey of 2006. Graphs with Box-Whisker plot representation are presented in the annexes.
In the first cluster (Communicable Diseases and Clinical Care) the median has increased from 11 to 13 points and, the inter-quartile range, particular the upper inter-quartile range has a wider variability, meaning that more health units are within a wider range of points above the median. The observation above the inter-quartile range is at 19 points, indicating a score above the target. This is related to the implementation of additional activities within this cluster (e.g. counselling and HIV testing), adding a total of 2 points to the maximum attainable score of 17. In the lower inter-quartile range the lowest observation is at 9 and there is a far observation (outlier) at 0, meaning that no comparative data was received from this facility. The median degree of completeness has increased from 58% in 2003 to 68% in 2006, still using 19 as denominator and not 17.

In the cluster of Child Health the median has remained static at 7, the inter-quartile range has decreased from 3 to 1.5 points. There is no lower inter-quartile range, but there are

observations at 6.5 and a number of far observations at 3 and 0, the latter meaning that no data was received. The median degree of completeness remained static at 88%.

In the cluster Sexual and Reproductive Health and Rights the median has increased from 6 to 9 points. The inter-quartile range is 10.5 (the highest amongst the five clusters) and increased with 1.5 points from 2003, meaning that the scope of the services has enlarged hence more varied services are offered. The upper-IQR has a variability of 3.5 points, whilst the lower-IQR has a variability of 7. The median degree of completeness has improved from 35% in 2003 to 53% in 2006. The wider variability in this cluster indicates that more facilities are conducting Reproductive Health services and that improvement has been made, particularly in the services of maternal care, which is in line with the Minimum Health Care Package and with additional obstetric care, because more HUs have a qualified midwife. On the contrary, there are also a number of facilities that exclude, either partially or completely, maternal services in their activities.

In the fourth cluster, Public Health, the median has also increased from 10 to 13 points. This is, amongst others, related to an increased number of health units conducting school health activities. The inter-quartile range has decreased from 4.5 to 3.5 meaning that more facilities are at a similar level. The observations below the lower inter-quartile range have a wider variability, between 12 and 8 points, with the lower observations at 6 and one at 0. The median degree of completeness has improved from 53% in 2003 to 68% in 2006.

In the cluster of Special Care the median has slightly increased from 2 to 3 points. The inter-quartile range has decreased from 3 to 2.5 points, indicating less variability, particularly in the lower IQR. That means that a number of facilities have improved in the services of this cluster, but for quite a number of facilities this remains the weakest cluster. The median degree of completeness has however increased from 25% in 2003 to 38 % in 2006.

Table 9: Results of Cluster Comparative Descriptive Analysis for HU of level II

Control Communicable Diseases and Clinical Care – 19 points	points	HU II
12 – 15	3	
11 – 12	**1**	**IQR – 2**
10 – 11	**1**	
8 – 10	2	

Median degree of completeness = 11/19 – 58%

Control Communicable Diseases and Clinical Care – 19 points	points	HU II
15 - 19	4	
13 - 15	**2**	**IQR – 3**
12 - 13	**1**	
10 - 12	2	

Median degree of completeness = 13/19 – 68%

Child Health – 8 points	points	HU II
7 – 8	**1**	**IQR – 3**
5 – 7	**2**	
1 – 5	4	

Median degree of completeness 7/8 = 88%

Child Health – 8 points	points	HU II
7 – 8	**1**	**IQR – 1.5**
6.5 - 7	**0.5**	
5 - 6.5	1.5	

Median degree of completeness 7/8 = 88%

Sexual and Reproductive Health & Rights – 17 Points	points	HU II
11.5 – 15	3.5	
6 – 11.5	**5.5**	**IQR–9**
2 – 6	**4**	
0 – 2	2	

Median degree of completeness 6/17 = 35%

Sexual and Reproductive Health & Rights – 17 Points	points	HU II
12.5 - 15	2.5	
9 – 12.5	**3.5**	**IQR–10.5**
2 – 9	**7**	
0 – 2	2	

Median degree of completeness 9/17 = 53%

Public Health – 19 Points	points	HU II
12 – 17	5	
10 – 12	**2**	**IQR – 4.5**
7.5 – 10	**2.5**	
5 – 7.5	2.5	

Median degree of completeness 10/19 = 53%

Public Health – 19 Points	points	HU II
15 - 18	3	
13 - 15	**2**	**IQR – 3.5**
11.5 - 13	**1.5**	
8 – 12	4	

Median degree of completeness 13/19 = 68%

Special Care – 8 Points	points	HU II
4 – 8	4	
2 – 4	**2**	**IQR – 3**
1 – 2	**1**	
0 – 1	1	

Median degree of completeness 2/8 = 25%

Special Care – 8 Points	points	HU II
4.5 – 8	3.5	
3 – 4.5	**1.5**	**IQR – 2.5**
1 – 3	**1**	
0 – 1	1	

Median degree of completeness 3/8 = 38%

7.5 Comparative analysis per cluster – HU III

The tables below show the parameters for HU level III in each of the five combined clusters; the left column represents the results of the survey of 2003, while the right column the results of the survey of 2006.

In the first cluster, Communicable Diseases and Clinical Care, the median has increased in 2006 from 13 to 15 points. The inter-quartile range has increased to 4 points. Observations above and below the inter-quartile range have moved upwards, denoting better performance. There is a far observation of 0 score (outlier) due to unavailability of data. The median degree of completeness has increased from 62% in 2003 to 71% in 2006. This is predominantly related to improved and expanded services in STI/HIV/AIDS.

In the Child Health cluster the results have remained static, the median has remained 7 and the degree of completeness has remained static at 88%

The third cluster, Sexual and Reproductive Health and Rights, has made a dynamic improvement. The median increased from 17 to 19 points in the inter-quartile range narrowed from 7 to 4 points, indicating that more facilities are at a similar level of services. There are however quite a number of far observations (outliers) at 0 score level. This means that a number of facilities at level III do not provide the required services for reproductive health. These same units, with all units standing between 11 and 0 points, represent the group of units that has dawn-graded their own level to HU II, for they do not provide a number of services under this cluster of the package. As results the overall performance in negatively affected by the poor performance of these units. If these were left out in the analysis, the distribution of the score will be positioned at a relatively higher level with a higher median score and a consequent higher degree of completeness. In order to grant comparability with the 2003 baseline, the units have been kept at the level they belong even though this has penalised the overall performance under this specific cluster. Despite this factor the median degree of completeness has still registered an increment from 71% in 2003 to 80% in 2006.

Under Public Health cluster the median has also increased from 13 to 15 points. The inter-quartile range has decreased from 5 to 3 points, indicating that more facilities are at a similar level. The lower inter-quartile range shows a narrower range, meaning less variability (6 points). There are a number of far observations (outliers) between 6 and 0 points. This is related, amongst others, to lack of school health activities or poor environmental health services. The median degree of completeness has increased from 68% in 2003 to 79% in 2006.

In the fifth cluster, Special Care, the median increased by 1 point, from 3 to 4 points. The inter-quartile ranges have remained unchanged. However in 2003 the highest observation in the upper inter-quartile range was 7 with one far observation at 8, while in 2006 the observations increased to the highest level of point 8, indicating that more facilities were providing the complete package of services for Special Care. The median degree of completeness increased from 25% in 2003 to 50% in 2006.

Table 10: Results of Cluster Comparative Descriptive Analysis for HU of level III

Control Communicable Diseases and Clinical Care – 21 points	points	HU III
15 – 19	4	
13 – 15	**2**	**IQR - 3**
12 – 13	**1**	
8 - 12	4	

Median degree of completeness 13/21 = 62%

Control Communicable Diseases and Clinical Care – 21 points	points	HU III
17 - 21	4	
15 - 17	**2**	**IQR - 4**
13 - 15	**2**	
9 - 13	4	

Median degree of completeness 15/21 = 71%

Child Health – 8 points	points	HU III
		IQR – 1
7 – 8	**1**	
6 – 7	1	

Median degree of completeness 7/8 = 88%

Child Health – 8 points	points	HU III
		IQR – 1
7 – 8	**1**	
6 – 7	1	

Median degree of completeness 7/8 = 88%

Sexual and Reproductive Health & Rights – 24 points	points	HU III
20 – 23	3	
17 – 20	**3**	**IQR - 7**
13 – 17	**4**	
3 – 13	10	

Median degree of completeness 17/24 = 71%

Sexual and Reproductive Health & Rights – 24 points	points	HU III
21 - 23	3	
19 - 21	**2**	**IQR - 4**
17 - 19	**2**	
11 – 17	7	

Median degree of completeness 19/24 = 80%

Public Health – 19	points	HU III
15 – 18	3	
13 – 15	**2**	**IQR – 5**
10 – 13	**3**	
3 – 10	7	

Median degree of completeness 13/19 = 68%

Public Health – 19	points	HU III
16 - 19	3	
15 - 16	**1**	**IQR – 3**
13 - 15	**2**	
9 – 13	4	

Median degree of completeness 15/19 = 79%

Special Care – 8	points	HU II
4 – 7	3	
3 – 4	**1**	**IQR – 2**
2 – 3	**1**	
0 – 2	2	

Median degree of completeness 3/8 = 38%

Special Care – 8	points	HU II
5 – 8	3	
4 - 5	**1**	**IQR – 2**
2 – 4	**1**	
0 – 2	2	

Median degree of completeness 4/8 = 50%

8. Conclusion of the comparison between the results of the 2003 and 2006 survey

For UCMB the ultimate aim of the 2003 baseline survey was to identify which elements, clusters and interventions of the MHCP were underprovided and to obtain a reference score for monitoring purposes in the future. The survey of 2006 was the follow-up against which the reference score of 2003 has been measured.

In the 2006 survey the methodology changed slightly. The interviews in the HU were conducted by diocesan staffs, who were trained by the author in a five-day workshop. Although the interview had a structured character, it should not completely be ignored that by using multiple interviewers from the home-based location of the HU, there is a possibility that responses of the interviewee are influenced, either because of unfamiliarity with the specific topics (e.g. non-medical interviewers) or because of wishful thinking.
In the 2003 report it was already mentioned that the scoring system has its limitations. The strength is that it substantiates a value that may help the HU to look critically at their performance and initiate a change for the better. The weakness of a scoring system is that it does not expose the underlying problems and constraints that may contribute to a poor performance and which may need to be tackled as a first priority.

The overall result of the 2006 survey, including all HU interviewed, has shown a steady improvement in the implementation of the Minimum Health Care Package in the RC lower level health units. The improvements were particularly made in Cluster one: Communicable Diseases & Clinical Care and which is the result of an increase in VCT services. In Cluster 3: Sexual and Reproductive Health and Rights, which is mainly related to an increase in maternal health services and institutional deliveries and in Cluster 4: Public Health, which is the result of an increased number of health facilities conducting school health and improved environmental health activities.

In the comparative descriptive analysis (participants of the 2003 survey only) the overall degree of completeness improved at both levels significantly, as mentioned above, in the field of Sexual and Reproductive Health and Rights, Communicable Diseases & Clinical Care and Public Health. The cluster of Child Health remained static. The cluster of Special Care, although slightly improved at both levels remains a weak cluster.

The results are encouraging, for the input of UCMB and for the compliance by the Diocesan Coordinators and the staff of the respective health units. There is still a way to go for a number of HU and for the others who managed to improve it will be a task to maintain the level of services which they have achieved, particularly taking into a account a decreasing availability of funds.

It is anticipated that this exercise, which involved the responsibility of the Diocesan Coordinators, will strengthen even more the commitment of performance monitoring as a routine activity and as an unavoidable and serious responsibility of management.
It must be clear by now that …..***if you cannot measure it, you cannot manage it!***

9. Comparative Descriptive Analysis of the results of 2003 and 2006 surveys per Diocese.

In the section above the comparative analysis is based on the total number of RCC Health Units that participated in both surveys. In this chapter results from each of the 19 individual dioceses and their respective health units, are compared to results for the entire sample surveyed. Comparisons are made for the Package in its entirety and for each of the 5 clusters of elements of the Package. It has to be emphasized again here, that for comparability reasons the level of the health facility is based on the survey of 2003, despite the fact that the 2006 survey has shown that in the course of the 3 years quite a number of health units have changed their level status (predominantly from level III to level II).

How to read the information presented here following:

The first table provided for each Dioceses shows the median score and the median degree of completeness of all health units in the Diocese, in 2003 and in 2006, for the entire Package.

The following graph shows the performance of each health units in the diocese in 2003 and in 2006, vis-à-vis the entire Package, expressed as absolute score (i.e. n. of interventions of the Package provided).

*The second table provided for each diocese shows the median score and the median degree of completeness per cluster of elements, for 2003 and 2006. In addition the table offers also the median degree of completeness 2006 for the entire sample **[All 2006]**, thus introducing the brief discussion presented and the conclusion.*

9.1 Diocese of Arua

The Diocese of Arua has 12 HU, all are at level III. In the 2006 survey 10 HU increased their score, one HU remained static and one HU decreased slightly.

Table 11: Median Scores and Median Degrees of Completeness – Diocese of Arua

2003	III	2006	III
Median	56/80	Median	61/80
Degree of completeness	**70%**	**Degree of completeness**	**76%**
All 2003	**70%**	**All 2006**	**75%**

Graph 5: Health Units' performance comparison in Diocese of Arua

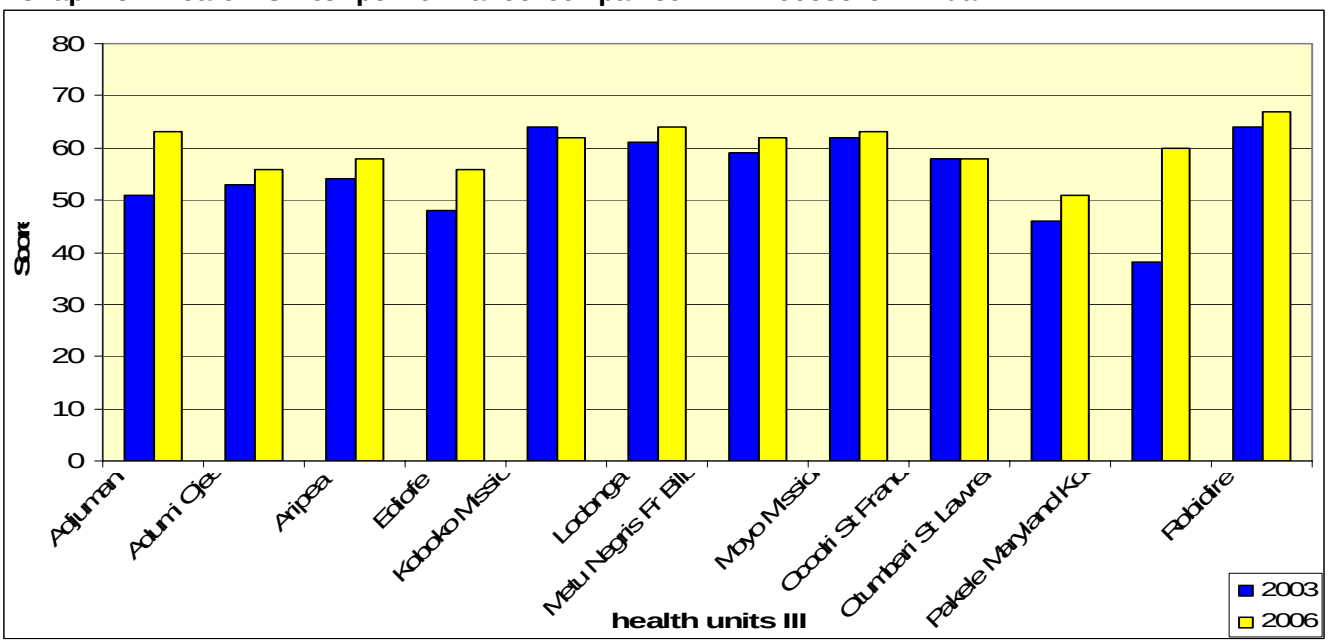


Table 12: Median Scores and Median Degree of Completeness per major Clusters – Diocese of Arua

	Comm.Diseases Cluster 1		Child Health Cluster 2		Sex & Rep.H Cluster 3		Public Health Cluster 4		Special Care Cluster 5	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
HU III	12.5	15.5	8	7	20	20	13	14.5	5	4
Degree	**60%**	**74%**	**100%**	**88%**	**83%**	**83%**	**68%**	**76%**	**63%**	**50%**
All 2006		**71%**		**88%**		**80%**		**79%**		**50%**

Table 12 shows that significant improvement has been made in Cluster 1 (all HU except Koboko) and Cluster 4 (particularly Adjumani and Ediofe). It has decreased in Cluster 2 (Adjumani, Adumi, Bilbao, Lodongo, Ocodri and Otumbari) and in Cluster 5 (Aripea, Koboko, Lodongo, Ocodri and Otumbari). Cluster 3 remained static but improvements were made in Maryland and Otumbari (obstetric care). In Koboko the overall score declined in Cluster 1 (TB), and 5 (Palliative Care).

Conclusion: Median degree of completeness improved in Cluster 1 and 4, the first one is above All 2006, the latter is below All 2006. Cluster 3 remained static and is above All 2006 and Cluster 2 and Cluster 5 decreased, but are in line with All 2006.
The median degree of completeness for the implementation of the MHCP in the Diocese has improved and is well above the All 2006 results.

9.2 Diocese of Fort Portal

The Diocese of Fort Portal has 12 HU, 11 at level III and one at level II. In the 2006 survey 8 HU increased their score, one HU remained static and 3 HU decreased their score.

Table 13: Median Score and Median Degree of Completeness – Diocese of Fort Portal

2003	II	III	2006	II	III
Median	59/68	46/80	Median	65/68	60/80
Degree of completeness	**87%**	**58%**	**Degree of completeness**	**96%**	**75%**
All 2003	**55%**	**70%**	**All 2006**	**68%**	**75%**

Graph 6: Health Units' performance comparison in Diocese of Fort Portal

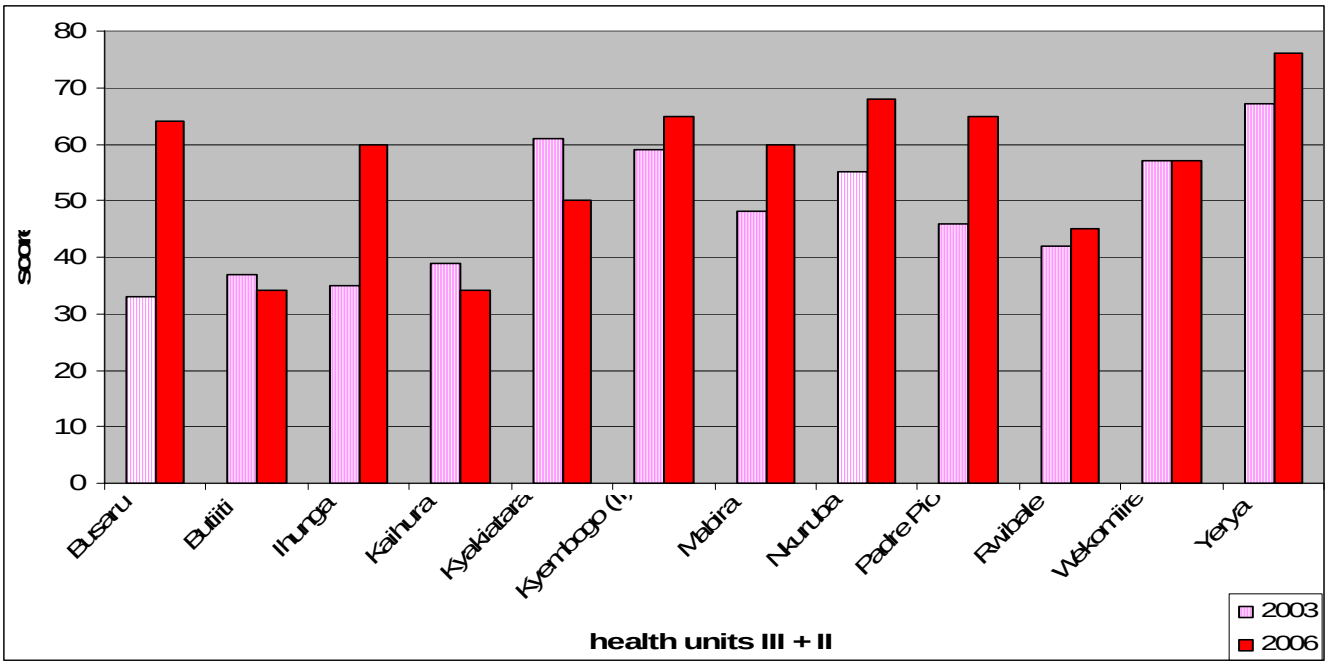


Table 14: Median Scores and Median Degree of Completeness per major Clusters – Diocese of Fort Portal

	Comm.Diseases Cluster 1		Child Health Cluster 2		Sex & Rep.H Cluster 3		Public Health Cluster 4		Special Care Cluster 5	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
HU III	14	14	7	7	12	19	11	15	4	4
Degree	**67%**	**67%**	**88%**	**88%**	**50%**	**79%**	**58%**	**79%**	**50%**	**50%**
All 2006		**71%**		**88%**		**80%**		**79%**		**50%**
HU II	14	16	8	7	15	18	16	17	6	7
Degree	**82%**	**94%**	**100%**	**88%**	**94%**	**113%**	**84%**	**90%**	**75%**	**88%**
All 2006		**68%**		**88%**		**53%**		**74%**		**38%**

Table 14 shows that at level III improvement has been made in Cluster 3 (Busaru, Ihunga, Mabira, Nkurubu, Padre Pio and Wekomire). Cluster 3 decreased in Butiti, Kaihura and Rwibale. None of the 3 latter HU has a qualified midwife. Cluster 4 improved in all HU except Kyakiatara and Wekomire. A slight improvement was made in Cluster 5 (Nkurubu, Padre Pio, Butiti, Kaihura, Rwibale and Yerya). Kyakiatara relatively decreased in score, particularly in Cluster 1, 4 and 5. The only HU II (Kyembogo) scored > 100% in Cluster 3 because of obstetric care.

Conclusion: At level III: median degree of completeness improved in Cluster 3 and 4, the latter in line with All 2006, the first one slightly below All 2006. The other 3 Clusters remained static and are in line with All 2006. For level II: median degree of completeness significantly improved in all Clusters, except Cluster 2 and is well above the All 2006 results. The median degree of completeness for the implementation of the MHCP at level II in the Diocese has improved and is well above the results of All 2006. For level III it was in 2003 below the median and is in now in line with the results of 2006.

9.3 Diocese of Gulu

The Diocese of Gulu has 8 HU, 4 at level III and 4 at level II. Two HU are newly registered and have not participated in the 2003 survey and do not have comparative data. Three HU increased in their score and 3 HU decreased in their score.

Table 15: Median Scores and the Median Degrees of Completeness – Diocese of Gulu

2003	II	III	2006	II	III
Median	50	56	Median	49	61
Degree of completeness	**74%**	**70%**	**Degree of completeness**	**72%**	**76%**
All 2003	**55%**	**70%**	**All 2006**	**68%**	**75%**

Graph 7: Health Units' performance comparison in Diocese of Gulu

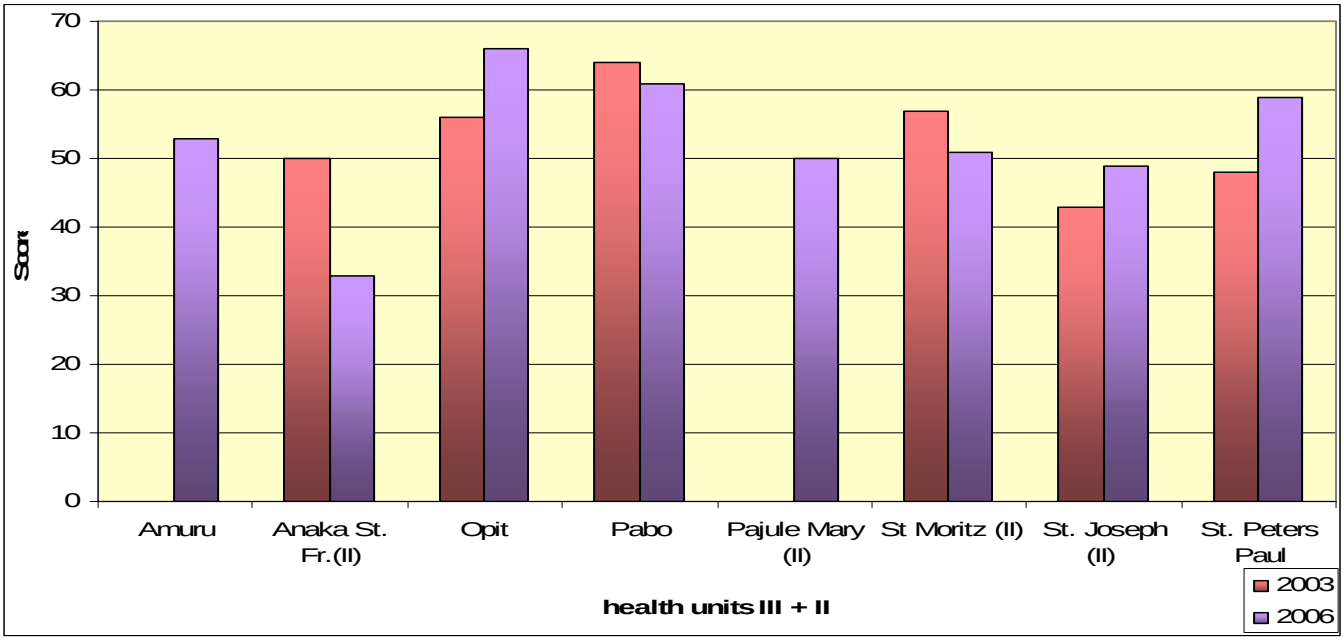


Table 16: Median Scores and Median Degree of Completeness per major Clusters – Diocese of Gulu

	Comm. Diseases Cluster 1		Child Health Cluster 2		Sex & Repr.H Cluster 3		Public Health Cluster4		Special Care Cluster5	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
HU III	13.0	17.0	7.0	8.0	20.0	21.0	12.0	12.0	5.0	5.0
Degree	**62%**	**81%**	**88%**	**100%**	**83%**	**88%**	**63%**	**63%**	**63%**	**63%**
All 2006		**71%**		**88%**		**80%**		**79%**		**50%**
HU II	11.0	12.0	7.0	8.0	14.0	8.0	14.0	15.0	6.0	5.0
Degree	**65%**	**71%**	**88%**	**100%**	**88%**	**50%**	**74%**	**79%**	**75%**	**63%**
All 2006		**68%**		**88%**		**53%**		**74%**		**38%**

Table 16 shows that at level III improvement has been made in Cluster 1 (Opit, Pabo and St Peter Paul), Cluster 3 (St Peter Paul) and Cluster 4 (Opit and St. Peter Paul). There is a decrease in Cluster 5 (Pabo and St. Peter Paul). For HU level II improvement has been made in Cluster 2 (St. Joseph) and a slight increase in Cluster 4 (St. Joseph).
However, there is a significant decrease in Cluster 3 (Anaka St Fr., St. Joseph and St Moritz) and Cluster 4 (Anaka and St Moritz). The HU Anaka decreased in score, particularly in Cluster 1, 3 and 4. The other 2 HU only had a marginal decline.

Conclusion: At level III the median degrees of completeness improved in Cluster 1, 2 and 3 and are all above All 2006. Cluster 4 and 5 remained static, the first one is below All 2006 and the latter is above. At level II the median degree of completeness improved in Cluster 1, 2 and 4 and is well above All 2006. Cluster 3 and 5 decreased, but are still above All 2006.
The median degree of completeness for the implementation of the MHCP at level II in the Diocese has slightly decreased but is just above the All 2006 results. For level III it has improved and is just above the results of All 2006

9.3 Hoima Diocese

The Hoima Diocese has 15 HU, 13 at level III and 2 at level II. Two HU did not participate in the 2003 survey and do not have comparative data.
Nine HU increased in their score, 2 HU remained static and 2 HU decreased in their score.

Table 17: Median Scores and the Median Degrees of Completeness – Hoima Diocese

2003	II	III	2006	II	III
Median	43	39	Median	48	49
Degree of completeness	**63%**	**49%**	**Degree of completeness**	**71%**	**61%**
All 2003	**55%**	**70%**	**All 2006**	**68%**	**75%**

Graph 8: Health Units' performance comparison in Hoima Diocese

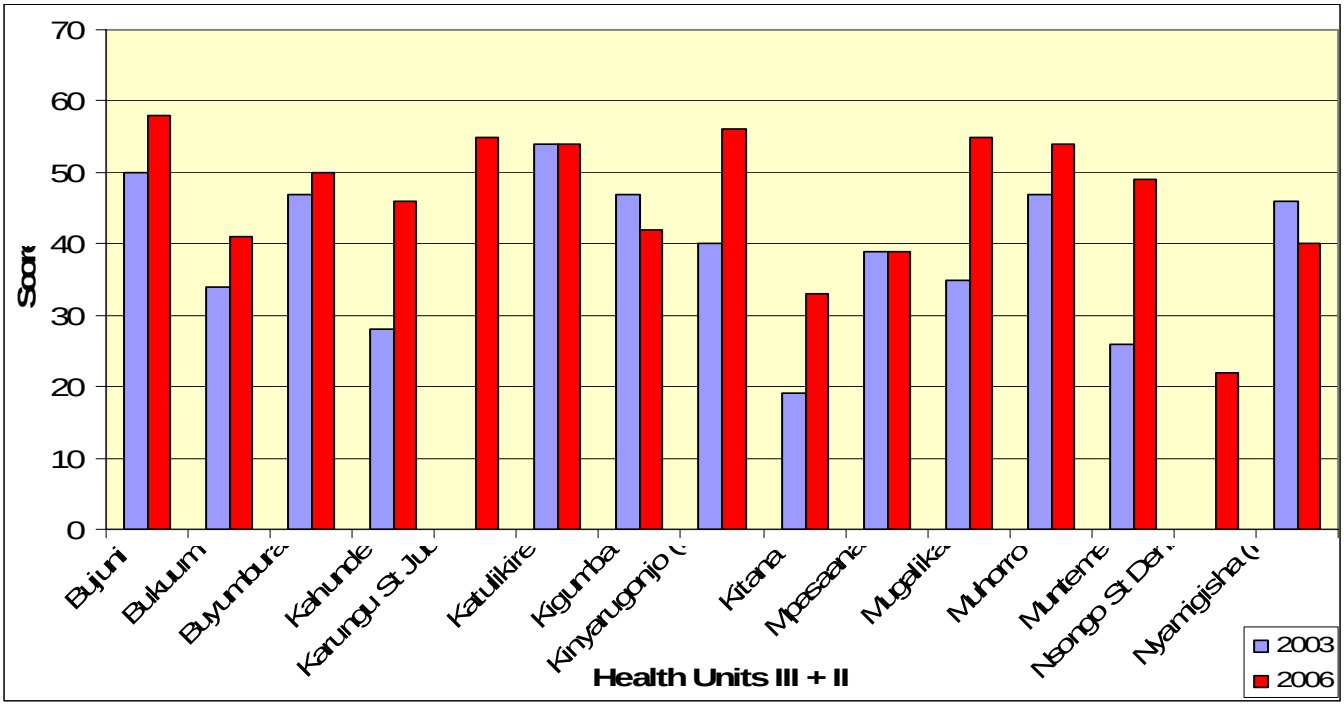


Table 18: Median Scores and Median Degree of Completeness per major Clusters – Hoima Diocese

	Comm. Diseases Cluster 1		Child Health Cluster 2		Sex & Repr.H Cluster3		Public Health Cluster4		Special Care Cluster 5	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
HU III	12.0	13.0	7.0	7.0	13.0	18.0	8.0	11.0	0.0	3.0
Degree	**57%**	**62%**	**88%**	**88%**	**54%**	**75%**	**42%**	**58%**	**0%**	**38%**
All 2006		**71%**		**88%**		**80%**		**79%**		**50%**
HU II	12.5	13.0	7.5	7.0	7.0	11.0	12.5	14.0	3.5	3.5
Degree	**74%**	**77%**	**94%**	**88%**	**44%**	**69%**	**66%**	**74%**	**44%**	**44%**
All 2006		**68%**		**88%**		**53%**		**74%**		**38%**

Table 18 shows that at level III improvement has been made in Cluster 1 (Katilukire, Muhorro, Mugalika, Kitana and Munteme), Cluster 3 (Bukuumi, Mugalika, Kahunde and Munteme), Cluster 4 (Mugalika, Kahunde, Kitana, Mpasaana and Munteme -related to improved school health) and Cluster 5 (Bujuni, Bukuumi, Muhorro,. Mugalika, Kitana & Munteme).

At level II improvement has been made in Cluster 1, 3 and 4. The other 2 Clusters remained static. The score in Nyamigisha decreased in Cluster 3 and 4 and in Kigumba in Cluster 2, 3 & 4.

Conclusion: at level III the median degree of completeness improved in all Clusters except Cluster 2, which remained static. All Clusters are below All 2006 except Cluster 2, which remains static. For level II the median degree of completeness improved in Cluster 1, 3 and 4, of which the first two are above All 2006 and the latter remains static. Cluster 2 decreased, but is in line with 2006 and Cluster 5 remained static and is above 2006.
The median degree of completeness for the implementation of the MHCP at level II in the Diocese has improved and is static with the results of All 2006. For level III it was below the overall results in 2003 and is still below the results of All 2006.

9.4 Diocese of Jina

The Diocese of Jinja has 6 HU, 5 at level III and one at level II. One HU did not participate in the 2003 survey and does not have comparative data. Two HU increased their score, 2 remained static and one HU declined its score.

Table 19: Median Scores and the Median Degrees of Completeness – Diocese of Jinja

2003	II	III	2006	II	III
Median	43/68	64/80	Median	42/68	64.5/80
Degree of completeness	**63%**	**80%**	**Degree of completeness**	**62%**	**81%**
All 2003	**55%**	**70%**	**All 2006**	**68%**	**75%**

Graph 9: Health Units' performance comparison in Diocese of Jinja

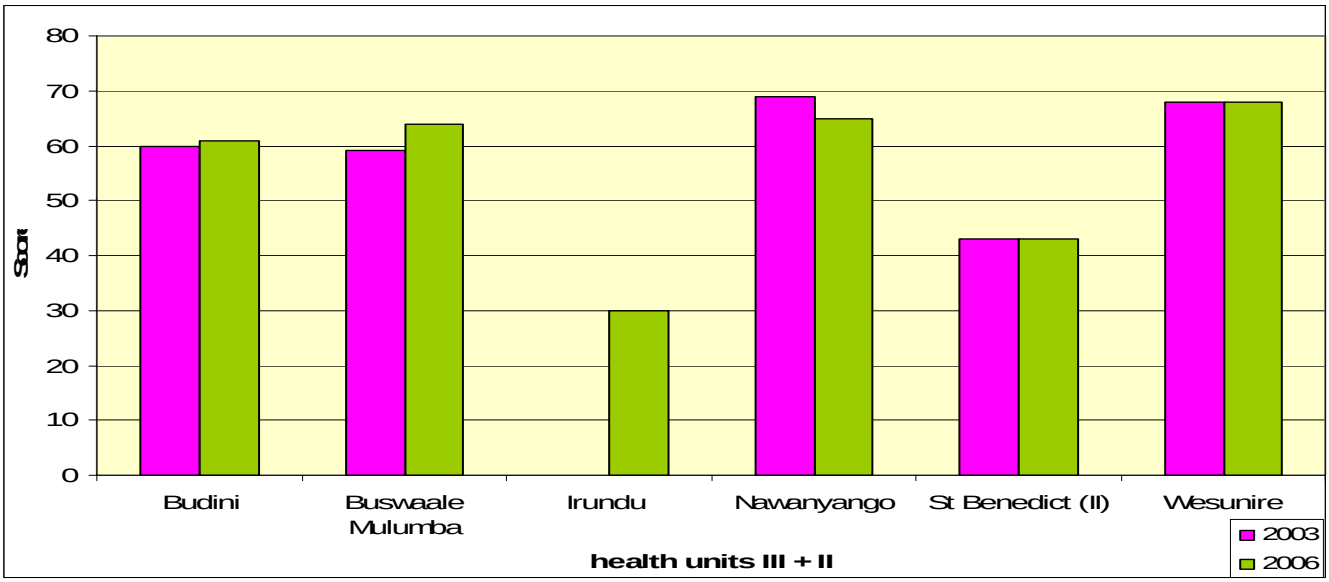


Table 20: Median Scores and Median Degree of Completeness per major Clusters – Diocese of Jinja

	Comm.Diseases Cluster 1		Child Health Cluster 2		Sex & Rep.H Cluster 3		Public Health Cluster 4		Special Care Cluster 5	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
HU III	15.5	15.5	8	8	21.5	21	15	15.5	3	4.5
Degree	**74%**	**74%**	**100%**	**100%**	**96%**	**88%**	**79%**	**82%**	**38%**	**56%**
All 2006		**71%**		**88%**		**80%**		**79%**		**50%**

HU II	16	19	8	8	6	1	9	10	4	4
Degree	**94%**	**119%**	**100%**	**100%**	**38%**	**6%**	**47%**	**53%**	**50%**	**50%**
All 2006		**68%**		**88%**		**53%**		**74%**		**38%**

Table 20 shows that at level III improvement has been made in Cluster 4 (Buswaale and Nawanyango) and Cluster 5 (Buswaale). Cluster 1 and 2 remained static and there was a decrease in Cluster 3. Nawanyango decreased in Cluster 3, 4 and 5. For the one HU level II there was a significant decrease in Cluster 3 (the HU does not conduct maternal health services) a slight increase in Cluster 4 (score is low due to no school health and outreach). There is an over-score in Cluster 1 due to additional counseling and HIV testing.

Conclusion: At level III the median degree of completeness improved in Cluster 4 and 5 and is well above All 2006. Cluster 1 and 2 remained static, but are above All 2006 and Cluster 3 has decreased, but is still above All 2006. For level II a median degree of completeness of > 100% in Cluster 1 and of 100% in Cluster 2 and a significant decrease in Cluster 3 and 4 which are both well below All 2006. Cluster 5 remained static and is above All 2006.
The median degree of completeness for the implementation of the MHCP at level II in the Diocese has decreased and is below the results of All 2006. For level III it has slightly increased and is well above the results of All 2006.

9.5 Diocese of Kabale

The Diocese of Kabale has 24 HU, 17 HU at level III and 7 HU level II. One HU did not have comparative data. In the 2006 survey 17 HU increased their score, one remained static and 5 decreased their score.

Table 21: Median Scores and the Median Degrees of Completeness – Diocese of Kabale

2003	II	III	2006	II	III
Median	36/68	56/80	Median	46.5/68	61/80
Degree of completeness	**53%**	**70%**	**Degree of completeness**	**68%**	**76%**
All 2003	**55%**	**70%**	**All 2006**	**68%**	**75%**

Graph 10: Health Units' performance comparison in Diocese of Kabale

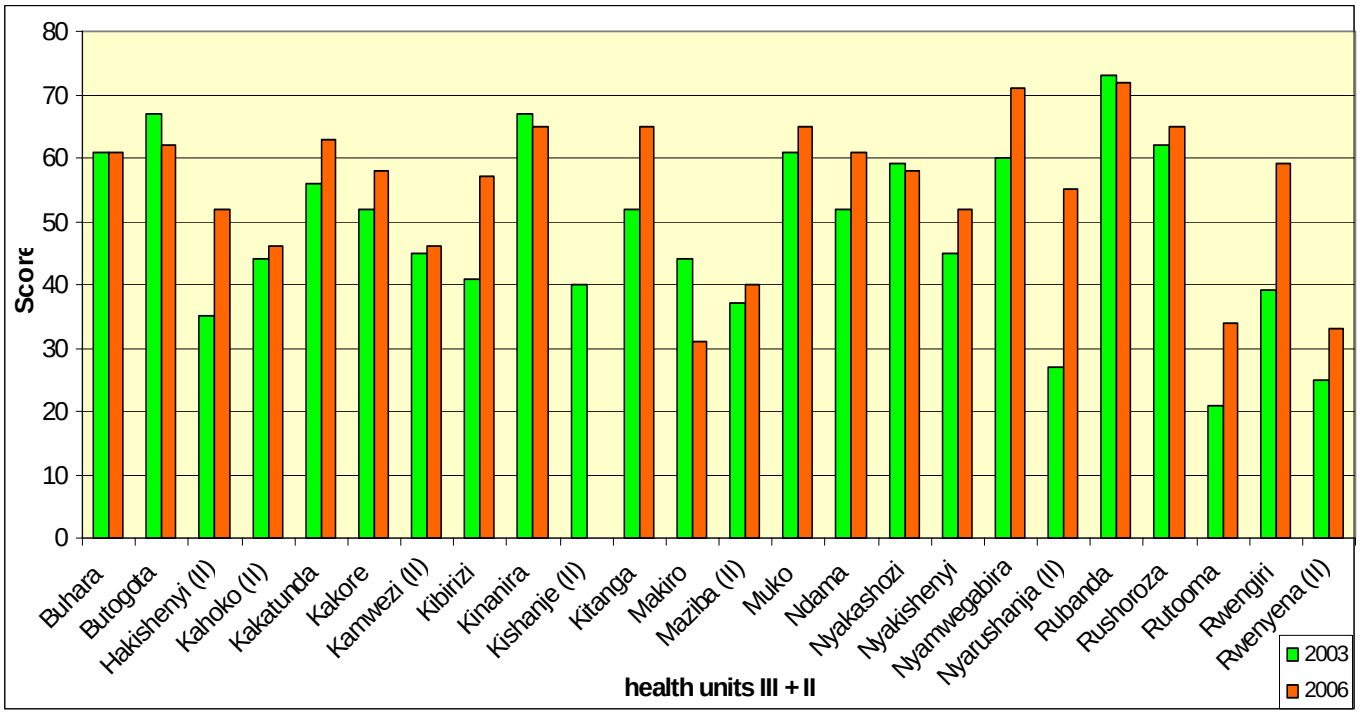


Table 21: Median Scores and the Median Degrees of Completeness – Diocese of Kabale

2003	II	III	2006	II	III
Median	36/68	56/80	Median	46.5/68	61/80
Degree of completeness	**53%**	**70%**	**Degree of completeness**	**68%**	**76%**
All 2003	**55%**	**70%**	**All 2006**	**68%**	**75%**

Table 22: Median Scores and Median Degree of Completeness per major Clusters – Diocese of Kabale

	Comm.Diseases Cluster 1		Child Health Cluster 2		Sex & Rep.H Cluster 3		Public Health Cluster 4		Special Care Cluster 5	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
HU III	14	18	8	8	18	21	16	16	3	2
Degree	**67%**	**87%**	**100%**	**100%**	**75%**	**88%**	**84%**	**84%**	**38%**	**25%**
All 2006		**71%**		**88%**		**80%**		**79%**		**50%**
HU II	11	13	6	7	6	14	10	13	1	1
Degree	**65%**	**76%**	**75%**	**88%**	**38%**	**88%**	**53%**	**68%**	**13%**	**13%**
All 2006		**68%**		**88%**		**53%**		**74%**		**38%**

Table 22 shows that at level III improvement has been made in Cluster 1 (Buhara, Kakatunde, Kitanga, Ndama, Nyakishenyi, Nyamwegabira and Rutooma) and 3 (Kakatunde Kakore, Kibirizi, Kitanga, Ndama, Nyamweg, Nyakashozi and Rwengiri). Cluster 2 (low score in Rutooma) and 4 remained static and Cluster 5 decreased (Kakatunde, Kibirizi, Makiro and Nyakashozi)
At level II improvements have been made in Cluster 1 (Nyarushanja, Maziba and Rwenyeno), Cluster 2 (Nyarushanja), Cluster 3 (Hakishenyi, Nyarushanja and Rwenyeno) and Cluster 4 (Hakishenyi, Kamwezi and Maziba) and Cluster 5 remained static (improvement in Hakishenyi and Kahoko and decrease in Kamwezi, Maziba and Rwanyeno).

Conclusion: At level III the median degrees of completeness improved in Cluster 1 and Cluster 3 and are both above All 2006. Cluster 2 and 4 remained static and are also above All 2006 and Cluster 5 declined and is well below All 2006.
At level II the median degree of completeness has improved in Cluster 1 – 4. The first and third Cluster are above All 2006, Cluster 2 remained static and Cluster 4 and 5 are well below All 2006.
The median degree of completeness for the implementation of the MHCP at level II in the Diocese has improved in comparison to the result of 2003, but remains below the results of All 2006. For level III it has also improved and is just above the results of All 2006.

9.7 Diocese of Kasese

The Diocese of Kasese has 3 HU, 2 are at level III and one HU is at level II. All three HU increased their score.

Table 23: Median Scores and the Median Degrees of Completeness – Diocese of Kasese

2003	II	III	2006	II	III
Median	42/68	56/80	Median	60/68	68/80
Degree of completeness	**62%**	**70%**	**Degree of completeness**	**88%**	**85%**
All 2003	**55%**	**70%**	**All 2006**	**68%**	**75%**

Graph 10: Health Units' performance comparison in Diocese of Kasese

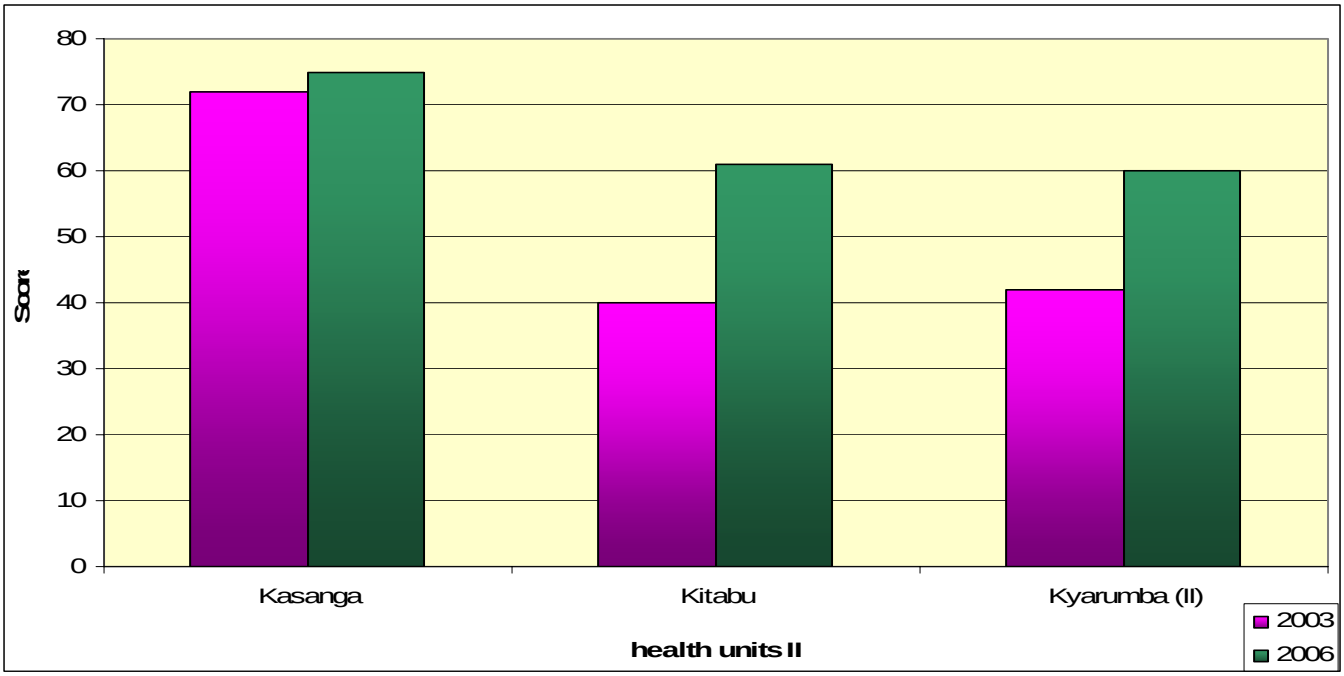


Table 24: Median Scores and Median Degree of Completeness per major Clusters – Diocese of Kasese

	Comm.Diseases Cluster 1		Child Health Cluster 2		Sex & Repr.H Cluster3		Public Health Cluster4		Special Care Cluster 5	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
HU III	14.5	15.5	6.5	8	18.5	21	11.5	17.5	5	6
Degree	**69%**	**74%**	**81%**	**100%**	**77%**	**88%**	**61%**	**92%**	**63%**	**75%**
All 2006		**71%**		**88%**		**80%**		**79%**		**50%**
HU II	10	13	7	7	13	20	10	12	2	8
Degree	**59%**	**77%**	**88%**	**88%**	**81%**	**125%**	**53%**	**63%**	**25%**	**100%**
All 2006		**68%**		**88%**		**53%**		**74%**		**38%**

Table 24 shows that in almost all Clusters and in each of the three HU improvements have been made, particularly in Cluster 3 (all 3 HU) and Cluster 4 (Kitabu). The three HU have each a qualified midwife and conduct each a significant number of deliveries and obstetric care.

Conclusion: At level III the median degree of completeness in all Clusters has improved and is for all Clusters above All 2006. At level II the median degree of completeness has also improved in all Clusters, except Cluster 2, which remained static. Cluster 1 and 3 are well above All 2006 and Cluster 4 is below All 2006.
The median degree of completeness for the implementation of the MHCP at level II in the Diocese has improved and is well above the results of All 2006. For level III it has also improved and is also well above the results of All 2006. Three well functioning health units.

9.8 Diocese of Kampala

The Diocese of Kampala has 18 HU, 11 at level III and 7 at level II. Three HU did not participate in the survey of 2003 and do not have comparative data. All 15 HU increased their score.

Table 25: Median Scores and the Median Degrees of Completeness – Diocese of Kampala

2003	II	III	2006	II	III
Median	33/68	47/80	Median	55/68	61/80
Degree of completeness	**49%**	**59%**	**Degree of completeness**	**81%**	**76%**
All 2003	**55%**	**70%**	**All 2006**	**68%**	**75%**

Graph 11: Health Units' performance comparison in Diocese of Kampala

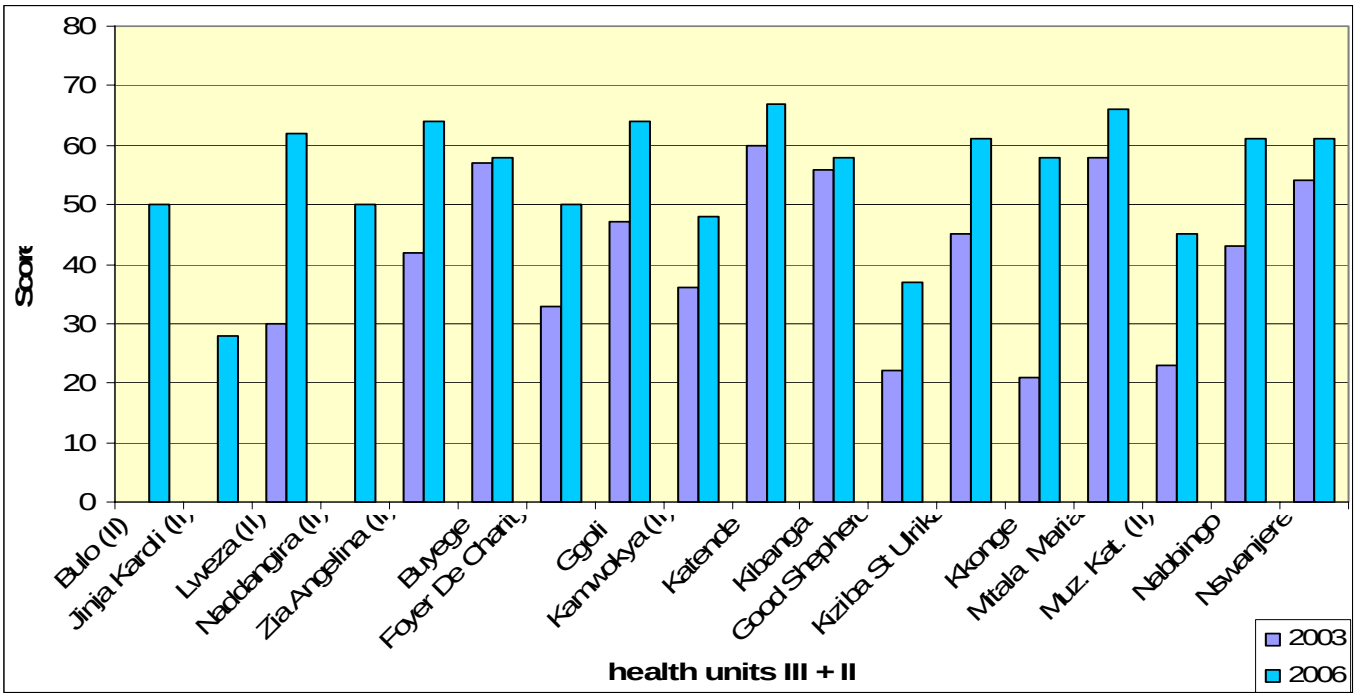


Table 26: Median Scores and Median Degree of Completeness per major Clusters – Diocese of Kampala

	Comm.Diseases Cluster 1		Child Health Cluster 2		Sex & Rep.H Cluster 3		Public Health Cluster 4		Special Care Cluster 5	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
HU III	13	15	6	8	18	19	10	14	1	4
Degree	**62%**	**71%**	**65%**	**100%**	**75%**	**79%**	**53%**	**74%**	**13%**	**50%**
All 2006		**71%**		**88%**		**80%**		**79%**		**50%**
HU II	14	17	6.5	8	1.5	14	6	14	2	3
Degree	**82%**	**100%**	**81%**	**100%**	**9%**	**88%**	**32%**	**74%**	**25%**	**38%**
All 2006		**68%**		**88%**		**53%**		**74%**		**38%**

Table 26 shows that at level III improvement has been made in Cluster 1 (All HU except Kiziba which remained static), Cluster 2 (Good Shepard and Kiziba), Cluster 3 (Foyer Charite, Ggoli, Kiziba, Kkonge and Nswanjere), Cluster 4 (Foyer Charite, Good Shepard, Kkonge and Nabbingo) and Cluster 5 (Ggoli, Good Shepard, Kibanga, Kiziba, Nabbingo and Nswanjero). At level II improvements were made in Cluster 1 (with 2 HU (Kamwokya and Lweza) scoring > 17 due to additional activities as counseling and HIV testing, and Muzinda Katereka), Cluster 2 (Muzinda Katereka) , Cluster 3 (a significant improvement in Lweza, Muz. Kat. And Zia Angelina) Cluster 4 (all HU) and Cluster 5 (all HU)

Conclusion: The median degree of completeness at level III has improved in all Clusters, however, Cluster 1 and 2 are above All 2006, Cluster 3 and Cluster 4 are below the results of All 2006 and Cluster 3 is in line with the results of All 2006.
The median degree of completeness for the implementation of the MHCP at level II in the Diocese has significantly improved and is well above the results of All 2006. For level III it was in 2003 below the median and is now just above the results of All 2006.

9.9 Diocese of Kasana Luweero

The Diocese of Kasana Loweero has 11 HU, all are at level III. Seven HU have increased their score and 4 HU have decreased their score.

Table 27: Median Scores and the Median Degrees of Completeness – Diocese of Kasana Luweero

2003	III	2006	III
Median	56/80	Median	61/80
Degree of completeness	**70%**	**Degree of completeness**	**76%**
All 2003	**70%**	**All 2006**	**75%**

Graph 12: Health Units' performance comparison in Diocese of Kasana Luweero

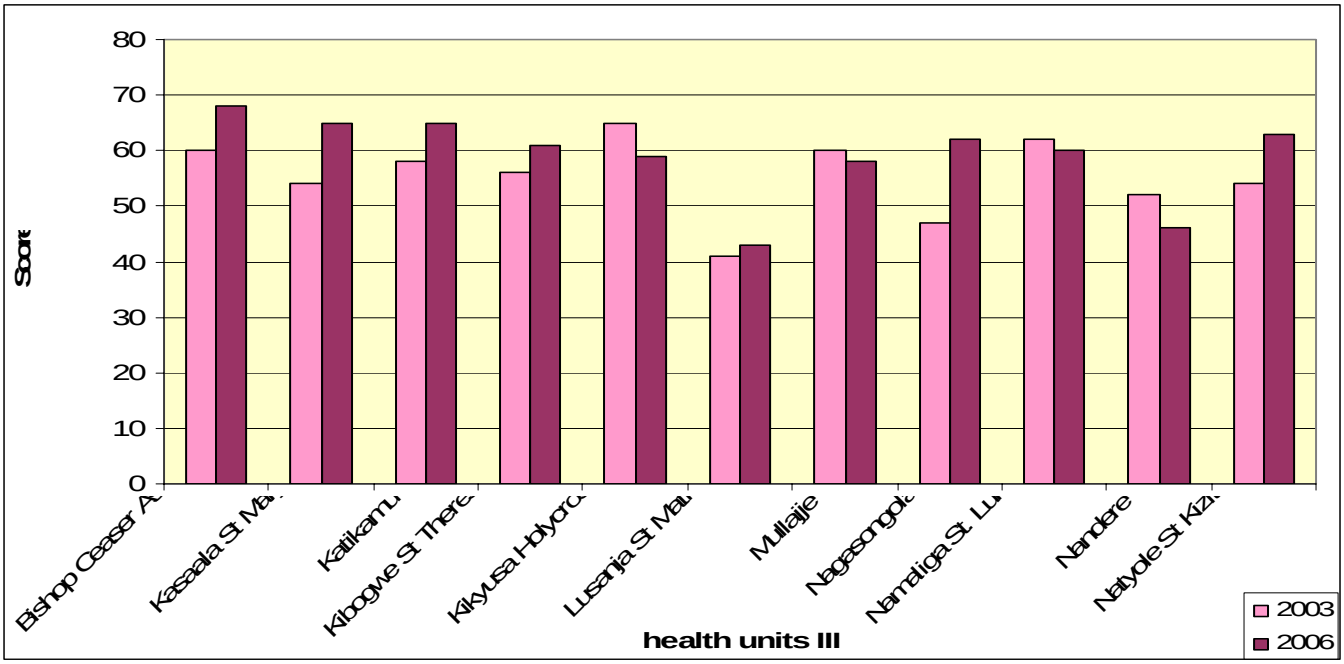


Table 28: Median Scores and Median Degree of Completeness per major Clusters – Diocese of Kasana Luweero

	Comm.Diseases Cluster 1		Child Health Cluster 2		Sex & Rep.H Cluster 3		Public Health Cluster 4		Special Care Cluster 5	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
HU III	14	14	8	8	19	20	12	15	4	4
Degree	**67%**	**67%**	**100%**	**100%**	**79%**	**83%**	**63%**	**79%**	**50%**	**50%**
All 2006		**71%**		**88%**		**80%**		**79%**		**50%**

Table 28 shows that improvement has been made in Cluster 3 (Katikamu, Lusanje and Nakasongola) and Cluster 4 (in practical all HU, but in particular in Bishop Asili, Kasaale, Kikyusa and Nakasongola). The other 3 Clusters remained static.
Three HU (Nakasongola, Lusanja and Natyole), are conducting deliveries and providing obstetric care but do not have a qualified midwife
In Kikyosa and Mulajje and Namaliga the score decreased in Cluster 1, 3 and 5 and in Nandere was a decrease in Cluster 4 and 5.

Conclusion: The median degree of completeness improved in Cluster 3 and 4, the first one is above All 2006 and the latter one is in line with All 2006. Cluster 1, 2 and 5 remained static, of which Cluster 2 is above All 2006 and Cluster 1 and 5 are in line with the results of All 2006.
The median degree of completeness for the implementation of the MHCP in the Diocese has improved and is just above the results of All 2006.

9.10 Diocese of Kiyinda Mytiana

The Diocese of Kiyinda Mytiana has 12 HU, 11 are at level III and 2 are at level II. One HU did not participate in the 2003 survey and does not have comparative data.
In the 2006 survey 8 HU increased their score and 3 decreased their score.

Table 29: Median Scores and the Median Degrees of Completeness – Diocese of Kiyinda Mytiana

2003	II	III	2006	II	III
Median	24/68	54.5/80	Median	56/68	59/80
Degree of completeness	**35%**	**68%**	**Degree of completeness**	**82%**	**74%**
All 2003	**55%**	**70%**	**All 2006**	**68%**	**75%**

Graph 13: Health Units' performance comparison in Diocese of Kiyinda Mytiana

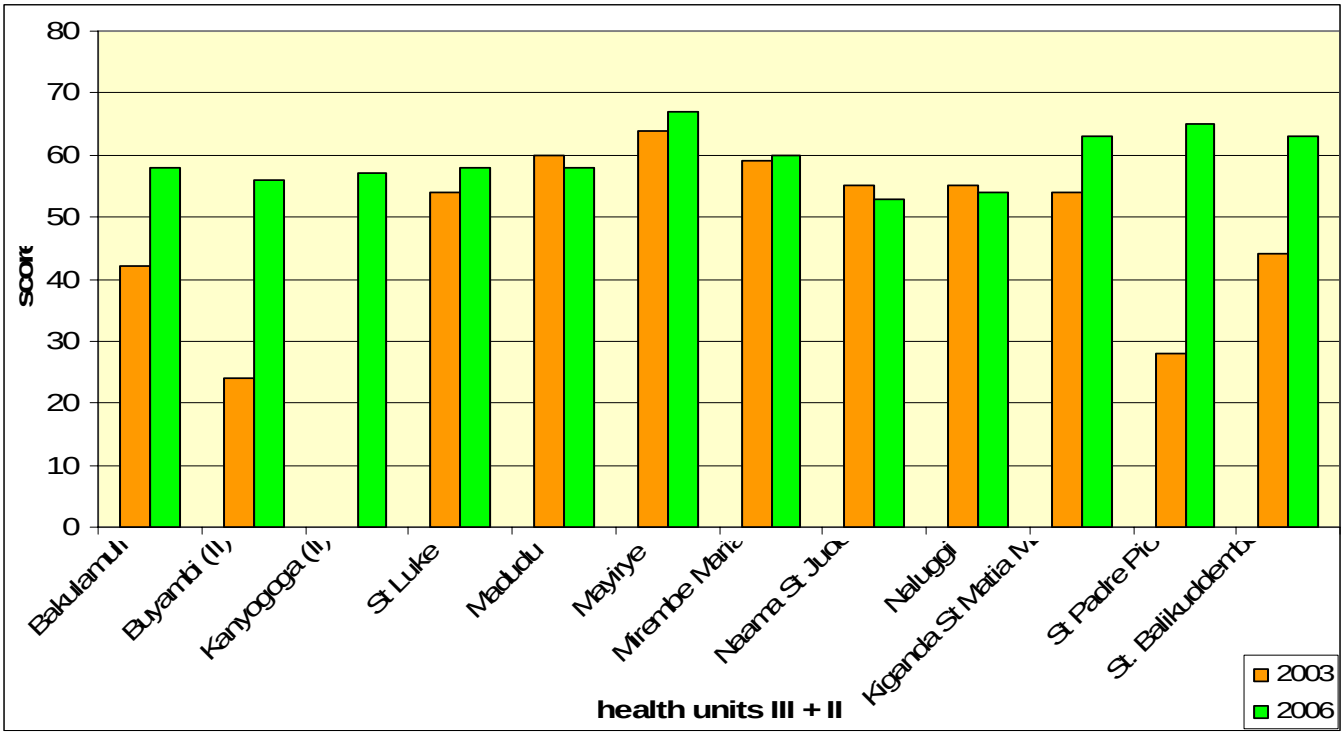


Table 30: Median Scores and Median Degree of Completeness per major Clusters – Diocese of Kiyinda Mytiana

	Comm.Diseases Cluster 1		Child Health Cluster 2		Sex & Repr.H Cluster3		Public Health Cluster4		Special Care Cluster 5	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
HU III	13	15	8	7	16.5	19.5	14	14	3.5	6
Degree	**62%**	**71%**	**100%**	**88%**	**69%**	**81%**	**74%**	**74%**	**44%**	**75%**
All 2006		**71%**		**88%**		**80%**		**79%**		**50%**

Table 30 shows that at level III improvement has been made in Cluster 1 (Padre Pio, Naama St Jude, Naluggi and St. Balikuddembe), Cluster 3 (Bukalamuli, Padre Pio, Kiganda Mayirye, Naluggi, St. Balikuddembe and St Luke), and Cluster 5 (all HU except Naluggi and St. Joseph Madudu). Cluster 2 decreased slightly and Cluster 4 remained static (improvements in Bukalamuli and Padre Pio and decrease in Miremba, Naama St Jude and Naluggi)
At level II (one HU - Buyambi) improvement has been made in all Clusters, but particularly in Cluster 3, this is due to maternal services, including obstetric care. The HU has a qualified midwife.
From the 3 HU with decreased score, Naluggi decreased in Cluster 4 and 5 and the other two (Madudu and Naama St. Jude) had marginal difference in Cluster 3, 4 & 5.

HU II	10	11	4	7	1	22	7	13	2	3
Degree	**59%**	**65%**	**50%**	**88%**	**6%**	**138%**	**37%**	**68%**	**25%**	**38%**
All 2006		**68%**		**88%**		**53%**		**74%**		**38%**

Conclusion: at level III the median degree of completeness has improved in Cluster 1,3 and 5 and are all above All 2006. Cluster 2 decreased but is in line with All 2006 and Cluster 4 remained static, but is below the results of All 2006.
At level II the median degree of completeness has improved in all Clusters and all are above the results of All 2006, except Cluster 2, which remained static.
The median degree of completeness for the implementation of the MHCP at level II in the Diocese has improved significantly from the 2003 survey and is well above the results of All 2006. For level III the median degree of completeness has improved but is slightly below the results of All 2006.

9.11 Diocese of Kotido

The Diocese of Kotido has 5 HU, 4 at level III and one at level II. In the 2006 survey 4 HU increased their score and one HU decreased slightly.

Table 31: Median Scores and the Median Degrees of Completeness – Diocese of Kotido

2003	II	III	2006	II	III
Median	37/68	64.5/80	Median	38/68	68.5/80
Degree of completeness	**54%**	**81%**	**Degree of completeness**	**56%**	**86%**
All 2003	**55%**	**70%**	**All 2006**	**68%**	**75%**

Graph 14: Health Units' performance comparison in Diocese of Kotido

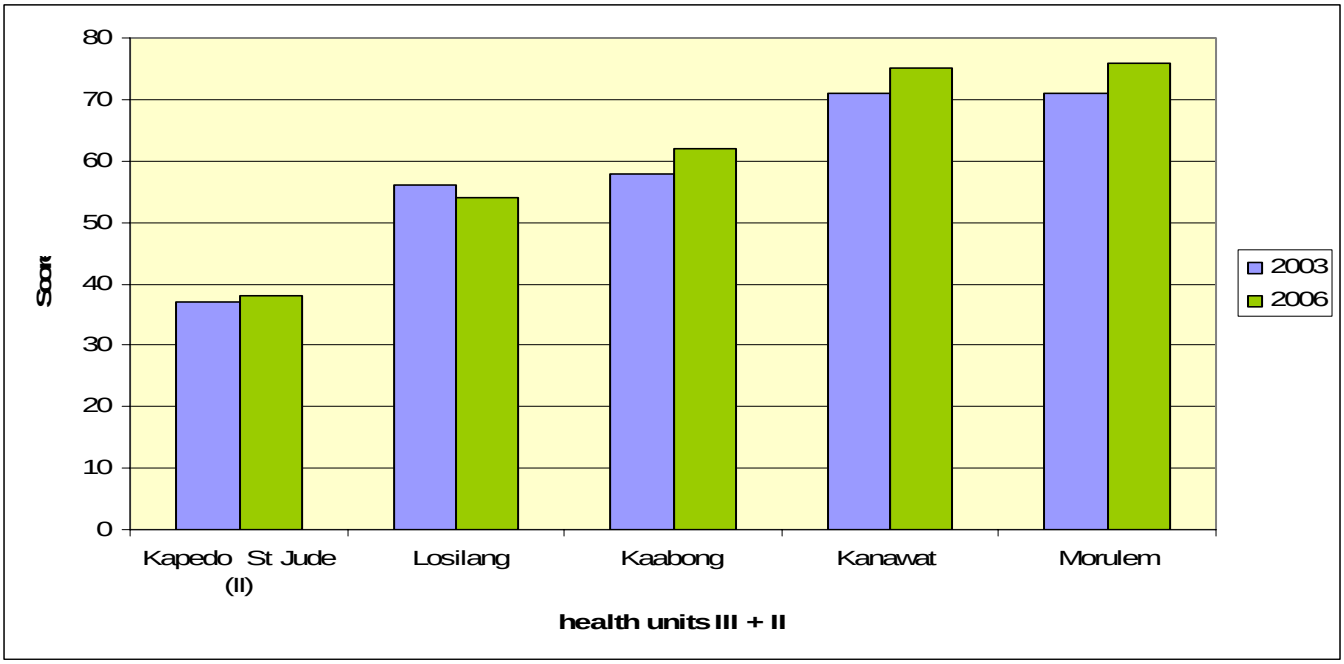


Table 32: Median Scores and Median Degree of Completeness per major Clusters – Diocese of Kotido

	Comm.Diseases Cluster 1		Child Health Cluster 2		Sex & Rep.H Cluster 3		Public Health Cluster 4		Special Care Cluster 5	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
HU III	16	18	8	8	21	20	14	18	5	5.5
Degree	**76%**	**86%**	**100%**	**100%**	**88%**	**83%**	**74%**	**95%**	**63%**	**69%**
All 2006		**71%**		**88%**		**80%**		**79%**		**50%**
HU II	12	12	6	6	5	7	13	13	2	0
Degree	**71%**	**71%**	**75%**	**75%**	**31%**	**44%**	**68%**	**68%**	**25%**	**0%**
All 2006		**68%**		**88%**		**53%**		**74%**		**38%**

Table 32 in the next page shows that at level III improvement has been made in Cluster 1 (all 4 HU), Cluster 4 (all 4 HU, particularly Morulem)) and Cluster 5 (Kabong and Losilang) . Cluster 2 is 100% and has remained static and Cluster 3 (Losilang – no obstetric care) has decreased slightly. At level II improvements were only made in Cluster 3. The other 3 Clusters 1, 2 and 4 remained static and Cluster 5 declined to point 0 of no activity.

Conclusion: at level III the median degree of completeness improved in Cluster 1, 4 and 5 and are all above All 2006. Cluster 2 remained static and is above All 2006 and Cluster 3 decreased and is just above All 2006.
Al level II the median degree of completeness increased only in Cluster 3, but is far below All 2006. Cluster 1, 2, and 3 remained static, the first one is above 2006 and the latter 2 are well below All 2006. In Cluster 5 there is no activity at all.
The median degree of completeness for the implementation of the MHCP in the Diocese at level II has slightly improved, but is still below the results of All 2006. At level III the median degree of completeness has improved and is well above the results of All 2006.

9.12 Diocese of Lira

The Diocese of Lira has 13 HU, 8 HU at level III and 5 HU at level II. Two HU did not participate in the survey of 2003 and do not have comparative data.
10 HU increased their score and one HU decreased its score

Table 33: Median Scores and the Median Degrees of Completeness – Diocese of Lira

2003	II	III	2006	II	III
Median	19/68	49/80	Median	32/68	63/80
Degree of completeness	**28%**	**61%**	**Degree of completeness**	**47%**	**79%**
All 2003	**55%**	**70%**	**All 2006**	**68%**	**75%**

Graph 15: Health Units' performance comparison in Diocese of Lira

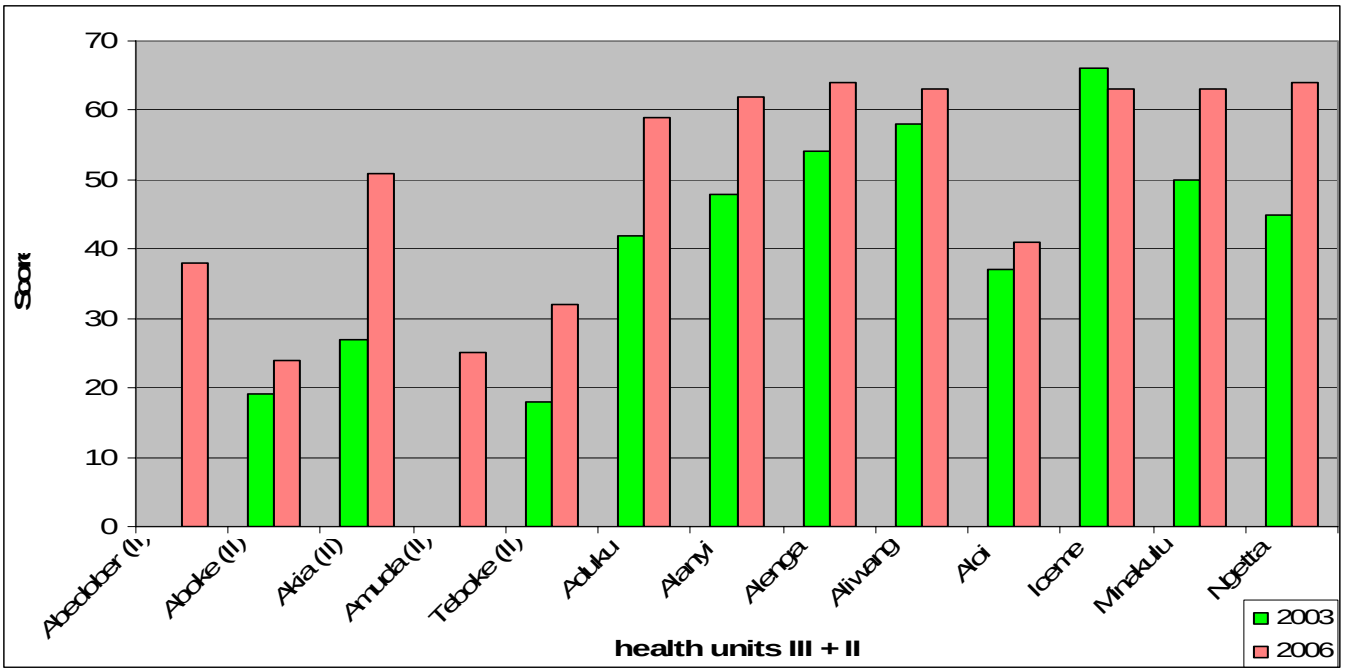


Table 34: Median Scores and Median Degree of Completeness per major Clusters – Diocese of Lira

	Comm.Diseases Cluster 1		Child Health Cluster 2		Sex & Rep.H Cluster 3		Public Health Cluster 4		Special Care Cluster 5	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
HU III	13	15	7.5	7	16.5	19.5	11	16	3	4
Degree	**62%**	**71%**	**94%**	**88%**	**69%**	**81%**	**58%**	**84%**	**38%**	**50%**
All 2006		**71%**		**88%**		**80%**		**79%**		**50%**
HU II	9	13	4	3	1	2	6	14	0	1
Degree	**53%**	**76%**	**50%**	**38%**	**6%**	**13%**	**32%**	**74%**	**0%**	**13%**
All 2006		**68%**		**88%**		**53%**		**74%**		**38%**

Table 34 in the next page shows that at level III improvement has been made in Cluster 1 (Alanyi, Aduku, Ngetta and Minakulu), Cluster 3 (in all HU, except Aloi), Cluster 4 (in all HU except Iceme, which remained static) and Cluster 5 (Alenga, Ngetta and Aliwang). Cluster 2 decreased slightly.
At level II improvement has been made in all Clusters, except Cluster 2, which decreased significantly. A number of aspects in IMCI are not implemented and a number of HU do not have the guidelines.

Conclusion: At level III the median degrees of completeness have improved in Cluster 1, 3, 4 and are all above All 2006. Cluster 5 has also improved and is in line with All 2006. Cluster 2 has decreased but is in line with All 2006.
At level II the median degree of completeness has improved in all Clusters, but only Cluster 1 is above All 2006, Cluster 4 is in line with All 2006. Cluster 2, 3, and 4 have improved but are well below the results of All 2006.
The median degree of completeness for the implementation of the MHCP at level II in the Diocese was in 2003 already below the median of 2003, it has improved slightly but remains well below the results of All 2006. For level III it was also below the median of 2003 it has improved and is now above All 2006.

9.13 Diocese of Lugazi

The Diocese of Lugazi has 8 HU, all at level III. One HU did not participate in the survey of 2003 and does not have comparative data.
In the 2006 survey 4 HU increased their score and 3 HU decreased their score.

Table 35: Median Scores and the Median Degrees of Completeness – Diocese of Lugazi

2003	III	2006	III
Median	51/80	Median	52/80
Degree of completeness	**64%**	**Degree of completeness**	**65%**
All 2003	**70%**	**All 2006**	**75%**

Graph 16: Health Units' performance comparison in Diocese of Lugazi

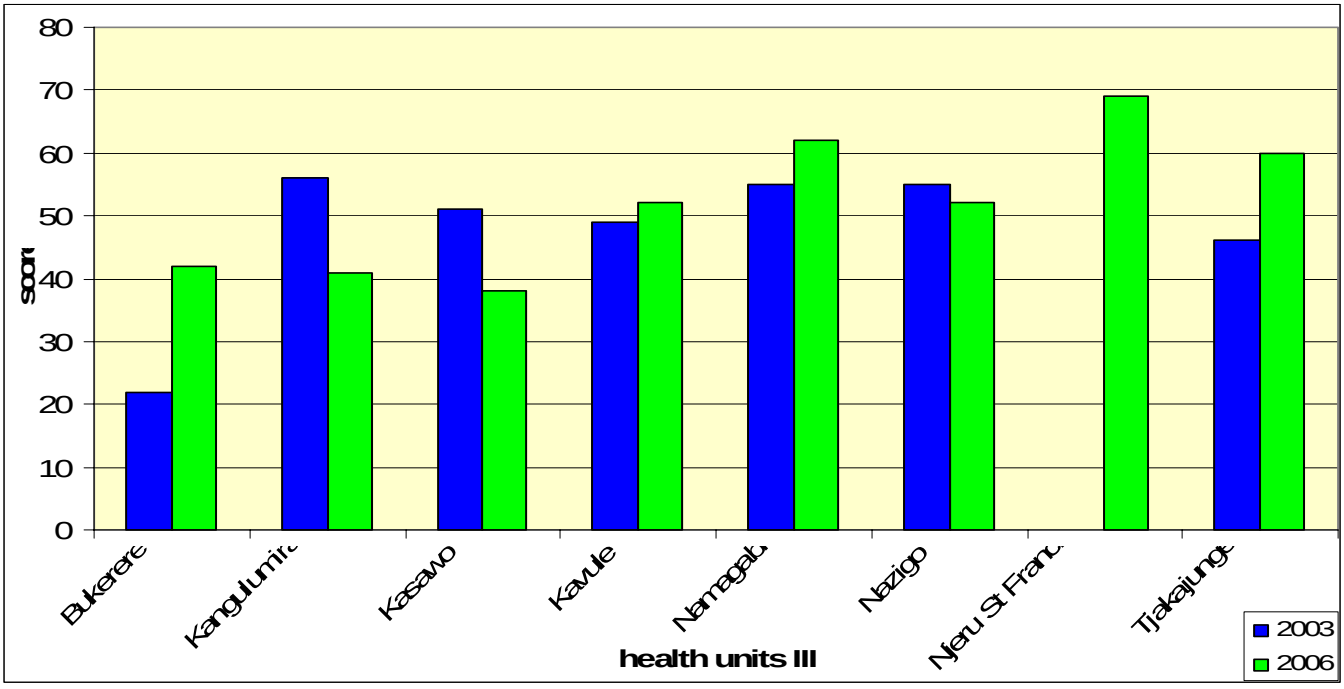


Table 36: Median Scores and Median Degree of Completeness per major Clusters – Diocese of Lugazi

	Comm.Diseases Cluster 1		Child Health Cluster 2		Sex & Rep.H Cluster 3		Public Health Cluster 4		Special Care Cluster 5	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
HU III	12	11	7	8	16	20	12	13	4	3
Degree	**57%**	**52%**	**88%**	**100%**	**67%**	**83%**	**63%**	**68%**	**50%**	**38%**
All 2006		**71%**		**88%**		**80%**		**79%**		**50%**

Table 36 shows that improvement has been made in Cluster 2, Cluster 3 (in all HU, particular Bukerere (improved maternal care), but not in Kasawo and Kangulumira) and Cluster 4 (all HU except Kasawo and Kangulumira).
In Cluster 1 (Kasawo, Namagabi, Nazigo, and Kangulumira) and Cluster 5 (Kavule and Kangulumire) decreased. Both HU Kasawo and Kangulumira decreased in score marginally.

Conclusion: The median degree of completeness improved in Cluster 2, 3 and 4, of which the first two are above the results of All 2006 and Cluster 4 is below the results of All 2006. Cluster 1 and Cluster 5 decreased in score and are well below the results of All 2006.
The median degree of completeness for the implementation of the MHCP in the Diocese has improved very slightly and is well below the results of All 2006.

9.14 Diocese of Masaka

The Diocese of Masaka has 27 HU, 25 at level III and 2 HU at level II. One HU did not participate in the 2003 survey and has no comparative data.
In the 2006 survey 16 HU increased their score, 2 HU remained static and 8 HU decreased in their score.

Table 37: Median Scores and the Median Degrees of Completeness – Diocese of Masaka

2003	II	III	2006	II	III
Median	53.5/68	59.5/80	Median	50/68	61.5/80
Degree of completeness	**79%**	**74%**	**Degree of completeness**	**74%**	**77%**
All 2003	**55%**	**70%**	**All 2006**	**68%**	**75%**

Graph 16: Health Units' performance comparison in Diocese of Masaka

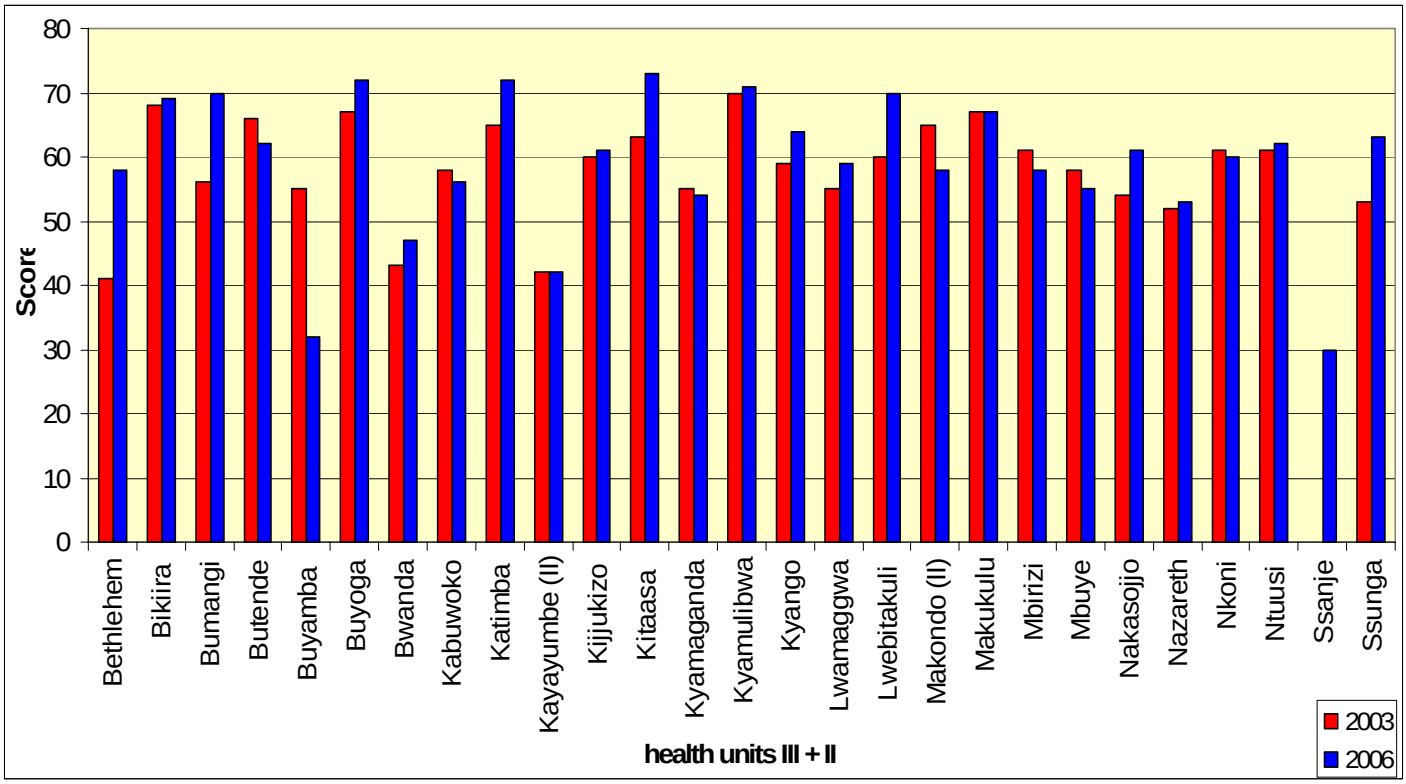


Table 38: Median Scores and Median Degree of Completeness per major Clusters – Diocese of Masaka

	Comm.Diseases Cluster 1		Child Health Cluster 2		Sex & Rep.H Cluster 3		Public Health Cluster 4		Special Care Cluster 5	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
HU III	14	14	8	8	19	19.5	15	16	3	5
Degree	**67%**	**67%**	**100%**	**100%**	**79%**	**81%**	**79%**	**84%**	**38%**	**63%**
All 2006		**71%**		**88%**		**80%**		**79%**		**50%**
HU II	14.5	15	8	7.5	12	6	13.5	15.5	5.5	6
Degree	**85%**	**88%**	**100%**	**94%**	**75%**	**38%**	**71%**	**82%**	**69%**	**75%**
All 2006		**68%**		**88%**		**53%**		**74%**		**38%**

Table 38 shows that at level III improvement has been made in Cluster 3 (Bethlehem, Bumangi, Kitaasa, Lwebitakoli, Mboyo, Nakasojjo, Ntuusi and Ssunga), Cluster 4 (Bethlehem, Bumangi, Buyoga, Bwanda, Katimba, Kitaasa, Lwamaggwa, Nakasojjo and Nkoni) and Cluster 5 (Bumangi, Katimba, Kijukizo, Kyango, Lwamaggwa, Mbirizi, Nazareth, Ntuusi and Ssunga). Cluster 1 and Cluster 2 remained static. (improvement in Cluster 1 in Bethlehem, Bumangi, Kitaasa, Lwebitakulu and Makuku and decrease in Butende and Mbirizi)
For Level II improvement has been made in Cluster 1 (Kayayumbe), Cluster 4 (Kayayumbe and Makondo) and Cluster 5 (Kayayumbe).
There was a decrease in Cluster 2 (Makondo) and Cluster 3 (Kayayumbe and Makondo).
The significant decrease in Buyamba is related to no maternal services.

Conclusion: For level III the median degrees of completeness improved in Cluster 3, 4 and 5 and are all above All 2006. Cluster 1 and 2 remained static, the first one is static with All 2006 and the second is above All 2006. At level II improvement has been made in Cluster 1, 4 and 5 and they are al above All 2006.
The median degree of completeness for the implementation of the MHCP at level II in the Diocese has decreased, but is still above the results of All 2006. For level III it has improved and is above the results of All 2006.

9.15 Diocese of Mbarara

The Diocese of Mbarara has 17 HU, 14 HU level III and 3 HU level II. In the 2006 survey 14 HU increased in their score and 3 HU decreased their score, as presented in the histogram.

Table 39: Median Scores and the Median Degrees of Completeness – Diocese of Mbarara

2003	II	III	2006	II	III
Median	32/68	50/80	Median	49/68	61/80
Degree of completeness	**47%**	**63%**	**Degree of completeness**	**72%**	**76%**
All 2003	**55%**	**70%**	**All 2006**	**68%**	**75%**

Graph 17: Health Units' performance comparison in Diocese of Mbarara

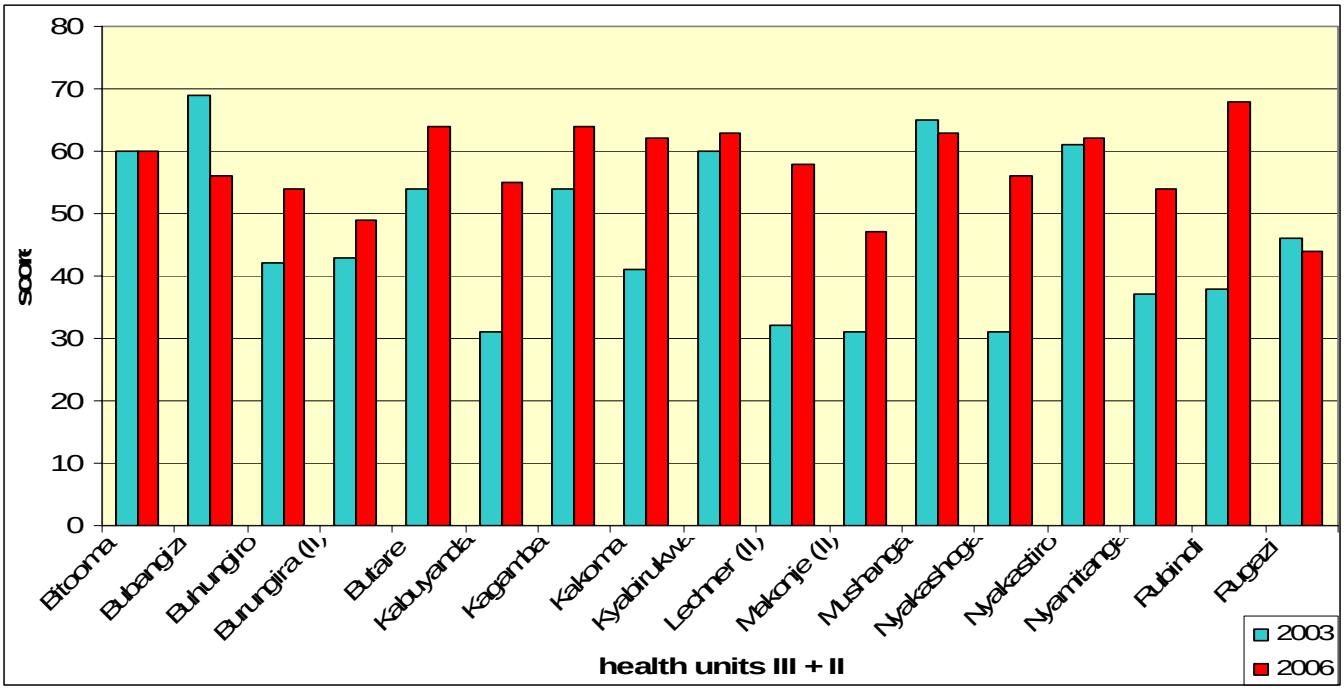


Table 40: Median Scores and Median Degree of Completeness per major Clusters – Diocese of Mbarara

	Comm.Diseases Cluster 1		Child Health Cluster 2		Sex.&Repr.H Cluster3		Public Health Cluster4		Special Care Cluster 5	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
HU III	13	14.5	7.5	7.5	15	20	13	14.5	2.5	4
Degree	**62%**	**69%**	**94%**	**94%**	**63%**	**83%**	**68%**	**76%**	**31%**	**50%**
All 2006		**71%**		**88%**		**80%**		**79%**		**50%**
HU II	11	13	6	8	2	11	8,5	14	5	3
Degree	**65%**	**76%**	**75%**	**100%**	**13%**	**69%**	**68%**	**74%**	**63%**	**38%**
All 2006		**68%**		**88%**		**53%**		**74%**		**38%**

Table 40 shows that at level III improvement has been made in Cluster 1 (Buhungiro, Kakoma, Nyamitanga and Rubindi), Cluster 3 (Butare, Kabuyande, Kagamba. Kakoma, Nyamitanga, Nyakashoga and Rubindi), Cluster 4 (Kabuyanda, Nyamitanga and Rubindi) and Cluster 5 (Buhungiro, Butare, Kabuyanda, Kagamba, Kagoma and Rubindi). Cluster 2 has remained static. Bubangizi decreased significantly in Cluster 1 (TB treatment) and Cluster 4 (school health). The other 2 HU Mushanga and Rugazi only had a marginal difference.
At level II improvement has been made in Cluster 1 (Burungiro, Lechner) Cluster 2 (Makonje) Cluster 3 (Lechner and Makonje) Cluster 4 (Lechner and Makonje) and Cluster 5 (Makonje) decreased.

Conclusion: At level III the median degree of completeness improved in Cluster1, 3, 4 and 5, of these Cluster 1 and 3 are above All 2006, Cluster 4 is below All 2006 and Cluster is in line with the results of All 2006. Cluster 2 remained static and is above All 2006.
At level II the median degree of completeness improved in Cluster 1-4, of these Cluster 1,2 and 3 are above All 2006 and Cluster 4 is in line with All 2006 and Cluster 5 decreased but is in line with All 2006.
The median degree of completeness for the implementation of the MHCP at level II in the Diocese has significantly improved and is just above the results of All 2006, At level III it has also improved and is just above the results of All 2006.

9.16 Diocese of Moroto

The Diocese of Moroto has 7 HU, 6 at level III and one at level II.
In the 2006 survey 5 HU increased their score and 2 HU decreased their score.

Table 41: Median Scores and the Median Degrees of Completeness – Diocese of Moroto

2003	II	III	2006	II	III
Median	38/68	41.5/80	Median	35/68	59/80
Degree of completeness	**56%**	**52%**	**Degree of completeness**	**51%**	**74%**
All 2003	**55%**	**70%**	**All 2006**	**68%**	**75%**

Graph 18: Health Units' performance comparison in Diocese of Moroto

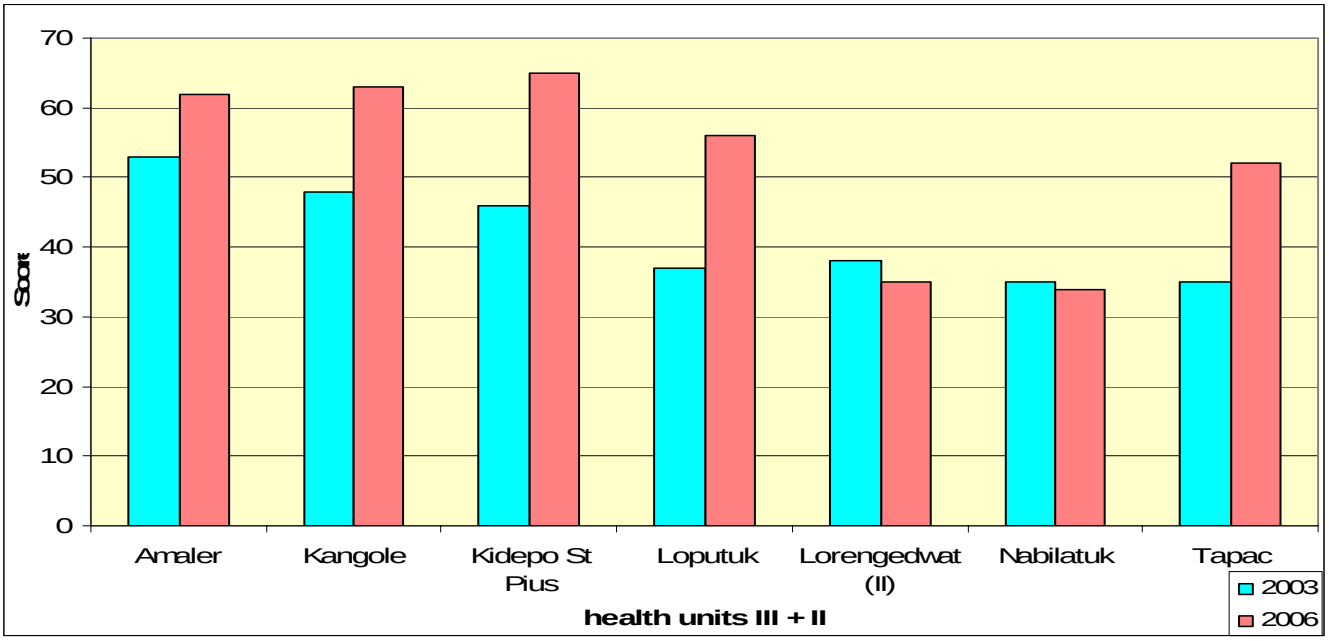


Table 42: Median Scores and Median Degree of Completeness per major Clusters – Diocese of Moroto

	Comm.Diseases Cluster 1		Child Health Cluster 2		Sex & Rep.H Cluster 3		Public Health Cluster 4		Special Care Cluster 5	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
HU III	11	15.5	7	7.5	13.5	17.5	11	15	1	1.5
Degree	**52%**	**74%**	**88%**	**94%**	**56%**	**73%**	**58%**	**79%**	**13%**	**19%**
All 2006		**71%**		**88%**		**80%**		**79%**		**50%**
HU II	11	13	7	8	9	0	10	14	1	0
Degree	**65%**	**76%**	**88%**	**100%**	**56%**	**0%**	**53%**	**74%**	**13%**	**0%**
All 2006		**68%**		**88%**		**53%**		**74%**		**38%**

Table 42 shows that at level III improvement has been made in Cluster 1 (in all HU, particular in Loputuk, Nabilatuk, Kidepo and Tapac), Cluster 2, Cluster 3 (all HU except Nabilatuk – no maternal service)), Cluster 4 (all HU, particular Kangole) and Cluster 5 (Loputuk).
At level II (one HU only) improvement has been made in Cluster 1, Cluster 2, and Cluster 4. In Cluster 3 and Cluster 5 there is a result of 0 point of action.

Conclusion: At level III median degree of completeness improved in all Clusters. Cluster 1 and Cluster 2 are above All 2006, Cluster 4 is in line with All 2006 and Cluster 3 and Cluster 5 are well below the results of All 2006.
The median degree of completeness for the implementation of the MHCP at level II in the Diocese has decreased and is well below the results of All 2006. For level III it has improved but is still below the results of All 2006.

9.17 Diocese of Nebbi

The Diocese of Nebbi has 4 HU, all are at level III. In the 2006 survey all 4 HU increased their score.

Table 43: Median Scores and the Median Degrees of Completeness – Diocese of Nebbi

2003	III	2006	III
Median	47/80	Median	60/80
Degree of completeness	**59%**	**Degree of completeness**	**75%**
All 2003	**70%**	**All 2006**	**75%**

Graph 19: Health Units' performance comparison in Diocese of Nebbi

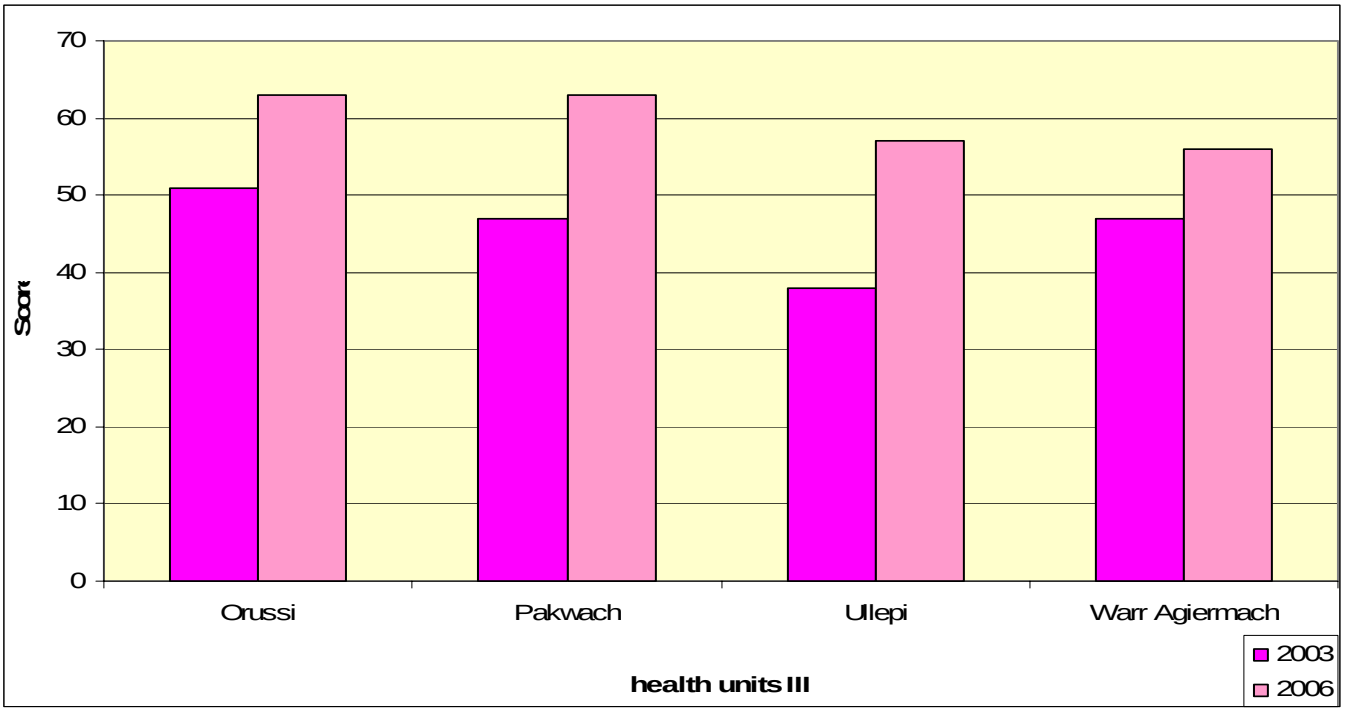


Table 44: Median Scores and Median Degree of Completeness per major Clusters – Diocese of Nebbi

	CommDiseases Cluster 1		Child Health Cluster 2		Sex & Rep.H Cluster 3		Public Health Cluster 4		Special Care Cluster 5	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
HU III	11.5	17	6	8	16.5	18	8	12.5	4.5	6
Degree	**55%**	**81%**	**75%**	**100%**	**69%**	**75%**	**42%**	**66%**	**56%**	**75%**
All 2006		**71%**		**88%**		**80%**		**79%**		**50%**

Table 44 shows that improvement has been made in all Clusters in all HU, except in Cluster 3 in Uleppi.

Conclusion: The median degree of completeness has improved in all Clusters of which Cluster 1, 2 and 5 are above the results of All 2006, and Cluster 3 and 4 are below the results of All 2006.
The median degree of completeness for the implementation of the MHCP in the Diocese has improved and is in line with the results of All 2006.

9.18 Diocese of Soroti

The Diocese of Soroti has 14 HU, 11 HU at level III and 3 HU at level II. One HU did not participate in the survey of 2003 and does not have comparative data.
In the 2006 survey 10 HU increased their score and 3 HU decreased their score.

Table 45: Median Scores and the Median Degrees of Completeness – Diocese of Soroti

2003	II	III	2006	II	III
Median	30/68	51/80	Median	45/68	57/80
Degree of completeness	**44%**	**64%**	**Degree of completeness**	**66%**	**71%**
All 2003	**55%**	**70%**	**All 2006**	**68%**	**75%**

Graph 20: Health Units' performance comparison in Diocese of Soroti

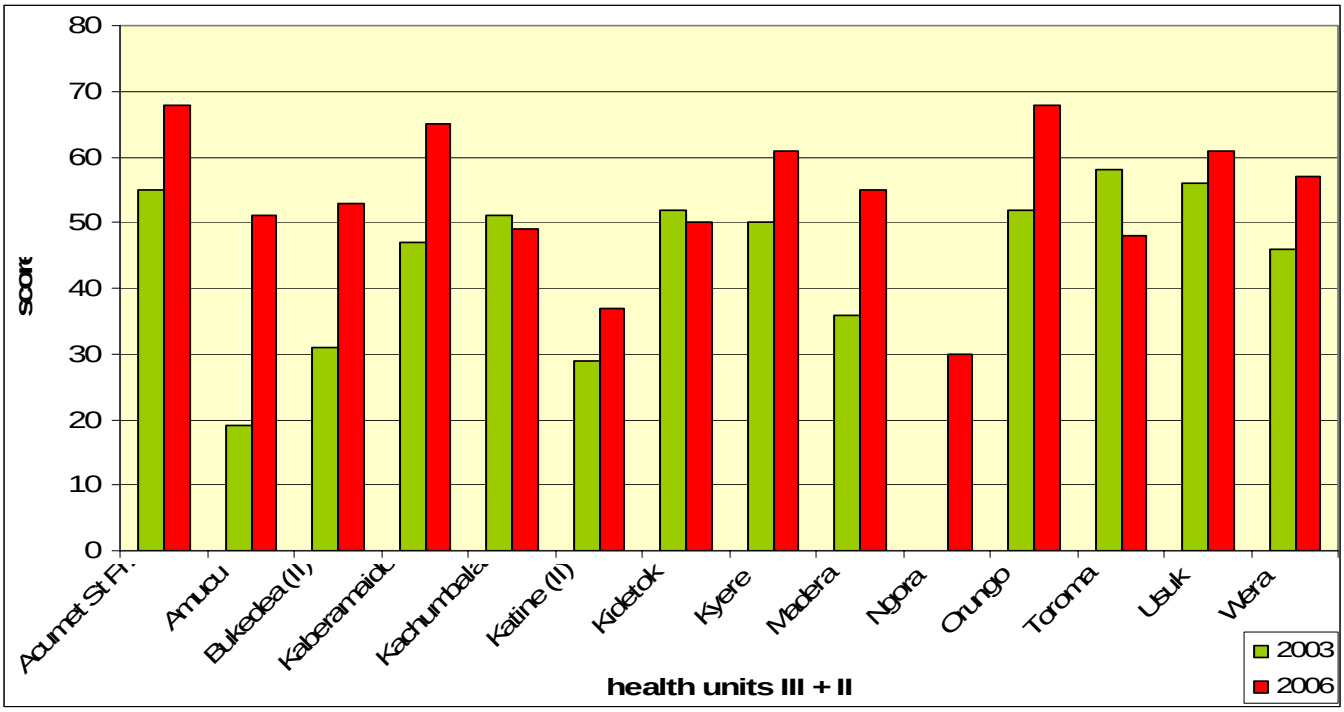


Table 46: Median Scores and Median Degree of Completeness per major Clusters – Diocese of Soroti

	Comm.Diseases Cluster 1		Child Health Cluster 2		Sex & Rep.H Cluster 3		Public Health Cluster 4		Special Care Cluster 5	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
HU III	13	15	7	7	17	20	10	13	3	3
Degree	**62%**	**71%**	**88%**	**88%**	**71%**	**83%**	**53%**	**68%**	**38%**	**38%**
All 2006		**71%**		**88%**		**80%**		**79%**		**50%**
HU II	10.5	14.5	8	7.5	2	5	8.5	15.0	1	3
Degree	**62%**	**85%**	**100%**	**94%**	**13%**	**31%**	**45%**	**79%**	**13%**	**38%**
All 2006		**68%**		**88%**		**53%**		**74%**		**38%**

Table 46 shows that at level III improvement has been made in Cluster 1 (Amucu, Orungo, Usuk and Wera), Cluster 3 (in all HU, particular AmucuKyere and Madera) and Cluster 4 (Acumet, Amucu, Kaberamaido, Madera, Orungo and Wera) Cluster 2 and Cluster 5 remained static. At level II improvement has been made

in Cluster 1 (Bukedea and Katine), Cluster 3 (Bukedea), Cluster 4 (Bukedea and Katine and Cluster 5 (Bukedea and Katine). Only Cluster 2 decreased (Katine).

Conclusion: At level III median degree of completeness improved in Cluster 1, 3 and 4. The first and Cluster 3 are above All 2006, Cluster 2 and 5 have remained static, the first one is in line with All 2006 and the latter is well below the results of All 2006. At level II the median degree of completeness improved in Cluster 1, 3, 4 and 5 of which the first and Cluster 4 are above the results of All 2006 and Cluster 3 and 5 are well below the results of All 2006.

The median degree of completeness for the implementation of the MHCP at level II in the Diocese has improved significantly but is far below the results of All 2006.
For level III the median degree of completeness has also increased, but is below the results of All 2006. was in 2003 below the median and is in now in line with the results of All 2006.

9.19 Diocese of Tororo

The Diocese of Tororo has 16 HU, 13 HU at level III and 3 HU at level II. Three HU did not participate in the survey of 2003 and do not have comparative data. Seven HU have increased their score and 5 HU decreased their score

Table 47: Median Scores and the Median Degrees of Completeness – Diocese of Tororo

2003	II	III	2006	II	III
Median	37/68	54/80	Median	36/68	44.5/80
Degree of completeness	**54%**	**68%**	**Degree of completeness**	**53%**	**56%**
All 2003	**55%**	**70%**	**All 2006**	**68%**	**75%**

Graph 21: Health Units' performance comparison in Diocese of Tororo

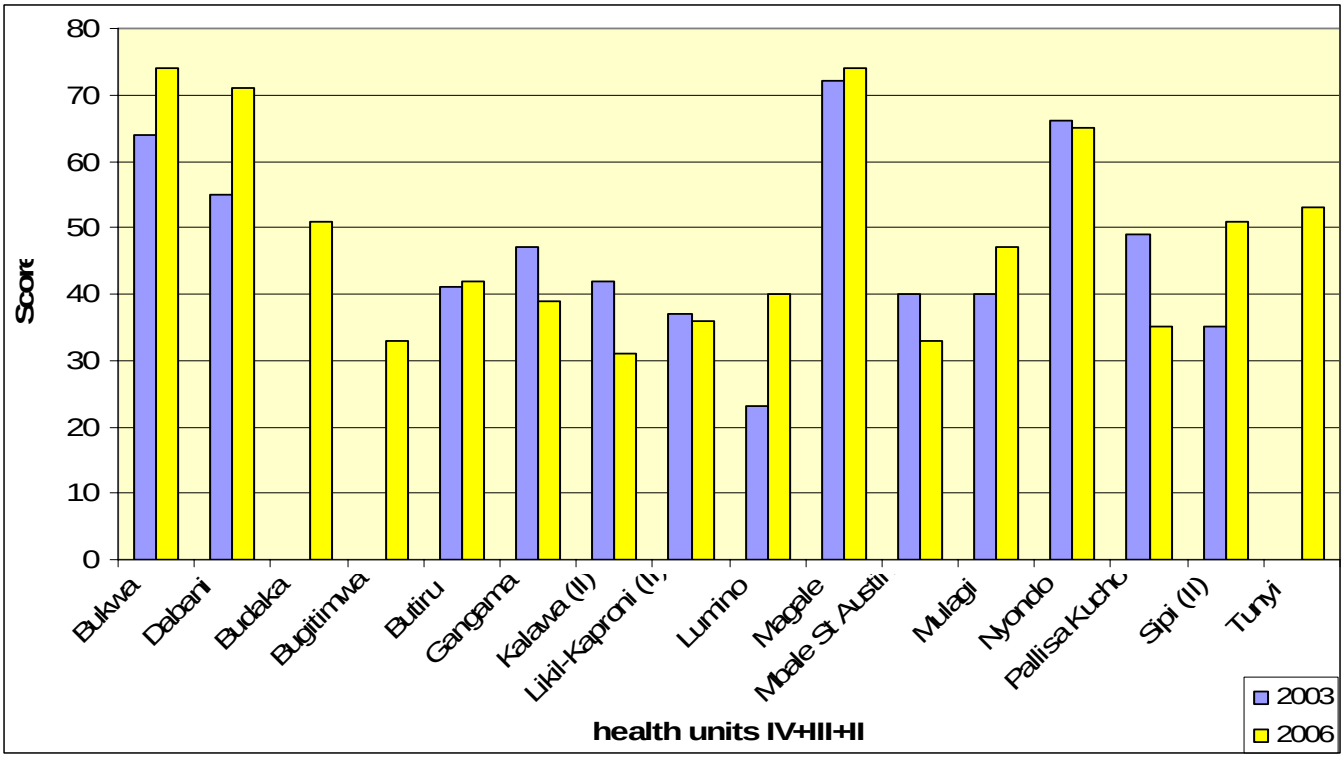


Table 48: Median Scores and Median Degree of Completeness per major Clusters – Diocese of Tororo

	Comm.Diseases Cluster 1		Child Health Cluster 2		Sex & Rep.H Cluster 3		Public Health Cluster 4		Special Care Cluster 5	
	2003	2006	2003	2006	2003	2006	2003	2006	2003	2006
HU III	11.5	12.5	8	7	15.5	14.5	13	14.5	3.5	2.5
Degree	**55%**	**60%**	**100%**	**88%**	**65%**	**60%**	**68%**	**76%**	**44%**	**31%**
All 2006		**71%**		**88%**		**80%**		**79%**		**50%**
HU II	9	12	8	6	10	7	12	11	4	1
Degree	**53%**	**71%**	**100%**	**75%**	**63%**	**44%**	**63%**	**58%**	**50%**	**13%**
All 2006		**68%**		**88%**		**53%**		**74%**		**38%**

Table 48 (next page) shows that at level III improvement has been made in Cluster 1 (Dabani, Lumino and Palisso) and in Cluster 4 (Bukwa, Gangama, Lumino, Lourdes and Palisso)
Cluster 2 (Palisso), Cluster 3 (Gangama, Palisso and St. Austin) and Cluster 5 (Butiru,Gangama, Lady of Lourdes, Palisso and Nyondo) decreased.
At level II only Cluster 1 (Likil and Sipi) improved, the other Clusters all decreased: Cluster 2 (Kalawa and Sipi), Cluster 3 (Likil), Cluster 4 (Kalawa and Likil) and Cluster 5 (Kalawa and Likil).

Conclusion: At level III the median degree of completeness improved in Cluster 1 and 4, but remained well below the results of 2006. In Cluster 2, 3 and 5 the median degree of completeness decreased and only Cluster 2 remains in line with All 2006, the other two Clusters are well below the results of All 2006.
At level II the median degree of completeness improved only in Cluster 1 and is above the results of 2006, the other Clusters decreased and were all well below the results of All 2006.
The median degree of completeness for the implementation of the MHCP at level II in the Diocese has decreased is far below the results of All 2006. For level III it also decreased and is also far below the results of All 2006.

10 Conclusion of the comparison between the results of the 2003 and 2006 survey per Dioceses

The comparative analysis per Diocese shows at level II an improvement in the median degree of completeness in 14/19 Dioceses and at level III an improvement in 18/19 Dioceses. The only Diocese that decreased at both levels is the Diocese of Tororo.

The median degree of completeness per Cluster at level II

Cluster one: 14/15 Dioceses above results of All 2006 and one (Hoima) below.
Cluster two: 8/15 Diocese above results of All 2006, 4/15 in line with All 2006 and 3/15 (Kotido, Lira and Tororo) below All 2006.
Cluster three: 7/15 Dioceses above results of All 2006 and 8/15 below All 2006 (Gulu, Jinja, Kotido, Lira, Masaka, Moroto, Soroti and Tororo)
Cluster four: 4/15 Dioceses above results of All 2006; 5/15 in line with results of All 2006 and 6/15 below results of All 2006 (Jinja, Kabale, Kasese, Kiy. Mit, Kotido and Tororo)
Cluster five: 6/15 Dioceses above results of All 2006, 4/15 in line with All 2006 and 5/15 Dioceses below the results of All 2006. (Kabale, Kotido, Lira, Moroto and Tororo)

The median degree of completeness per Cluster at level III

Cluster one 8/19 Dioceses above the results of All 2006, 4/19 in line with All 2006 and 7/19 below results of All 2006 (Fort Portal, Hoima, Kasana Luweero, Lugazi, Masaka and Tororo)
Cluster two 12/19 Dioceses above results of All 2006 and 7/19 in line with All 2006
Cluster three 13/19 Dioceses above results of All 2006, 6/19 Dioceses below All 2006 (Fort Portal, Hoima, Kampala, Moroto, Nebbi and Tororo)
Cluster four 6/19 Dioceses above results of All 2006, 3/19 in line with All 2006 and 10/19 Dioceses below the results of All 2006 (Arua, Gulu, Hoima, Kampala, Kiy. Mit, Lugazi, Mbarara, Nebbi, Soroti and Tororo)
Cluster five 7/19 Dioceses above results of All 2006, 6/19 in line with All 2006 and 6/19 below results of All 2006 (Hoima, Kabale, Lugazi, Moroto, Soroti and Tororo.

ANNEXES

Annex 1
List of parameters of the Minimum Health Care Package for Health Units II and III

Control of Communicable Diseases			
Malaria			
	HC	**Parameter**	**Description**
1	II III	National treatment guidelines available	Edition 2002 including poster (occasionally laminated) and booklet from the National Malaria Control Programme and/or new treatment guidelines of 2005.
2	II III	Referral procedures in place	Number of cases referred during past month or an indication when cases are being referred
3	II III	Malaria preventive activities conducted	Health education with preventive measures & promotion of treated bed-nets. Selling of bed-nets.
4	II III	Case follow up where indicated	Patients are requested to come back after a number of days, the condition is assessed and if necessary a laboratory test is conducted and/or second line drugs are provided. Patients pay for the new second line drugs and the laboratory tests.
STI/HIV/AIDS			
1	II III	STI treatment guidelines available	Poster with syndromatic treatment of STIs from the Ministry of Health available at HU.
2	II III	Partner included in treatment of STIs	Obligatory or advised
3	II III	HIV/AIDS preventive activities conducted	Health Education, VTC, Drama Clusters, Home-visiting
4	III	Counselling services provided	Counselling of clients who want to know their HIV status.
5	III	HIV testing provided	Laboratory staff trained and test kits available or drawing blood from clients and having blood tested elsewhere.
6	III	Staff trained in VCT	Trained by formal institution: Taso, AIC, Mildmay, Ardo, Hospital or Districts.
TB & Leprosy			
1	II III	TB patients treated	Mandate and drugs received from HSD and/or District Office.
2	II III	Staff trained in diagnosing and treatment of TB	Trained by respective district.
3	III II	Focal point for DOTS implementation	Direct to community providers or for HC III as a storage to HC II
4	III	Leprosy patients treated	Mandate and drugs provided by district
Integrated Management of Childhood Illness			
1	II	IMCI guidelines available at	Poster (laminated) or booklet available.

	III	HU	
2	II III	Immunisation conducted	Immunisation on daily basis or on fixed days per week. Cold chain equipment established in health unit or vaccines are collected from the nearest source.
3	II III	Functioning ORT corner available	Jug with cups available and ORS prepared on a daily basis
4	II III	Growth monitoring conducted	Weighing scale available and weight indicated on Road to Health Card of each child.
5	II III	Vitamin A supplementation distributed	During immunisation sessions
6	II III	Nutrition education and promotion provided	Including breast feeding and balanced diet
7	II III	Case management of malaria conducted	According to national guidelines
8	II III	Case management of ARI conducted	According to national guidelines
Sexual and Reproductive Health			
Antenatal care + unexpected deliveries			
1	II III	Pregnant women are registered and examined	Registration according to set guidelines of MoH.
2	II III	High risk in pregnancy identified and referred	High risk cases registered in registration book
3	II III	Good nutrition promoted during pregnancy	Balanced diet
4	II III	Iron and folic acid distributed	According to national guidelines
5	II III	TT vaccination provided	According to national guidelines
6	II III	Intermittent Presumptive Treatment (IPT) provided	Guidelines available
7	II III	Referral system in place	Access to ambulance or possibility to call hospital by radio.
8	II	Unexpected deliveries are conducted	In HC II
Obstetric Care			
1	III	Deliveries conducted	Delivery bed available and minimum equipment present: foetal scope, suction, weighing scale
2	III	Management of minor obstetric emergencies according to Life Saving Skills Guidelines	Ergometrine, IV fluids
3	III	Obstetric emergencies of	Referral to nearest higher-level facility.

		mother and newborn baby referred.	
4	I I I	Resuscitation of the new born baby	Basic equipment preferably in place: suction and ambu-bag
5	I I I	Care of the new born baby (BCG, OPV 0 and tetracycline eye ointment)	Vaccination and ointment provided immediately after birth and prior to departure
6	I I I	Post abortion care including manual vacuum aspiration for incomplete abortions conducted	Appropriate equipment available
7	I I I	Concurrent illness of the mother treated	
8	I I I	Maternal & peri-natal mortality review meetings conducted	Meetings with all staff involved
Postnatal Care			
1	I I I I I	12 steps of successful breast feeding promoted	Poster available and/or HU provides health education and promotes breast feeding.
2	I I I I I	Vitamin A supplementation provided to mothers 6 weeks after delivery	Or distributed immediately after birth.
3	I I I I I	Babies are weighed and examined during post natal care	
4	I I I I I	Complications of mother during post natal services identified	Including STIs
5	I I I	Cervical examination conducted when required	Aided or visual inspection
Family Planning Services			
1	I I I I I	Modern family planning services provided	Selected pills and condoms.
2	I I I I I	Natural family planning services provided	Knowledge about natural family planning available.
3	I I I I I	Health education and information about modern family planning services provided	Referral to where services are being provided
Violence against Women			
1	I I I I I	Treatment & counselling of women confronted with violence	Physical treatment, pain relief and counselling (if possible both partners) and refer when required.

2	I I I I I	Follow-up on legal procedures for women	Report to local authorities
Adolescent Reproductive Health			
1	I I I I I	Integrated Adolescent Reproductive Health provided	Includes: FP, treatment of STIs, health education about preventive measures HIV/AIDS, counselling, ANC and TT vaccination. Services provided to individuals, Clusters and/or at schools.
Environmental Health			
1	I I I I I	Promotion of hygiene practices at household level	Hand washing, promotion of latrines, garbage collection
2	I I I I I	Promotion of hygiene practices in public institutions and places	Markets, shops, schools
3	I I I I I	Control of mosquito breeding sites and vector control measures	Health education, spraying
4	I I I I I	Activities to improve access to safe water	Health education, construction of wells, access to water
Health Education			
1	I I I I I	Dissemination of key health messages	Immunisation, hygiene, reproductive health, nutrition, mental health, sanitation
School Health			
1	I I I	Promotion of hygiene and healthy lifestyle at school	Sanitation messages and prevention of STIs/HIV/AIDS
2	I I I	Supervision of latrines and water facilities at the schools	
3	I I I	Medical examination of school children conducted	Parade or referral of the sick and/or examination of girls in case of pregnancy
4	I I I	TT vaccination at schools provided	To girls from 14 years and older
Epidemics & Disaster Prevention, Preparedness and Response			
1	I I I I I	Submission of notifiable surveillance report to HSD	On a weekly basis
2	I I I I I	Reserve stock of drugs in place	In case of outbreaks (malaria, diarrhoea)
Nutrition			
1	I I I I I	Demonstration gardens established	Within compound of HU, emphasis on vegetables.
2	I I	Demonstration on	Cooking at HU or demonstration with posters and/

	I I I	preparation of nutritious meals conducted	vegetables
Interventions against diseases targeted for Eradication			
4	I I I I I	Diseases targeted for Eradication known	Knows at least 1-2 diseases
4	I I I I I	Information about these diseases available.	Information available of at least one disease (polio)
3	I I I I I	Collaboration with community for control measures	With Parish Development Committee or with the LC office
Integrated outreaches			
4	I I I I I	Outreaches in catchment area conducted	Services provided are: immunisation, health education, anc, growth monitoring
Mental Health			
4	I I I I I	Cases of mental health problems identified	HU provides first aid and refers.
2	I I I I I	Patients with epilepsy treated	Drugs available and patients registered
3	I I I I I	Health education to the community on mental health issues provided	On stigmatisation and how community should respond to mental health cases
Clinical Care			
1	I I I I I	National treatment guidelines available	Treatment guidelines 1993 or 2003 available
2	I I I I I	Basic interventions for patients with major injuries provided	IV fluids, immobilisation of fractures, control bleeding, control pain, dress wounds and suture wounds.
3	I I I I I	Access to transport for referral of emergency cases	Ambulance available or access to a vehicle.
4	I I I I I	Referral letter provided when required	National format of referral letter of MoH or with the heading from the HU or just a blanc note.
Disabilities and Rehabilitative Health			
1	I I I I I	Patients with disabilities identified	Patients receive first aid and are referred to the hospital or to specific centres.
2	I I I I I	Follow-up on patients with disabilities in the community	Regular re-visit at OPD or special clinic.
Palliative Care			
1	I I I I I	Palliative care services known	Knows what palliative care is and has heard of Hospice Uganda
2	I I I	Clients for palliative	Through a mobile team of Hospice Uganda or refers

		services identified and referred.	patients to the hospital
3	I I I	Staff have received training in Palliative Care	By Hospice Uganda or by the District
Oral/Dental Care			
1	I I I I I	Pain relief for patients with dental problems provided	
2	I I I I I	Health education on oral health provided	
3	I I I I I	Simple extractions conducted	Equipment available. Dentist consultancy

Annex 2
Results of scores per level Health Unit II and III

Health Unit Level I I

Control Communicable Diseases and Clinical Care – 19 points	points	HU II
12 – 15	3	
11 – 12	**1**	**IQR – 2**
10 – 11	**1**	
8 – 10	2	

Median degree of completeness = 11/19 – 58%

Control Communicable Diseases and Clinical Care – 19 points	points	HU II
15 - 19	4	
13 - 15	**2**	**IQR – 3**
12 - 13	**1**	
10 - 12	2	

Median degree of completeness = 13/19 – 68%

Child Health – 8 points	points	HU II
7 – 8	**1**	**IQR – 3**
5 – 7	**2**	
1 – 5	4	

Median degree of completeness 7/8 = 88%

Child Health – 8 points	points	HU II
7 – 8	**1**	**IQR – 1.5**
6.5 - 7	**0.5**	
5 - 6.5	1.5	

Median degree of completeness 7/8 = 88%

Sexual and Reproductive Health & Rights – 17 Points	points	HU II
11.5 – 15	3.5	
6 – 11.5	**5.5**	**IQR–9**
2 – 6	**4**	
0 – 2	2	

Median degree of completeness 6/17 = 35%

Sexual and Reproductive Health & Rights – 17 Points	points	HU II
12.5 - 15	2.5	
9 – 12.5	**3.5**	**IQR–10.5**
2 – 9	**7**	
0 – 2	2	

Median degree of completeness 9/17 = 53%

Public Health – 19 Points	points	HU II
12 – 17	5	
10 – 12	**2**	**IQR – 4.5**
7.5 – 10	**2.5**	
5 – 7.5	2.5	

Median degree of completeness 10/19 = 53%

Public Health – 19 Points	points	HU II
15 - 18	3	
13 - 15	**2**	**IQR – 3.5**
11.5 - 13	**1.5**	
8 – 12	4	

Median degree of completeness 13/19 = 68%

Special Care – 8 Points	points	HU II
4 – 8	4	
2 – 4	**2**	**IQR – 3**
1 – 2	**1**	
0 – 1	1	

Median degree of completeness 2/8 = 25%

Special Care – 8 Points	points	HU II
4.5 – 8	3.5	
3 – 4.5	**1.5**	**IQR – 2.5**
1 – 3	**1**	
0 – 1	1	

Median degree of completeness 3/8 = 38%

Control Communicable Diseases and Clinical Care – 21 points	points	HU III
15 – 19	4	
13 – 15	**2**	**IQR - 3**
12 – 13	**1**	
8 - 12	4	

Median degree of completeness 13/21 = 62%

Control Communicable Diseases and Clinical Care – 21 points	points	HU III
17 - 21	4	
15 - 17	**2**	**IQR - 4**
13 - 15	**2**	
9 - 13	4	

Median degree of completeness 15/21 = 71%

Child Health – 8 points	points	HU III
		IQR – 1
7 – 8	**1**	
6 – 7	1	

Median degree of completeness 7/8 = 88%

Child Health – 8 points	points	HU III
		IQR – 1
7 – 8	**1**	
6 – 7	1	

Median degree of completeness 7/8 = 88%

Sexual and Reproductive Health & Rights – 24 points	points	HU III
20 – 23	3	
17 – 20	**3**	**IQR - 7**
13 – 17	**4**	
3 – 13	10	

Median degree of completeness 17/24 = 71%

Sexual and Reproductive Health & Rights – 24 points	points	HU III
21 - 23	3	
19 - 21	**2**	**IQR - 4**
17 - 19	**2**	
11 – 17	7	

Median degree of completeness 19/24 = 80%

Public Health – 19	points	HU III
15 – 18	3	
13 – 15	**2**	**IQR – 5**
10 – 13	**3**	
3 – 10	7	

Median degree of completeness 13/19 = 68%

Public Health – 19	points	HU III
16 - 19	3	
15 - 16	**1**	**IQR – 3**
13 - 15	**2**	
9 – 13	4	

Median degree of completeness 15/19 = 79%

Special Care – 8	points	HU II
4 – 7	3	
3 – 4	**1**	**IQR – 2**
2 – 3	**1**	
0 – 2	2	

Median degree of completeness 3/8 = 38%

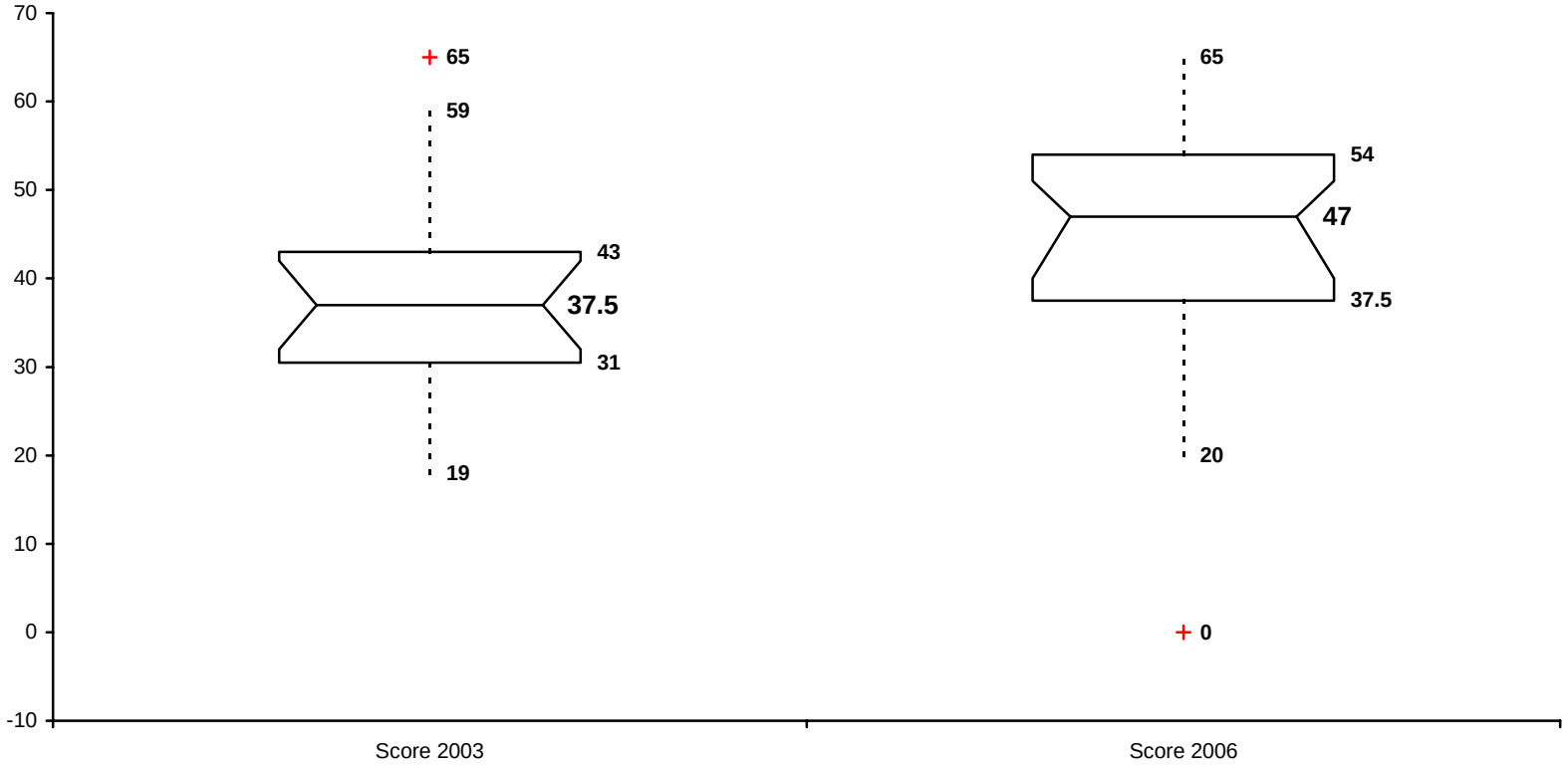
Special Care – 8	points	HU II
5 – 8	3	
4 - 5	**1**	**IQR – 2**
2 – 4	**1**	
0 – 2	2	

Median degree of completeness 4/8 = 50%

Annex 3
Comparative Descriptive analysis (graphs) HU II and III
Health Unit Level II

analysed with: Analyse-it + General 1.71

Test	**Comparative descriptives**
Variables	Score 2003, Score 2006
Performed by	Andrea Mandelli
Date	14 August 2006



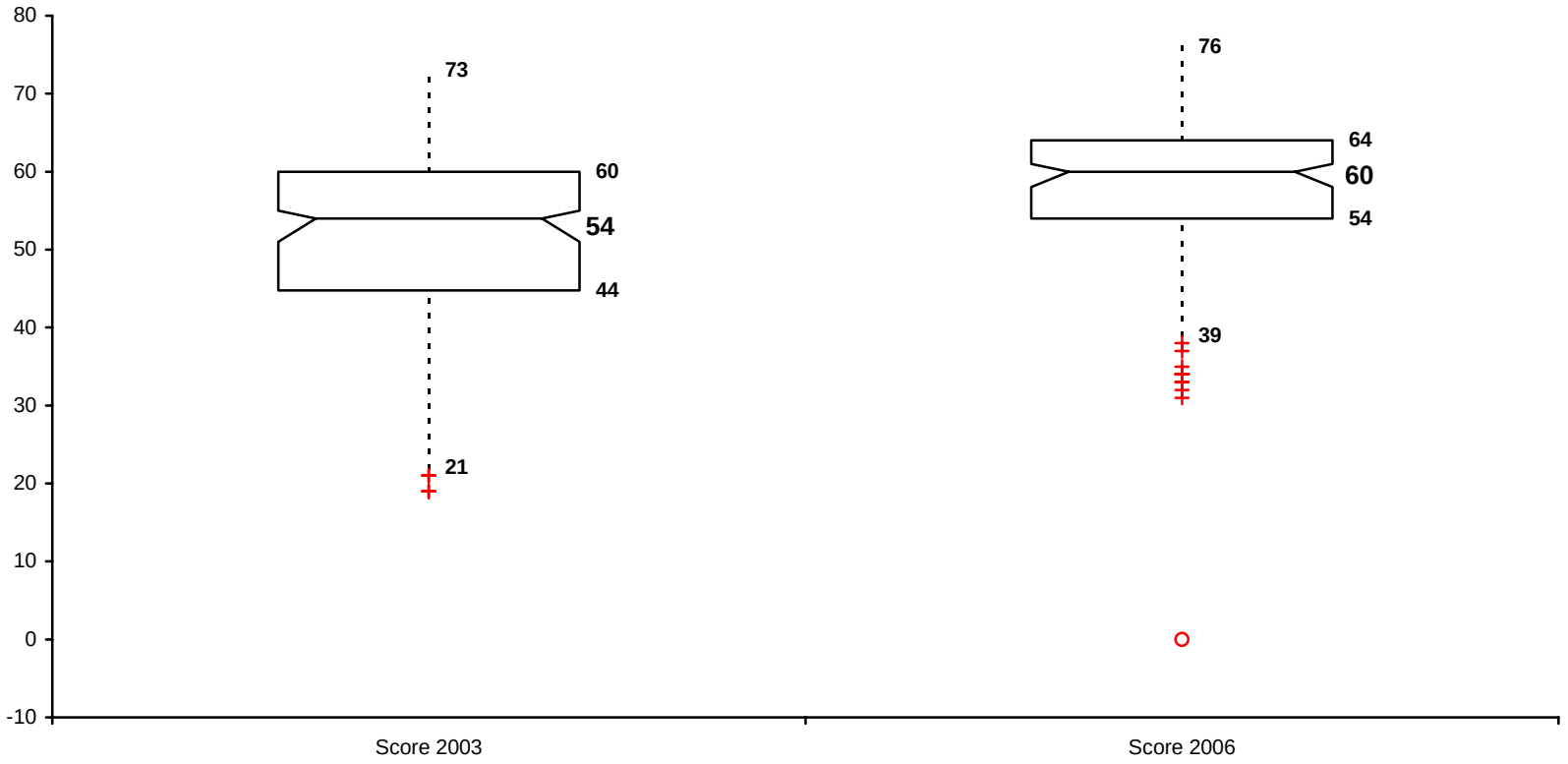
	n	Mean	SD	SE	95% CI of Mean	Median	IQR	95% CI of Median
Score 2003	35	37.514	10.6643	1.8026	33.851 to 41.178	37.000	12.500	32.000 to 42.000
Score 2006	35	44.971	13.4547	2.2743	40.350 to 49.593	47.000	16.500	40.000 to 51.000

analysed with: Analyse-it + General 1.71

Test **Comparative descriptives**

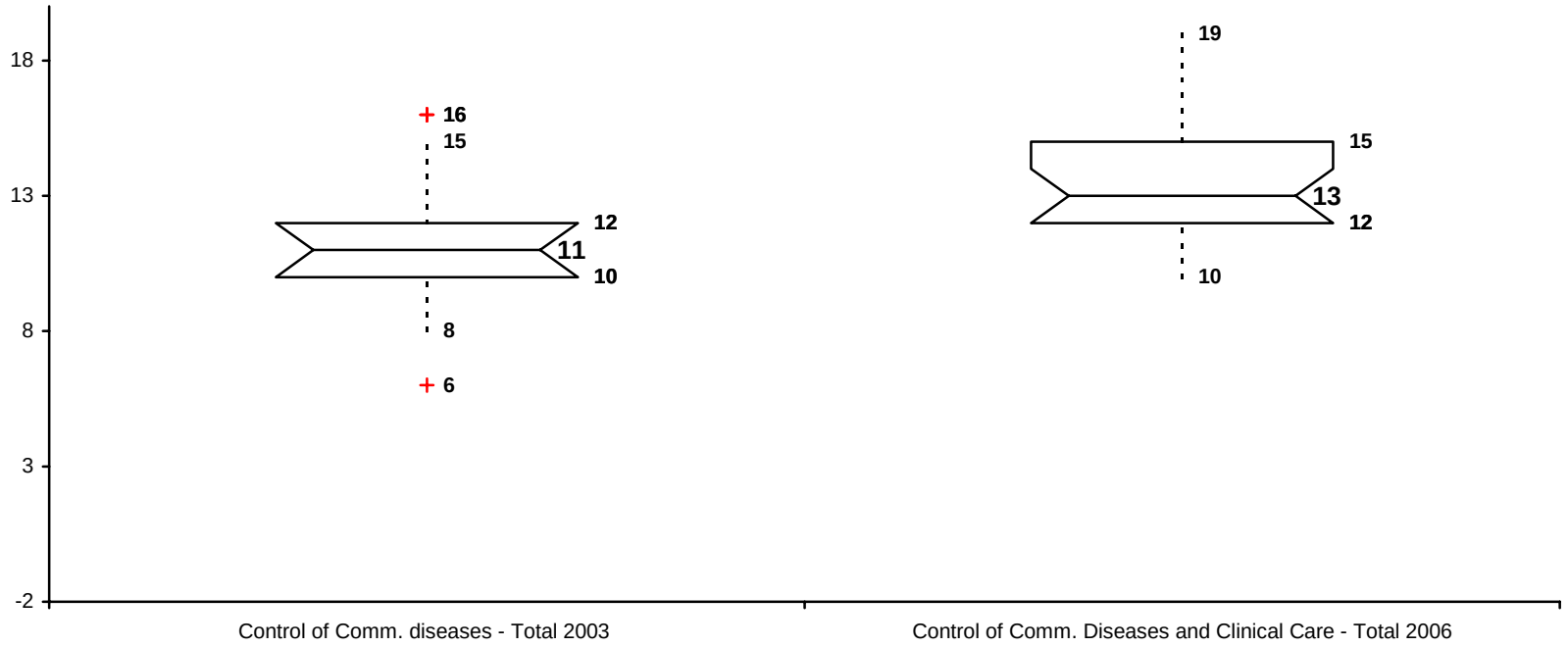
Variables Total Score Health Centres III and IV (2003, 2006)

Performed by Andrea Mandelli **Date** 14 August 2006



	n	Mean	SD	SE	95% CI of Mean	Median	IQR	95% CI of Median
Score 2003	180	51.317	11.8602	0.8840	49.572 to 53.061	54.000	15.250	51.000 to 55.000
Score 2006	180	57.558	10.6314	0.7902	55.999 to 59.117	60.000	10.000	58.000 to 61.000

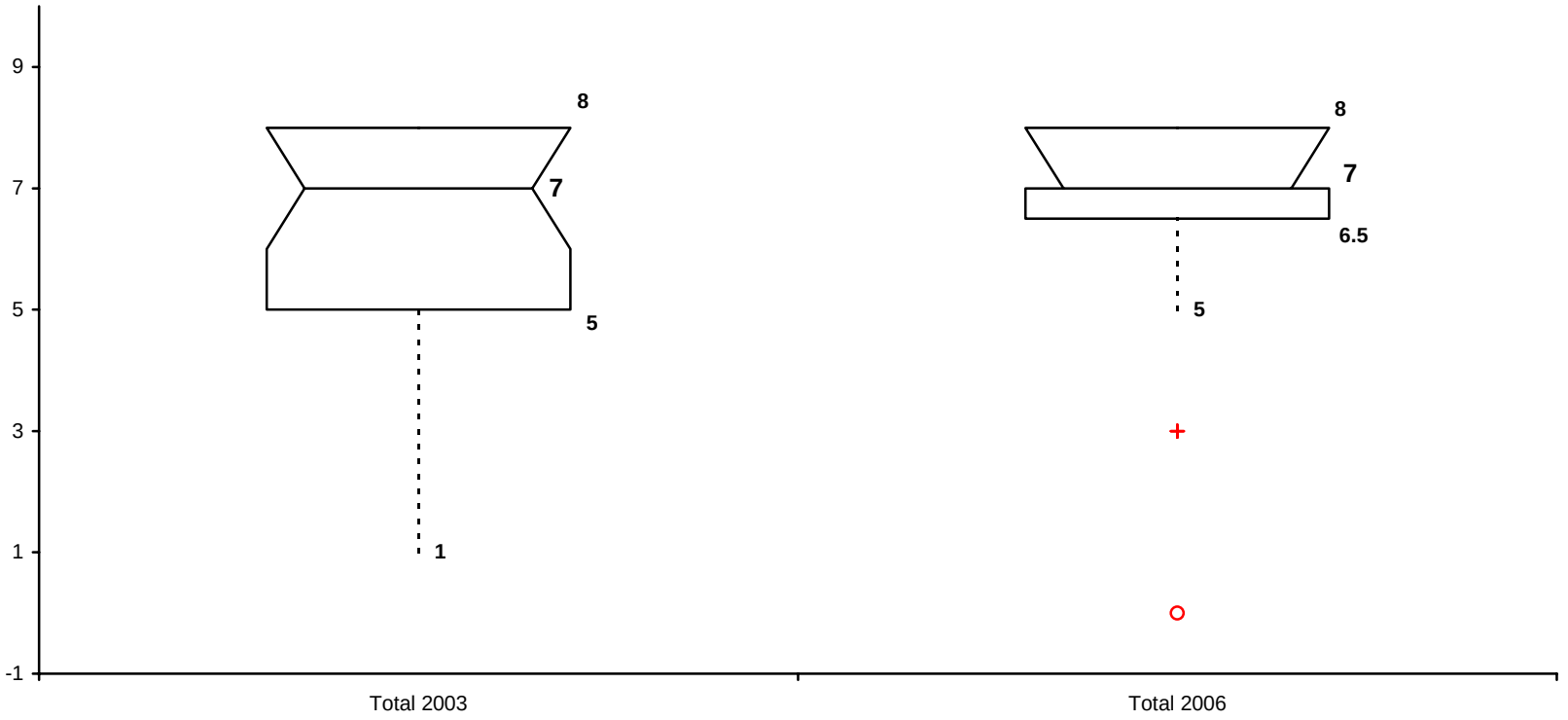
Test	**Comparative descriptives**
Variables	Control of Comm. Diseases and Clinical Care - Total 2003 and Total 2006
Performed by	Andrea Mandelli
Date	14 August 2006



	n	Mean	SD	SE	95% CI of Mean	Median	IQR	95% CI of Median
Control of Comm. Disease	35	11.571	2.8210	0.4768	10.602 to 12.540	11.000	2.000	10.000 to 12.000
Control of Comm. Disease	35	13.343	3.3863	0.5724	12.180 to 14.506	13.000	3.000	12.000 to 14.000

analysed with: Analyse-it + General 1.71

Test	**Comparative descriptives**
Variables	Child Health: Total 2003, Total 2006
Performed by	Andrea Mandelli
Date	14 August 2006



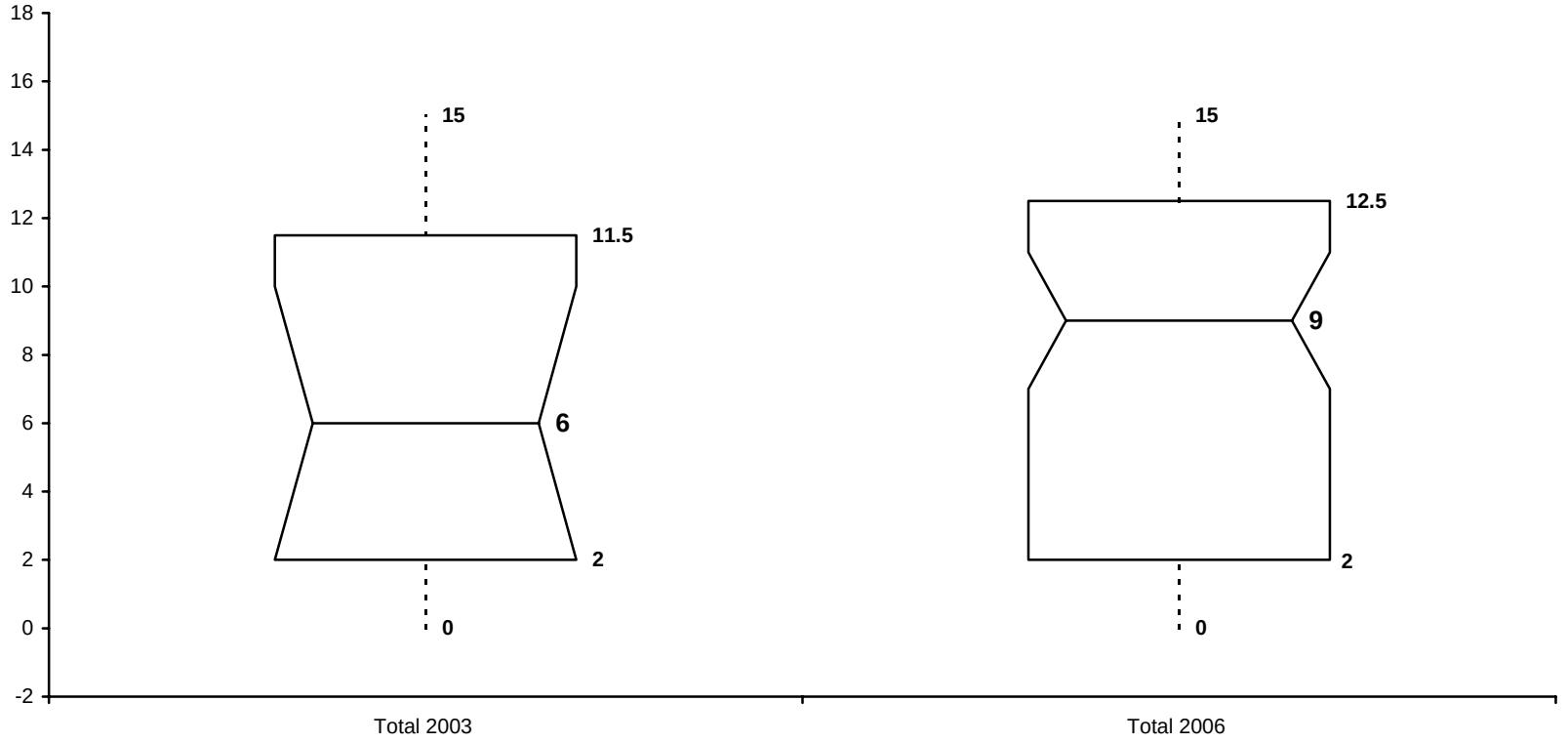
Child Health	n	Mean	SD	SE	95% CI of Mean	Median	IQR	95% CI of Median
Total 2003	35	6.286	1.9640	0.3320	5.611 to 6.960	7.000	3.000	6.000 to 8.000
Total 2006	35	6.714	1.7417	0.2944	6.116 to 7.313	7.000	1.500	7.000 to 8.000

analysed with: Analyse-it + General 1.71

Test **Comparative descriptives**

Variables Sexual and Reproductive Health & Rights: Total 2003, Total 2006

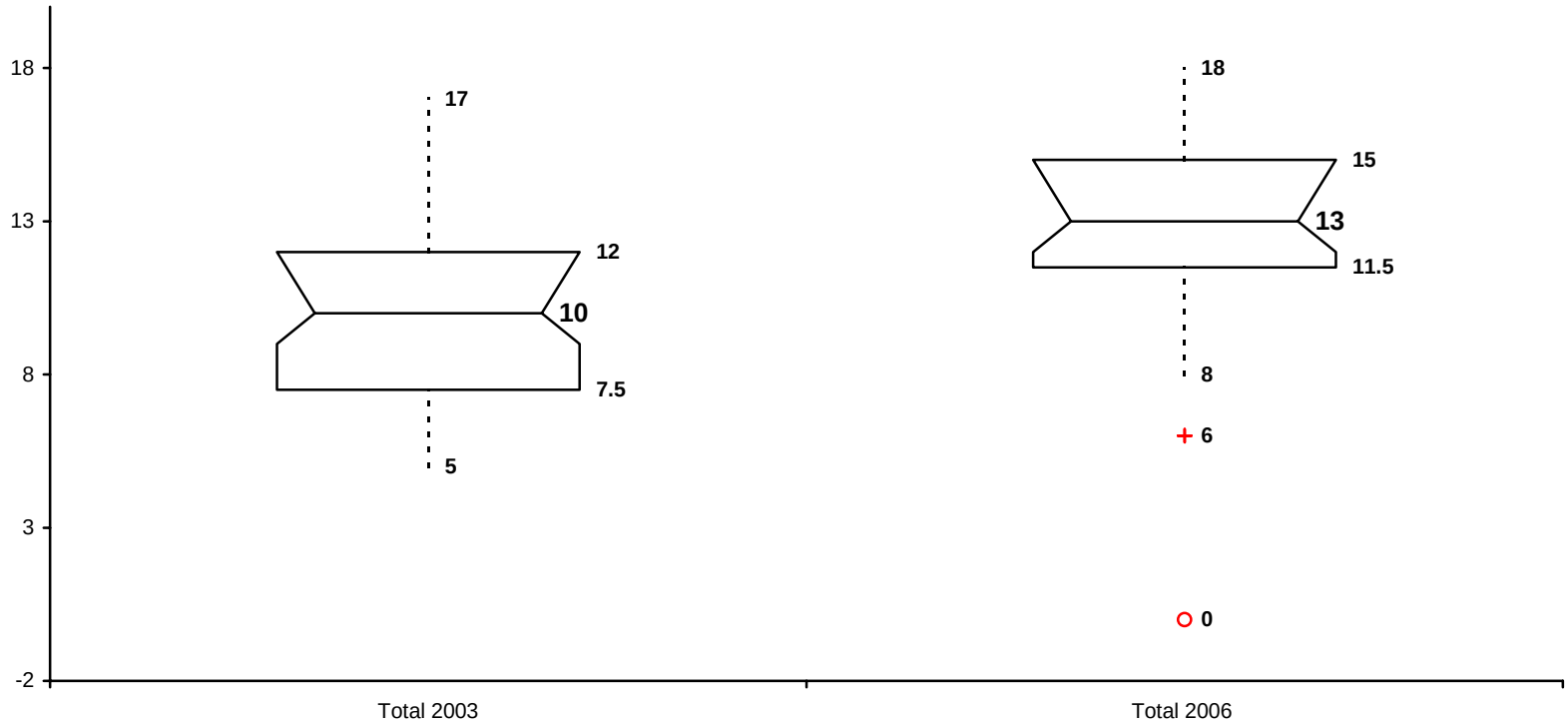
Performed by Andrea Mandelli **Date** 14 August 2006



Sex-Reprod-Health-Rights	n	Mean	SD	SE	95% CI of Mean	Median	IQR	95% CI of Median
Total 2003	35	6.829	5.2998	0.8958	5.008 to 8.649	6.000	9.500	2.000 to 10.000
Total 2006	35	7.829	5.1705	0.8740	6.052 to 9.605	9.000	10.500	7.000 to 11.000

analysed with: Analyse-it + General 1.71

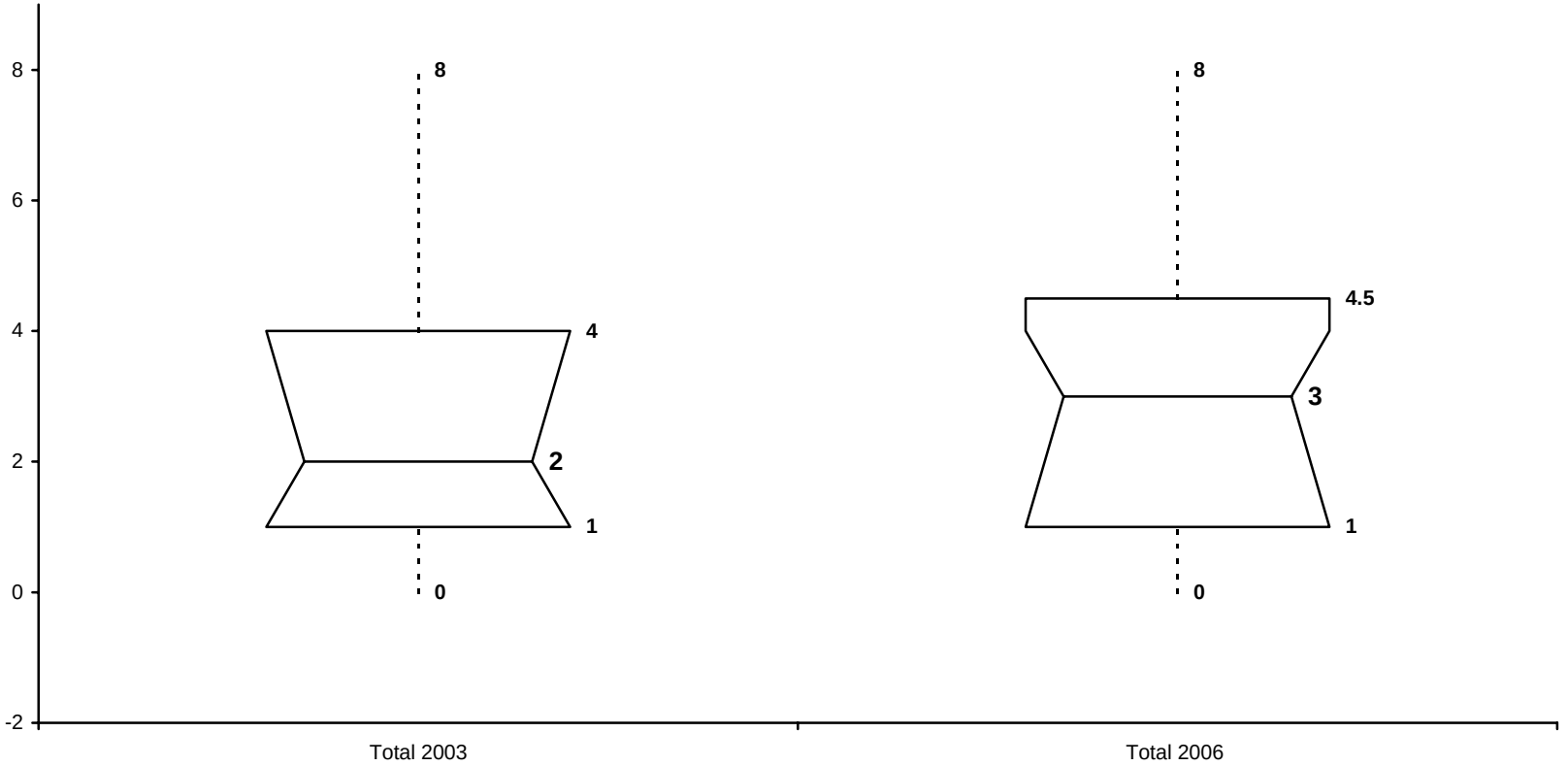
Test	**Comparative descriptives**
Variables	Public Health: Total 2003, Total 2006
Performed by	Andrea Mandelli
Date	14 August 2006



Public Health	n	Mean	SD	SE	95% CI of Mean	Median	IQR	95% CI of Median
Total 2003	35	10.171	3.1388	0.5306	9.093 to 11.250	10.000	4.500	9.000 to 12.000
Total 2006	35	12.771	3.7108	0.6272	11.497 to 14.046	13.000	3.500	12.000 to 15.000

analysed with: Analyse-it + General 1.71

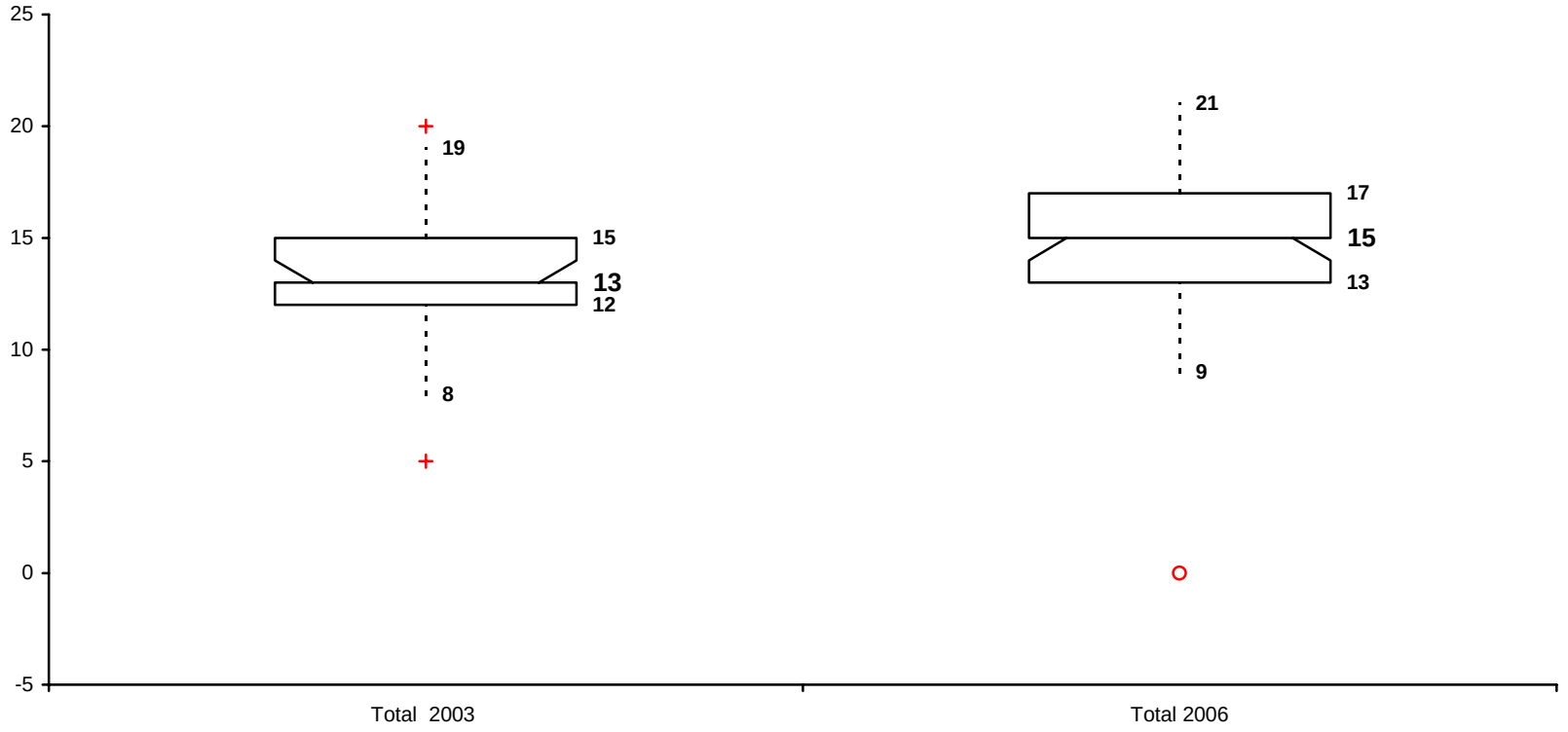
Test	**Comparative descriptives**
Variables	Special Care: Total 2003, Total 2006
Performed by	Andrea Mandelli
Date	14 August 2006



Special Care	n	Mean	SD	SE	95% CI of Mean	Median	IQR	95% CI of Median
Total 2003	35	2.657	2.3382	0.3952	1.854 to 3.460	2.000	3.000	1.000 to 4.000
Total 2006	35	2.943	2.5198	0.4259	2.077 to 3.808	3.000	3.500	1.000 to 4.000

analysed with: Analyse-it + General 1.71

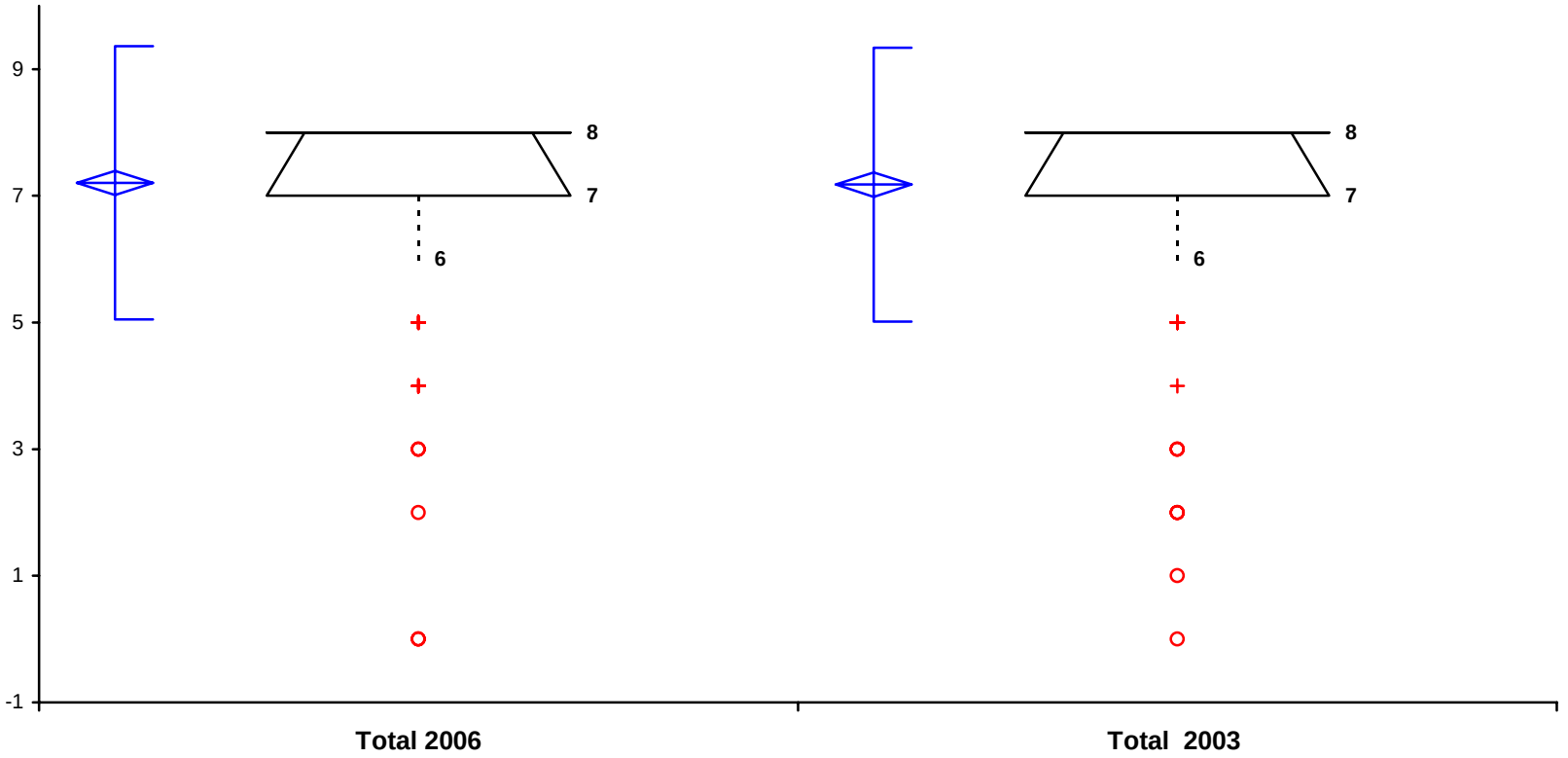
Test	**Comparative descriptives**
Variables	Control of Comm. Diseases and Clinical Care - Total 2003, Total 2006
Performed by	Andrea Mandelli
Date	14 August 2006



Control Comm. Diseases	n	Mean	SD	SE	95% CI of Mean	Median	IQR	95% CI of Median
Total 2003	181	13.409	2.7505	0.2044	13.005 to 13.812	13.000	3.000	13.000 to 14.000
Total 2006	181	14.790	2.8578	0.2124	14.371 to 15.209	15.000	4.000	14.000 to 15.000

analysed with: Analyse-it + General 1.71

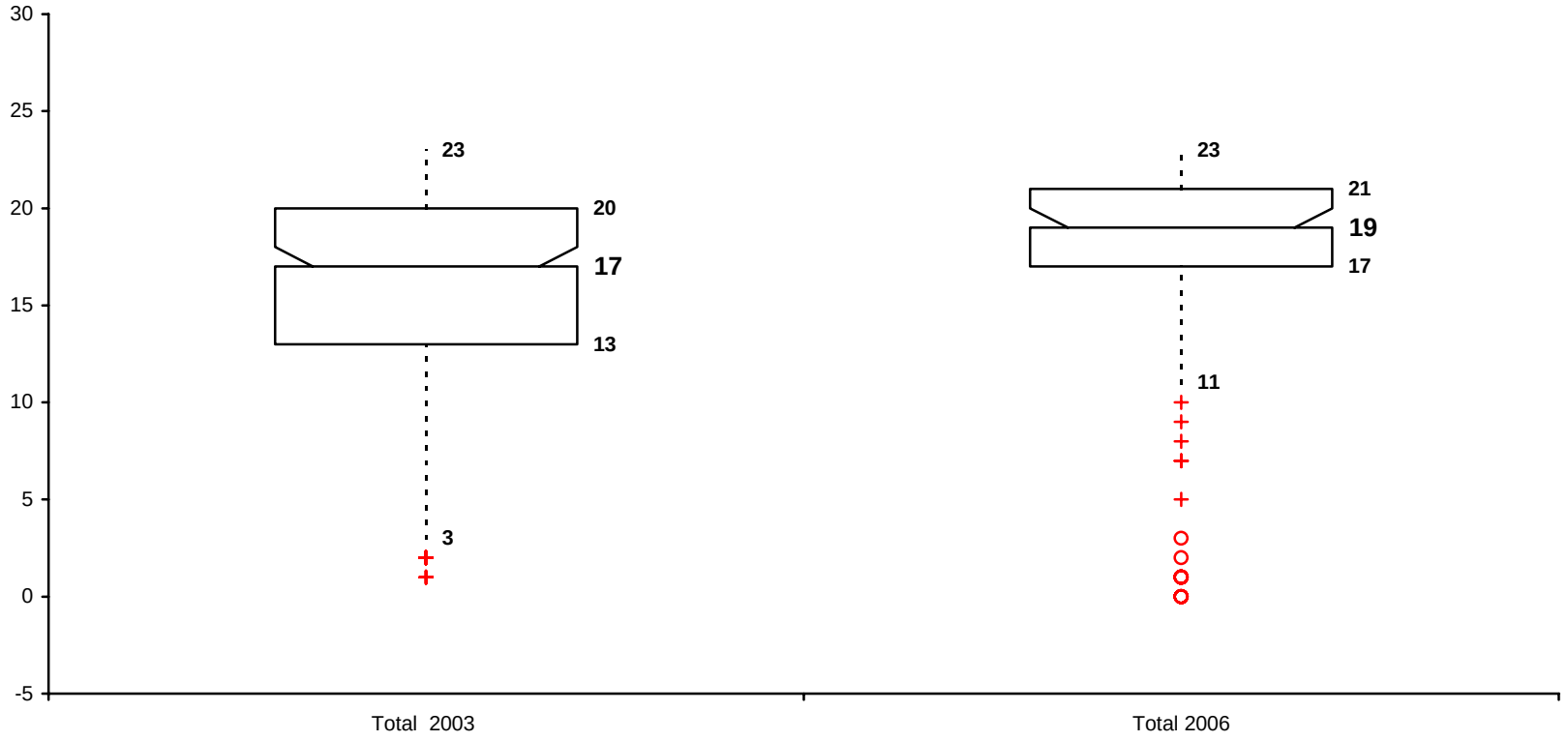
Test	**Comparative descriptives**
Variables	Child Health - Total 2006, Total 2003
Performed by	Andrea Mandelli
Date	1 August 2006



	n	Mean	SD	SE	95% CI of Mean	Median	IQR	95% CI of Median
Total 2006	181	7.204	1.3111	0.0975	7.012 to 7.397	8.000	1.000	7.000 to 8.000
Total 2003	181	7.177	1.3131	0.0976	6.984 to 7.369	8.000	1.000	7.000 to 8.000

analysed with: Analyse-it + General 1.71

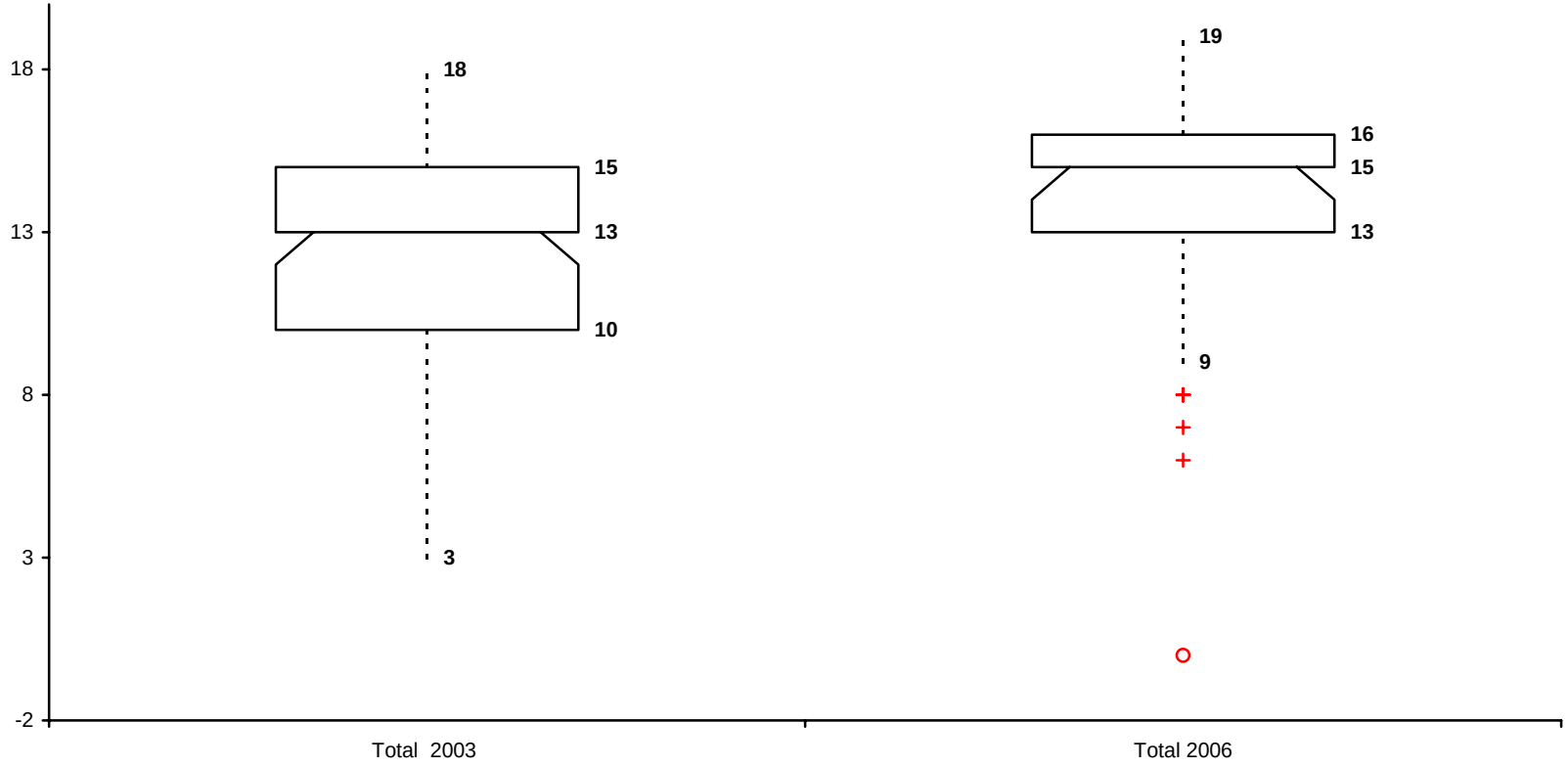
Test	**Comparative descriptives**
Variables	Sexual and Reproductive Health and Rigths - Total 2003, Total 2006
Performed by	Andrea Mandelli
Date	14 August 2006



	n	Mean	SD	SE	95% CI of Mean	Median	IQR	95% CI of Median
Total 2003	181	15.227	6.0441	0.4493	14.340 to 16.113	17.000	7.000	17.000 to 18.000
Total 2006	181	17.580	5.6372	0.4190	16.753 to 18.407	19.000	4.000	19.000 to 20.000

analysed with: Analyse-it + General 1.71

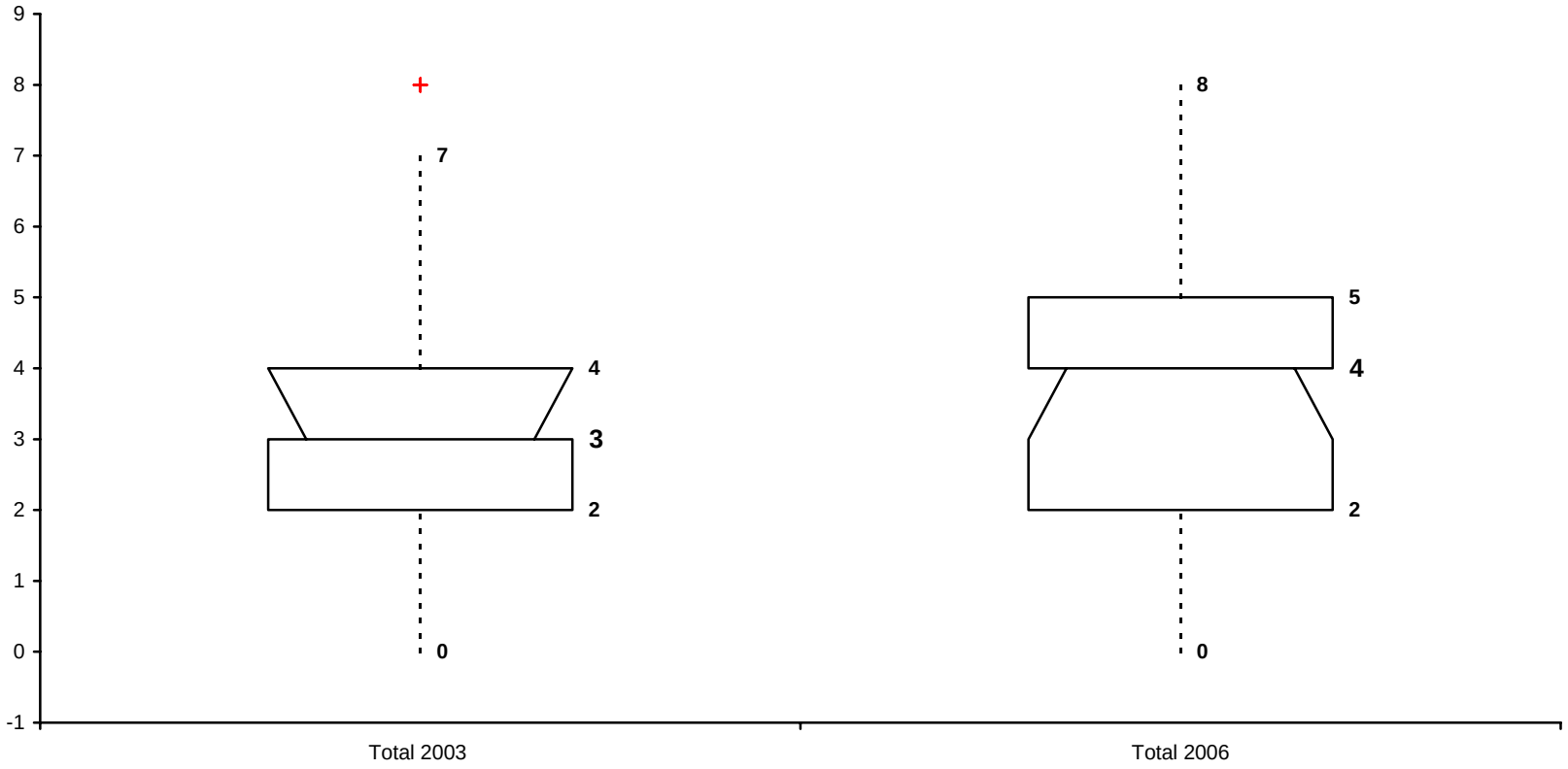
Test	**Comparative descriptives**
Variables	Public Health, Total 2003, Total 2006
Performed by	Andrea Mandelli
Date	14 August 2006



	n	Mean	SD	SE	95% CI of Mean	Median	IQR	95% CI of Median
Total 2003	181	12.227	3.3530	0.2492	11.735 to 12.718	13.000	5.000	12.000 to 13.000
Total 2006	181	14.254	2.8909	0.2149	13.830 to 14.678	15.000	3.000	14.000 to 15.000

analysed with: Analyse-it + General 1.71

Test	**Comparative descriptives**
Variables	Special care: Total 2003, Total 2006
Performed by	Andrea Mandelli
Date	14 August 2006



Special care	n	Mean	SD	SE	95% CI of Mean	Median	IQR	95% CI of Median
Total 2003	181	3.204	1.9740	0.1467	2.915 to 3.494	3.000	2.000	3.000 to 4.000
Total 2006	181	3.602	2.1825	0.1622	3.282 to 3.922	4.000	3.000	3.000 to 4.000

Annex 4
Questionnaire

Survey:	Baseline
Subject:	Delivery of the Minimal Health Care Package by the LL Health Units.
	Part 1: Health Services and Activities
Target Groups:	Health Centre II and III
Source:	UCMB

	Name of the Unit:	
	Grade of the Health Unit (HC II / III / IV):	
	Diocese:	
	District:	
	Sub-district:	
	County / sub-county / parish(administration)	
	Person interviewed:	
	Function / position:	
	Distance to and name of nearest Government Health Unit of the same level: (In Kilo Meters)	

	Distance to and name of nearest NGO (PNFP) Health Unit of the same level:				
	Distance to and name of nearest HU providing higher level of services:				
	Include name and ownership (govern or NGO)				
	How many private Health units are near (radius of five kilometre):				
	Date:				
	SUBJECT	*Yes*	*No*	*U*	*Descriptive answer*
A	INSTITUTIONAL SET-UP				
1	Who owns the Health Unit?				
2	Who owns the land where the unit is located?				
3	Are religious sisters/brothers working in the unit?				
3.1	If yes: which congregation(s)? (open)				
3.2	If yes: does the congregation(s) have a written agreement with				

		the Diocese?				
	3.3	If yes: is the in charge of the unit a member of the religious congregation(s)?				
4		Is the local Catholic Parish involved in the running of the unit?				
		Other bodies involved in running of the HU				
		If yes: How is the Parish involved: select from the following options / more than one option is possible:				
	4.1	Is the Parish council represented in the Health Unit management Committee (HUMC)?				
	4.2	Is the Parish Priest is a member of the HUMC?				
	4.3	Is the Parish Priest the chairperson of the HUMC?				
	4.4	Is the Parish Priest the Treasurer of the HU?				
	4.4	Is the Parish Priest the Administrator of the HU				
	4.6	Is another member of the Parish council is the treasurer of the HUMC				

5	Is there a Health Unit Management Committee?				
6	Does the HUMC meet quarterly				
7	Are minutes of the HUMC meetings available in the HU				
8	Does the In Charge attend the HUMC meetings				
9	Does the HUMC decide on the annual work plan and the annual budget				
10	How many members are there in the committee?				
11	Who are they representing?[2]				**Tick what is Applicable** **1.** Parish ☐ **2.** Local Government ☐ **3.** Congregation ☐ **4.** Staff ☐ **5.** Youth ☐ **6.** Diocese ☐ **7.** Women association ☐ Other (specify):
12	How many representatives are female?				
13	Which representatives hold the following functions (from the categories above):				**Function** / **Representatives hold the functions** 8.1) Chairperson: 8.2) Secretary: 8.3) Treasurer:

14		Do the HUMC members have terms of reference?				
15		Do you have a copy of the Terms of Reference at the HU				
16		How often do they meet?				
17		Is the file of the HUMC minutes kept at the HU?				
18		Have the HUMC received training?				
19		Was this training conducted by Amref?				
20		Does the HU have a written annual work plan?				
	20.1	If not, why not?				
22		Does the HU have a 3yr developmet plan?				

B	MISSION and POLICY					
1		Do you have a copy of the Mission and Policy Statement of the RCC in your health unit?				
2		Have you read the paper?				

3	Do you have a copy of the Diocesan Health Policy?					
4	Do you have a copy of the Charter of the Health Unit?					
5	Was this charter discussed in the team?					
6	Do you have a copy of the ethical code of the Catholic Church on health matters?					
7	Has your unit received a certificate of accreditation for year 2005/6?					
7.1	If yes: can you see the certificate on any of the walls of the Health Units?					
8	Is any of the fees you charge flat?					
8.1	If yes: for which services/groups?				**Services Provided**	**Groups**
					1)	1)
					2)	2)
					3)	3)
					4)	4)
					5)	5)
					6)	6)
					Per Services mentioned Above	**Per group Mentioned Above**
8.2	If yes: how much for eaach one of these services/groups?(Respectively)				1)	1)
					2)	2)
					3)	3)

						4)	4)
						5)	5)
						6)	6)
9		**Accreditation Criteria**					
	9.1	Is the unit having a Patients' Register?					
	9.2	Is the unit having at least one professional staff at Enrolled level?					
	9.3	Is the unit having a protected bin for the disposal of sharp objects?					
	9.4	Is a copy of the Uganda Clinical Guidelines 2003 available in the unit?					
	9.5	Is soap and water in/near consulting rooms?					
	9.6	Is the unit having a clean waiting area?					
	9.7	Is the unit having a sectioned off examination area to protect the patients' privacy?					
	9.8	Is the unit having clean latrines/toilets?					

C.	SERVICE DELIVERY AREA				
1	Have you officially been assigned a catchment area for your HU by the HSD/DDHS office?				
2	What is your total target population?				
3	What is the number of children under one yr?				
4	What is the number of children between one and five years?				
5	What is the number of expected pregnancies?				
6	Have you done or re-done an analysis of the health situation of your catchment population (community diagnosis) in the past 3 years?				
7	List five of the main health problems?				1 2 3 4 5

D SERVICE PROVISION

1	What time does the HU open and what time does it close?							
2	Do you provide emergency service outside these hours?							
3	Do you have a person on call after the OPD closes and at night?							
4	If yes: how many patients did you attend to at night (after closing hours) in the last week?							
4.2	What was your OPD utilisation during the last financial year (Jun 2004 – Jul 2005) (annual form of HMIS)				**OPD utilisation during the last FY (Jun 2004 – JulY 2005)**			
					New cases < 5 years	**New cases> 5 years**	**Re-attendance's**	
5	How many beds does the HU have?							
6	What was your inpatient utilisation during the last financial year (2004 – 2005)?				**IP utilisation during the last FY (Jun 2004 – JulY 2005)**			
					UNDER FIVE		**ADULTS**	
7	If already tallied specify				**Female / Male for each group**			
					OPD		**IPD**	
					FEMALE	**MALE**	**FEMALE**	**MALE**
		UNDER FIVE						
		ADULTS						

8	What were the 3 main diagnoses for admission during the last FY?		1					
			2					
			3					
9	Which support services does the HU provide / have at its disposal?		**Tick what is Applicable**					
			Laboratory Services			Catering Services		
			Cleaning and Maintenance of Compound		Building and	Shelter / Kitchen for relatives		
			Others Specify:					
10	What laboratory tests are carried out?		**A) Bloods**	**Tick**		**B) Urine**	**Tick**	
			A.1 Haemogram			**B.1** Protein		
			A.2 Blood grouping and cross matching			**B.2** Sugar		
						B.3 Microscopy		
			A.3 Syphilis screening			**C.1** Stool - Microscopy		
			A.4 Pregnancy test			**D.1** Skin – Skin scraping for leprosy		
			A.5 HIV/AIDS screening			**E.1** Sputum – Microscopy for AAFB's (TB)		
11	Has the person responsible for the laboratory been trained formally?							
11.1	If, so where and which training?							
12	Is the laboratory supervised by the HSD?							
12.1	If so, How many visits took place last FY?							

13	Have slides been sent for quality control to a hospital laboratory?						
14	Does the HU perform blood transfusions?						
15	Do you undertake outreach services?						
15.1	If so how many outstations?						
16	Are all the outstations in your catchment area?						
16.1	If not, how many fall outside the catchment area?						
17	How frequent do you visit each outstation?						
18	What services are provided then?				**Services are provided**		
					Health Education		**Others Specify;**
					Antenatal Care		**1**
					Growth Monitoring		**2**
					Immunisation		**3**
19	Does the Parish Development Committee of your outstations have a health committee?						
20	Do you have contact with these health committees at each out reach visit?						
21	If not, how often do you have contact with them?						

22	If there is no health committee, with whom do you discuss health issues or activities with in the villages?					
23	Are there trained Traditional Birth Attendants in your villages?					
23.1	If so, do they report to you?					
24	Do you supervise them?					
25	If you do not supervise them, who does?					
26	Does the HU organise outreaches to women groups?					
E	MINIMUM HEALTH CARE PACKAGE					
1	Do you have any written information about the Minimum Health Care Package that your HU should offer in the health unit?					
2	From whom did you receive the information about MHCP?				**Source of Information abaut MHCP**	
					DHC	**Others Specify;**
					HSD	**1**
					DDHS	**2**
E I	I Control of Communicable diseases					

1		Do you have the national guidelines for the treatment of uncomplicated malaria (2001)				
2		Do you ask patients with severe malaria to return for a follow-up visit?				
	3a	What do you do when they come for a follow-up visit?				
	3b	Do they have to pay for a re-visit?				
4		How many patients with complicated malaria did you refer last month?				
5		Which other Malaria prevention activities do you carry out?				
	5a	What is the content of your HE message for malaria?				
	5b	Does the HU have bednets for each bed? (only HU with IP SERVICES)				
6		Do the villagers and Parish Development Committees follow-up your advice?				
7		Do you supervise their activities?				
8		Do you have the national guidelines for syndromic management				

	of STIs?				
9	How many patients with STI did you refer in the last FY?				
10	Do you ask the patient to send their partner for treatment?				
11	Which other activities do you carry out in view of HIV / AIDS prevention and control?				
11a	Do you know your Focal Point from HIV/AIDS of UCS?				
12	Do you counsel individuals who want to know their HIV status?				
13	Do you provide HIV tests for clients?				
14	If you do not provide testing, where do you refer clients to?				
15	If the HU provides counselling services, was the staff trained?				
16	Who provided the training?				
17	Is the HU treating TB patients?				
18	Has staff been trained in diagnosing and treatment of TB cases				
19	How many TB cases (all) are on treatment at this moment?				

20	Does the HU staff undertake activities to trace contacts of TB patients?				
21	What do you do to trace patients defaulting from TB treatment?				
22	Do you provide DOTS drugs to:				
22.1	- Community members (providers)				
22.2	- HC II's (only for HC III's)				
23	Did you treat patients with leprosy during the last FY?				
E II	**II. Integrated Management of Childhood Illness (IMCI)**				
1	Do you carry out all the aspects of IMCI daily in your HU:				**IF YES, which aspects of IMCII**
					Immunisations
					Growth monitoring
					Nutrition education
					Vitamin A supplementation
					CDD (ORT corner)
					Case management of malaria
					Case management of ARI
2	Do you have the IMCI treatment guidelines?				
E III	**III. Sexual and Reproductive Health**				
1	What services do you provide during Antenatal Care?				

		Others (specify)
Immunisations		**1**
Growth monitoring		**2**
Nutrition education		**3**
Vitamin A supplementation		**4**
CDD (ORT corner)		**5**
Case management of malaria		**6**
Case management of ARI		

	1.1.	- Registration				
	1.2.	- Examination				
	1.3.	- BP recording				
	1.4.	- Identification of high risk cases				
	1.5.	- Promotion of good nutrition				
	1.6.	- Provision of iron and folic acid				
	1.7.	- Tetanus vaccination				
	1.8.	Administration of Intermittent Preventive Treatment of malaria in pregnancy with SP				
	1.9.	- Refer cases through radio call				
	1.1	- Refer cases by village ambulance				
	1.11	- Refer though other means (specify)				
2		How many days per week do you provide ANC services?				
3		How many women attended ANC during the last FY?				
4		How many times do women attend ANC on average per pregnancy?				
5		Do you know what the coverage in ANC is of your HU's?				
	5.1	If Yes, what is the coverage rate?				
6		Do you know about				

		PMTCT services?				
	6a	If so, do you provide PMTCT services?				
	6b	If not, do you refer women for PMTCT services?				
7		Which obstetric services does your HU provide?				
	A.1.	- Unexpected deliveries (only HC II)				
B.		**For HC III**				
	B.1	- Normal deliveries				
	B1a	Do you have a qualified (enrolled or registered) midwife at the HU?				
	B.2	- Management of minor obstetric complications according to LSS guidelines				
	B2a	Can you administer parenteral (per injection or intravenous drip) antibiotics?				
	B2b	Can you administer parenteral anticonvulsivants for pre-eclampsia and eclampsia?				
	B.3	- Referral of obstetric emergencies & complications of mother?				
	B.4	- Referral of emergencies & complications of the				

		newborn baby				
	B.5	- Resuscitation new born baby				
	a	Do you have an ambu bag (baby)?				
	b	Do you have a suction?				
	B.6	- Care of the new born baby (BCG, OPV 0, tetracycline eye ointment)				
	B.7	Post abortion care including Manual Vacuum Aspirator (MVA) for incomplete abortions				
	B.8	If yes: is a Manual Vacuum Aspirator available?				
	B.9	Can you perform removal of retained products? (see also for cross checking B7 and post B7)				
	B.10	- Treatment of concurrent illness of the mother				
	B.11	Regular maternal & peri-natal mortality review meetings in only HC lll				
	B12	Can you perform manual removal of placenta?				

8		How many deliveries did your HU perform during the last FY?				
9.1		Do you know what the coverage of supervised deliveries is for your HU?				
	9.2	If so, what is the coverage rate?				
10		How many women did you refer for delivery or ANC problems last FY?				
11		Do you provide post-natal care?				
		If yes which services do you provide?				
	11.1	- Implementation of the 12 steps of successful breastfeeding				
	11.2	- Vitamin A supplementation to mothers within 6 weeks of after delivery				
	11.3	- Examination of mother and child				
	11.4	- Weighing of the baby				
	11.5	- Identification of complications				
	11.6	- Detection of STD's (STI's)				
	11.7	- Cervical examination (unaided or aided visual inspection)				
12		Do you provide Family Planning services?				
		If so which services do you provide:				

	12.1	- Provision of Family Planning counselling						
	12.2	- Provision of selected methods:				**Methods**	**P**	**Oral others (specify**
						Oral lo-femenal		**1**
						Oral mycrogynon		**2**
						Oral ovrette		**3**
						Condoms		**4**
						Foam tablets		**5**
	12.3	- Insertion and removal of IUDS (copper T)						
	12.4	- Norplant insertion and removal						
	12.5	- Natural family planning counselling and assistance						
	12.6	- others (specify)						
13		If you do not provide Family Planning services, do you provide information about where clients can obtain these services?						
	13a	Have you seen women with gynaecological problems at the OPD?						
	13b	If so, How many women did you refer for gynaecological problems last FY?						
14		Do you treat women who have been subject to violence?						

15	If so, how many women did you treat last FY year?					
16	What kind of treatment do you give in general?					
17	If needed, where do you refer women who have been subject of violence to?					
18	How many women, who have suffered violence, did you refer last FY?					
19	Have you informed the authorities about cases of violence against women?					
20	Do you provide Adolescent Reproductive Health Services?				**Adolescent Reproductive Health Services?**	**TICK**
					1) Family Planning	
					2) STI / HIV/AIDS counselling	
					3) STI treatment	
					4) STI / HIV/AIDS prevention	
					5) Antenatal care and TT vaccination	
21	If you do not, where do you refer adolescents to for these services?					
E IV	IV. Immunisations					
1	Do you provide immunisations every day at the HU (updating immunisation status at every contact)?					

2	If not, how many days a week do you provide immunisations at the HU?						
3	Do you provide immunisations during outreach visits?						
4	Which cold chain equipment does the HU have?				**Cold Chain Equipment**		**TICK**
					1) Refrigerator		
					2) Vaccine carrier		
					3) Cool box (large)		
					4) Ice packs		
					5) Antenatal care and TT vaccination		
5	Do you provide Vitamin A supplementation during vaccination sessions?						
6	How many children under one year of age received the following vaccinations during the last FY?:				**Vaccinations**	**Number of children under one year**	
					1) BCG		
					2) DPT 3		
					3) Measles		
7.1	Do you know what the vaccination coverage is for your catchment area?						
7.2	If so, what is the coverage rate:						
8	How many ANC attending women received full TT (=TT 2+) vaccinations?						

9.1		Do you know what the coverage rate for TT is for you catchment area?				
	9.2	If so, what is the coverage rate?				
10.1		Do you provide TT booster immunisations at primary schools?				
	10.2	If so, how many pupils did you vaccinate during last FY?				
E V		V. Environmental Health (other Public Health Measures)				
1		Which activities do you undertake to improve people's access to safe water? (access to safe water within 1,5 km)				
	1a	What is your HALTH EDUCATION message concerning safe water?				
2		Which activities do you undertake to improve sanitation?			**Activities undertaken to improve sanitation**	**TICK Please**
					A) Promote hygiene practises in households	
					B) Promote hygiene practices in public institutions and places	
					C) Control of mosquito breeding sites	
	D)	- Other vector control measures (specify)				
3		What source of water does the HU have?[3]			**Tick what is Applicable**	
					A) Piped water	D) Shallow well
					B) Bore hole	E) Rain water
					C) Protected spring	

	F	- Other specify					
4		Is your source of water considered safe for drinking?					
	4a	Does your HU have sufficient water throughout the year?					
5		Which of power does the unit have or use ?				**Type of Power Used at the unit**	**Tick what is Application**
						A) National Grid	
						B) Solar	
						C) Generator	
6		Does the HU have the following refuse disposal facilities?				**Disposal facilities Used**	**Tick what is Application**
						- Rubbish pit	
						- Placenta pit	
						- Incinerator	
7		Are they protected against children, properly used and not overflowing? *					
8		Does the HU have clean latrines?*					
9		Is soap and water available near the latrine to wash hands?*					
10		Is there a separate latrine for staff?*					
E VI		VI. Health Education and Promotion **(other Public Health Measures)**					
1		Do you give health education sessions at the health unit?					

2	If so, to whom?				
3	Can you list three key topics you address in you r health education sessions?				
4	Do you have a time table and / or fixed schedule for health education sessions?				
5	Do you have a list of topics for health education?				
6	Do you have education material (for instance posters, visual aides) for HE?				
7	If so, from whom did you receive these?				
8	Is any education material visible in the HU?*				
9	Do you provide individual health education during consultations?				
10	Has any of the HU staff receive any training in Health Education?				
10.1	If so, specify:				
EVII	VII. School Health **(other Public Health measures)**				
1	Do you undertake school health activities?				

2		How many schools are there in your catchment area?				
3		How many of these do you visit				
4		At which frequency do you visit each school?				
5		Which activities do you carry out:				
	5.1.	- Promote hygiene at the school				
	5.2.	- Promote healthy lifestyles among children				
	5.3.	- Supervision to ensure adequate latrines and water facilities				
	5.4.	- Regular medical examinations				
	5.5.	- Detection of eyesight problems				
	5.6.	- Train teachers in first aid				
	5.7.	- Ensure first aid facilities are available				
6		Which additional activities do you undertake at the schools? Specify:				
7		How many schools did you visit last month?				
E VIII		**VIII Epidemic & Disaster Prevention, Preparedness and Response** (other Public Health Measures)				
1		Which are the potential epidemic diseases in your area?				

2		Do you provide the weekly 'notifiable diseases' reports on epidemic diseases to the HSD (or DDHS)?				
3		Would you have enough drugs in stock if suddenly there would be a huge increase in malaria?				
	3a	Do you keep a buffer-stock for a malaria outbreak seperately?				
E IX		IX Improving Nutrition (other Public Health Measures)				
1		Do you undertake activities to improve the nutrition of the population by:				
1.1.		- establish demonstration gardens				
1.2.		- hold demonstrations on preparation of nutritious meals				
2		How do you identify malnourished children?				
3		Which services do you provide for malnourished children at the HU?				
4		Where do you refer severely malnourished children to?				
5		How many did you refer during the last FY				

6	Are there other organisations and / or departments working for nutrition improvement in your area?					
7	Do you work together with them?					
8	If so, which activities do you undertake together?					
E X	X Interventions against diseases targeted for eradication (other Public Health Measures)					
1	Do you know which diseases are targeted for eradication in your area?					
2	Can you name them:				**1**	**5**
					2	**6**
					3	**7**
					4	**8**
3	Have you received information about these diseases?					
4	Have you received training regarding what to do?					
5	Do you work with the Parish Development (or Health) Committee for control measures?					
E XI	XI Mental Health Services					

1		Do you see patients with mental health problems at the HU?				
	1a	How many patients with mental health problems did you see last FY?				
2		What did you do?				
	2.1.	- Provide treatment				
	2.2.	- Refer these patients				
	2.3.	- Nothing				
3		Do you provide care for epilepsy patients?				
4		How do you ensure continuity care and follow-up for epilepsy patients?				
5		Where do you refer mentally ill patients to?				
6.1		Besides epilepsy, do you follow-up on patients with mental health problems in the community?				
	6.2	If so, what do you do?				
7		If you do not provide follow-up, why not?				
8		What health education messages do you give on mental health to the community?				
E XII		XII Clinical Care				

1	Name the five most frequent common conditions that you treat at the HU:				
2	How many patients did you refer last FY?				
3	Where do you refer patients to? (level)?				
4	Name the HU you refer most patients to?				
5	At what distance from your HU is this referral HU?				
6	What were the main reasons for referring patients?				
7	Do you have a written procedure for referring patients? (referral note)				
8	Does the referral HU provide you with a report about the patient? (referral back / feed back				
9	Do you have any means to contact the nearest hospital (referral HU) (radio, telephone)				
10	Do you have easy access to transport in case of an emergency referral?				
11	Is this means of transport owned by the HU?				
12	If you do not have easy access to transport, what to you do an				

		emergency referral?				
13		What basic interventions can you provide for patients with major injuries?				**Basic interventions provided for patients with major injuries** 1) IV fluids 4) Control pain 2) Temporary immobilisation fractures 5) Dress wounds 3) Control bleeding 6) Suture wounds
13.7		- Other (specify):				
14		Do you have the standard guidelines for treatment of common diseases?				
15		Can you show the guidelines you use*:				
16		How many patients with disabilities did you see during the last FY?				
17		Which kind of disabilities did you see:				
	17.1	- Skin contractions (post burn or injury)				
	17.2	- Eyesight problems (including blindness)				
	17.3	- Hearing problems (including deafness)				
	17.4	- Amputees				
	17.5	- Loco-motive problems				
	17.6	- Others (specify):				
18		What did you do?				
	18.1	- Provide treatment				

	18.2	- Provide assistance				
	18.3	- Refer to hospital				
	18.4	- Refer to special centre				
	18.5	- Nothing				
19		How many patients with disabilities did you refer last FY?				
20		Where do you refer most patients with disabilities to? (name / level centre (s)/ departments / organisations)				
21		Are any of the persons with disabilities coming regularly for follow-up at the HU?				
22		Which services do you provide for oral and dental health?				
	22.1	- Promotion of oral health through health education				
	22.2	- Pain relief for dental / oral problems				
	22.3	- Simple extraction				
	22.4	- Referral				
23		Do you provide symptomatic care for patients with severe pains? (palliative care)				
	23.1	- AIDS patients				
	23.2	- Cancer patients				

	23.3	- Sickle cell patients in a pain crisis				
	23.4	- Others (specify)				
24.1.		If the HU does provide symptomatic care, was anyone of the staff trained in palliative care?				
24.2		If so, where (or by whom) was s/he trained?				
		Comments / Observations / unlisted information:				

Thank you very much for all the information and assistance provided and above all for your patience!!!

Annex 5
TERMS OF REFERENCE

A. Purpose of the assistance

To train interviewers for gathering follow-up information of delivery of essential package of health services by catholic health units in all dioceses of Uganda, ending with the production of a report consistent with previous information available.

B. Background.

The Uganda Catholic Medical Bureau operates with the general purpose to improve quality of services to the users of catholic health units and service coverage of the respective population.
During 2003 Dioceses were surveyed by the consultant to asses the degree at which the diocesan LLUs were able to provide components of the Uganda Minimum Package of Health service Delivery. The wealth of information thus generated has allowed the identification of critical areas in need of address, on which the Bureau has formulated its operational plan 2004-6. Objective 19 of the current plan states that by the end of 2006 the median completion rate of MHCP delivered by HC3 exceeds 54%. Hence the need of gathering information on the MHCP delivered.
The fundamental choice of the Bureau is that surveys should first and foremost produce information useful for planning at grass-root and intermediate (Diocesan Co-ordination) level. Central monitoring and evaluation objectives should be harmonious with the needs of the grass-root. For this reason it has been deemed necessary to avoid a randomised sampling survey (lees time consuming and less involving for the Co-ordinations but with no practical use for the grass-root level). Contrary to the methodology adopted in the survey of 2003, this time the capacity of collecting information will be build in staff/persons from the grass-root and intermediate level, indicated by the co-ordinator. This opens the way to the reproducibility of the initiative in three years from now.
The consultant has been directly involved in the collection of information in 2003 and has developed extensive skills that must now be transferred to the peripheral staff. For this purpose her expert assistance is required for the training of the interviewers and for the final report writing. Data entry and primary analysis will be arranged within the scope of the routine activities of the Uganda Catholic Medical Bureau.

C Terms of Reference

The expert will:
1. Review the 2003 MHCP Part I questionnaire to adapt it to the changed scenario – i.e. variation of components of the MHCP plus additional information, together with the staff of UCMB
2. Elaborating/reviewing list of parameters for the interpretation/scoring of the information gathered (i.e. List of MHCP indicators of 2003), consistent with the new questionnaire
3. Develop training methodology and material for a 5 days session of groups of max 20 interviewers, including on the ground testing.
4. Train two separate groups of interviewers from the 19 Dioceses during week 23 and 24 of 2005.
5. Agree with UCMB staff format on which analysed data have to be submitted to her.
6. Receive analytic data from UCMB staff within end of week 30 (28th July)
7. Submit draft report, consistent with the format used in 2004, within end of week 31 (4th August)
8. Receive feed-back from UCMB by 8th August
9. Submit final report in electronic format before end of week 32 (11th August), of no less than 20 pages and no more than 40 pages, excluding annexes, graphics and tables.

D. Consultant profile

The expert is a holder of diploma or master of public health or community health, with prior proven experience in similar exercises.

E. Timeframe

Travel	**2days**
Adaptation of questionnaire - Preparation of training material	**2days**
Training	**12days**
Report writing	**7 days**