UGANDA

Service Provision Assessment Survey 2007

Key Findings on Family Planning, Maternal and Child Health, and Malaria

This report summarises the reproductive and maternal and child health findings of the 2007 Uganda Service Provision Assessment Survey (USPA), carried out by the Uganda Ministry of Health in collaboration with the Uganda Bureau of Statistics. Macro International Inc. provided technical assistance. The 2007 USPA is part of the worldwide MEASURE DHS project which assists countries in the collection of data to monitor and evaluate population, health, and nutrition programmes. The survey was funded by the United States Agency for International Development (USAID), the President's Emergency Plan for AIDS Relief (PEPFAR), and the President's Malaria Initiative (PMI).

Additional information about the 2007 USPA may be obtained from the headquarters of the Uganda Ministry of Health, P.O. Box 7272, Kampala, Uganda; Telephone: 256.41.340.874; Fax: 256.41.340.877; E-mail: HSRP@IMUL.com

Additional information about the DHS project may be obtained from Macro International Inc., 11785 Beltsville Drive, Calverton, MD 20705 USA; Telephone: 301-572-0200, Fax: 301-572-0999, E-mail: reports@measuredhs.com, Internet: http://www.measuredhs.com.

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Contents

The regions used in the USPA, though not official administrative regions, are the same regions used in the 2004-05 Uganda Sero-behavioral Survey and allow for the analysis of geographical differentials. The regions, and the districts they comprise, are as follows:

Central:	Kalangala, Kiboga, Luwero, Masaka, Mpigi, Mubende, Nakasongoloa, Rakai, Sembabule, and Wakiso districts
Kampala:	Kampala district
East Central:	Bugiri, Iganga, Jinja, Kamuli, Kayunga, Mayuge, and Mukono districts
Eastern:	Busia, Kapchorwa, Mbale, Pallisa, Sironko, and Tororo districts
Northeast:	Kaberamaido, Katakwi, Kotido, Kumi, Moroto, Nakapiripirit, and Soroti districts
North Central:	Apac, Gulu, Kitgum, Lira, and Pader districts
West Nile:	Adjumani, Arua, Moyo, Nebbi, and Yumbe districts
Western:	Bundibugyo, Hoima, Kabarole, Kamwenge, Kasese, Kibaale, Kyenjojo, and Masindi districts
Southwest:	Bushenyi, Kabale, Kanungu, Kisoro, Mbarara, Ntungamo, and Rukungiri districts

Introduction

The 2007 Uganda Service Provision Assessment survey (USPA) describes how the formal health sector in Uganda provides services for family planning, maternal health, child health, malaria, HIV/AIDS, and other communicable diseases.

The USPA was carried out by the Ministry of Health in collaboration with the Uganda Bureau of Statistics. Macro International Inc. provided technical assistance. The survey was funded by the United States Agency for International Development (USAID), the President's Emergency Plan for AIDS Relief (PEPFAR), and the President's Malaria Initiative (PMI).

The major objectives of the 2007 USPA are to:

- determine the level of preparedness of health facilities for providing quality services;
- provide a comprehensive body of information on the performance of the full range of public and private health care facilities that offer reproductive, child health, and HIV/AIDS services;
- pinpoint strengths and weaknesses in the delivery of health care services in order to better target interventions;
- describe the processes used in providing child, maternal, and reproductive health services and the extent to which accepted standards for quality service provision are followed;
- provide information for periodically monitoring progress in improving the delivery of services at Ugandan health facilities;
- provide input into the evolution of a system of accreditation of health facilities in Uganda; and
- provide baseline information on the capacity of health facilities to provide basic and advanced level HIV/AIDS care and support services.

The USPA involved a nationally representative sample of 491 facilities, including: 1) all national referral hospitals, regional hospitals, general hospitals, and other hospitals; and 2) all levels of health centre (HC-IV, HC-III, and HC-II). Facilities are also identified by managing authority, that is, facilities run by the Government of Uganda, or private groups. Facilities were selected from all nine regions of Uganda. Trained interviewers collected the data between July and October 2007.

This report summarises the major USPA findings on family planning, maternal health, child health, and malaria based on interviews and observations at 491 health care facilities. To put the results of the 2007 USPA into context, this report also includes data from the 2006 Uganda Demographic and Health Survey (UDHS) based on data collected from over 11,000 Ugandans. Data from the 2006 UDHS are presented in yellow boxes in each section.

2007 USPA Results: Family Planning Services

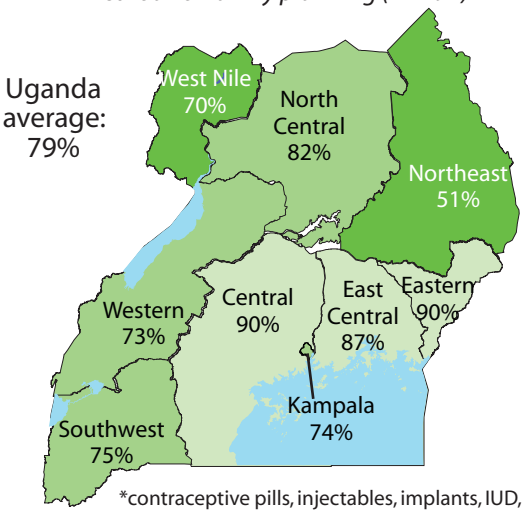
Modern family planning services are available in 79 percent of all health care facilities. Nine in ten government facilities offer family planning compared to only half of private facilities. Family planning services are least likely to be available in hospitals (71 percent), while 99 percent of HC-IVs provide modern methods. In most facilities (77 percent) services are available five days per week.

Availability of family planning services varies by region. Only about half of facilities in Northeast and seven in ten facilities in West Nile offer any modern methods, compared to nine in ten facilities in Central and Eastern Regions.

Long-term methods are less widely available. Only 21 percent of facilities offer male or female sterilisation. Sterilisation is most available at hospitals (56 percent).

Availability of Modern Family Planning Methods

Percent of facilities offering any modern method of family planning (N=491)*



*contraceptive pills, injectables, implants, IUD, male condoms, spermicides or diaphragm

Putting the USPA into Context: Family Planning in Uganda

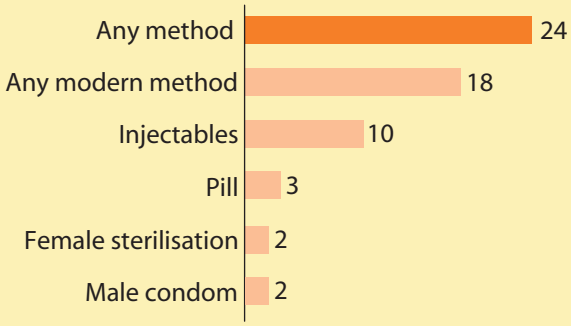
According to the 2006 UDHS, Ugandan women have an average of 6.7 children. Fertility has decreased only slightly in recent years. Almost all men and women know of at least one modern method of family planning, but only 18 percent of married women are currently using a modern method. This is an increase from 14 percent in 2000-01, due primarily to the increasing popularity of injectables.

Injectables, male condoms, and pills are the most commonly used modern methods. The UDHS reported that half of modern method users obtained their methods from a private source, such as a private hospital or clinic, while about one-third of users obtained their methods from a government hospital, health centre, or family planning clinic.

Two in five married women have an unmet need for family planning—that is, they do not want any more children or want to wait at least two years before having their next child but are not using any family planning. Eighty-six percent of non-users of family planning have not recently discussed contraception with a health worker.

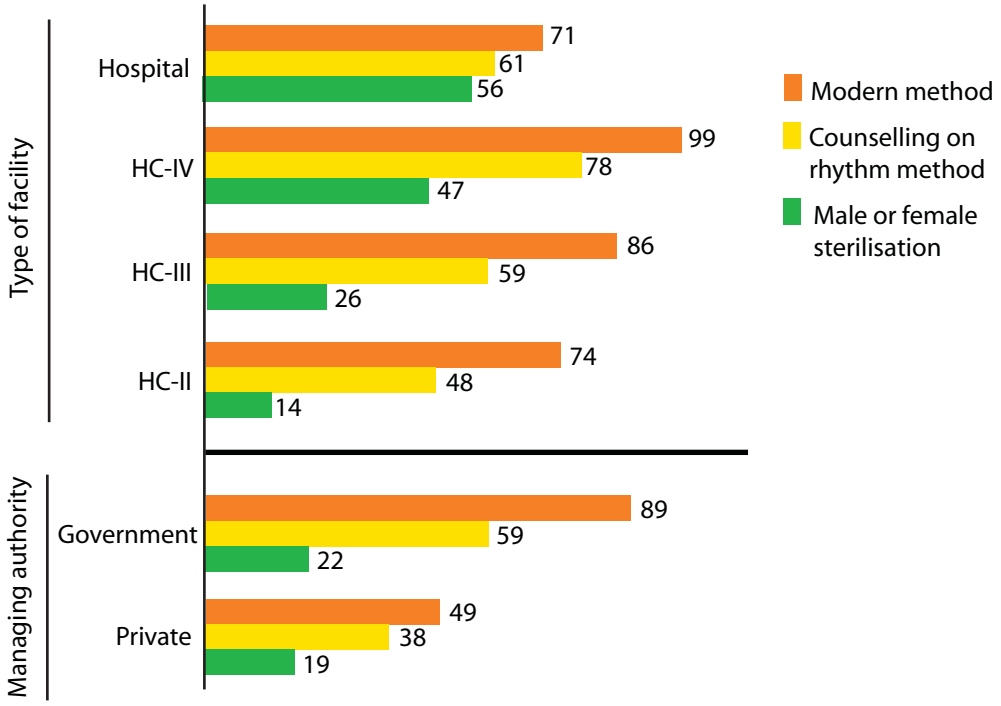
Discontinuation of family planning use is a problem in Uganda— 58 percent of users discontinue use of their method after one year.

Current Use of Family Planning, UDHS 2006



Percent of currently married women currently using a method

Availability of Family Planning Services by Facility Type and Managing Authority



Percent of facilities (N=491)

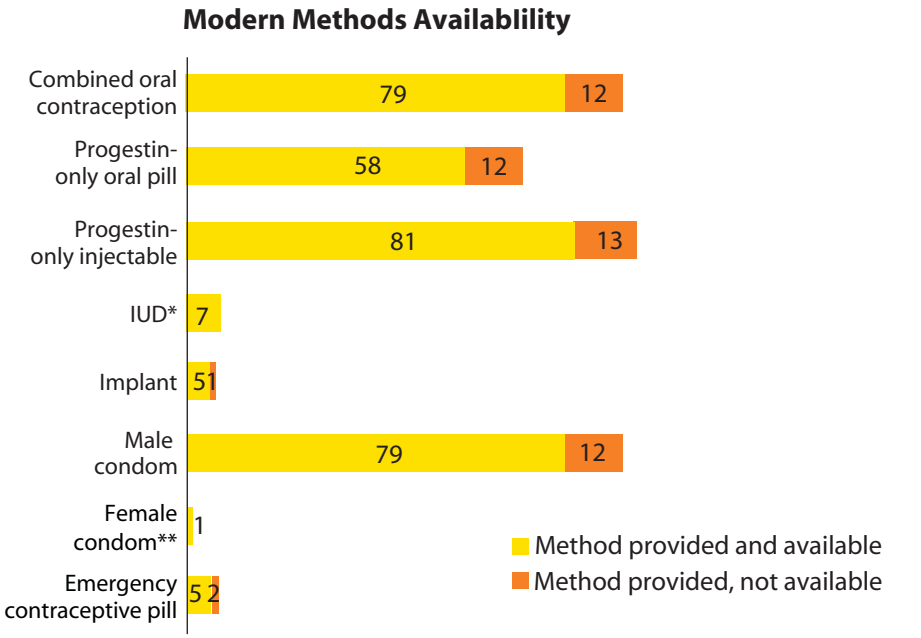
Method Availability

Family planning services that offer many different contraceptive methods are best able to meet the needs of their clients. Nationwide, 74 percent of facilities offering any family planning services reported that they offer at least four different reversible family planning methods. Ninety-seven percent of facilities offer at least two methods. Fewer facilities actually had these methods available on the day of the survey (see figures on page 3).

According to the DHS, injectables, pills, and condoms are the most widely used methods. They are also the most available methods. More than 90 percent of facilities either provide these methods, prescribe them, or counsel about them. Availability of male condoms is especially important, as they provide dual protection against pregnancy and HIV/AIDS. Eighty-five percent of facilities that report providing condoms actually had male condoms on the day of the survey.

Many fewer facilities provide long-term methods. While 26 percent of facilities report that they provide, prescribe or counsel about IUDs, in fact only 7 percent of all facilities actually have the IUD in stock, and only 4 percent have a provider trained to insert IUDs. Similarly, only 5 percent of facilities had implants available for insertion. Only half of facilities that provide IUDs have all the items needed for IUD insertion (clean latex gloves, antiseptic, speculum, forceps, tenaculum and uterine sound).

Emergency contraception is not a family planning method but instead is used just after unprotected intercourse to prevent unplanned pregnancy. Eighteen percent of facilities report that they provide, prescribe, or counsel about emergency contraception, and only a quarter of these facilities had emergency contraception in stock the day of the survey. The progestin-only pill, which also can be used as emergency contraception, and which is recommended during breastfeeding, is available in 76 percent of the facilities that report providing the method.



Percent of facilities providing family planning services (N=395)

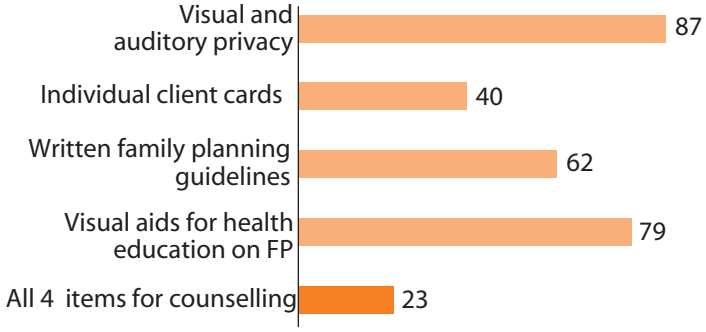
**Althouth 7% had IUD, only 4% of faciltities reported providing the method*
*** 1 percent of facilities had the female condom but zero percent report providing it*

Components Supporting Quality Family Planning Services

High quality family planning services may reduce discontinuation and contraceptive failures and help attract new users. Findings from the USPA present a mixed picture of family planning services in Uganda. On the plus side, 87 percent of facilities offering family planning have both visual and auditory privacy for client counselling. In addition, eight in ten facilities have visual aids for counselling on family planning, and 62 percent have written FP guidelines to help providers. Only 40 percent have individual client health cards, which help providers counsel and care for clients more effectively. In all, less than one quarter of facilities have all of the four components for quality counselling.

Facilities in Central, Eastern, Southwest and Kampala are most likely to have all four items for quality counselling (24 percent or better), compared to fewer than 15 percent of facilities in West Nile and North Central. One quarter of government facilities have all items for quality FP counselling compared to 11 percent of private facilities.

Items to Support Quality Counselling for Family Planning



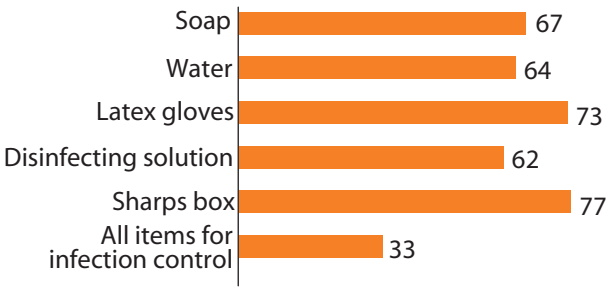
Percent of facilities offering family planning services (N=395)

Infection Control

Only one in three family planning facilities have all the items needed for infection control, including soap, running water, latex gloves, disinfecting solution, and sharps box for safe disposal for needles and blades at the service site. Infection control is less important during provision of oral contraceptives, condoms, and other methods that pose no risk of viral or bacterial infection to the client. There are very few facilities, however, that offer only these methods. Hospitals are most likely to have all the items needed for infection control (52 percent), while only one-quarter of HC-IIs have all necessary items. Private facilities are slightly more likely than government facilities to have the needed items (38 versus 32 percent).

Photo by Paul Ametepi, Macro International

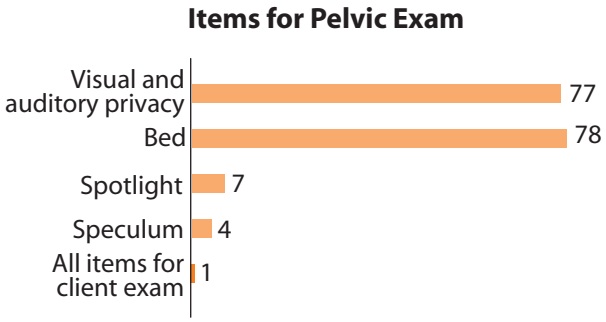
Infection Control in Family Planning Facilities



Percentage of facilities offering family planning services (N=395)

Equipment and Supplies for Specific Methods

Only one percent of all facilities and 10 percent of hospitals that offer FP have all the equipment needed for a quality pelvic exam. For example, only 7 percent of facilities have an examination light and only 4 percent have a speculum.



Percentage of facilities offering family planning services (N=395)

Some experts advocate that clients receiving oestrogen-containing methods should have their blood pressure checked; however, only 64 percent of facilities offering these methods had blood pressure equipment available.

As noted on page 4, only half of facilities providing IUDs had all the basic items necessary for IUD insertion and/or removal. In all, only 9 percent of facilities providing IUDs have IUDs, all basic items for insertion, and are able to provide quality conditions including infection control, privacy, an examination bed, and examination light. Less than half of facilities providing implants have all the items for implant insertion.

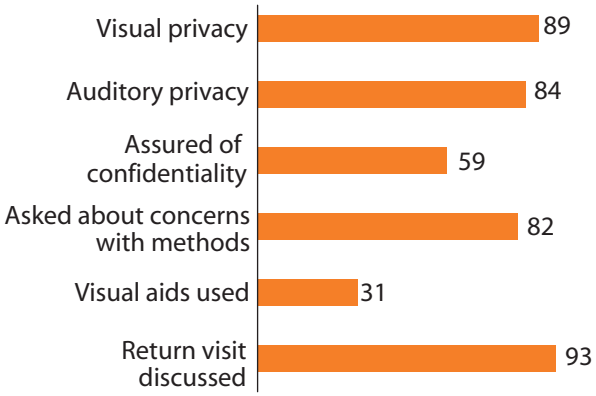
Sexually Transmitted Infections (STI) Services

Women in need of family planning are, by definition, sexually active, and therefore also at risk of contracting STIs. Routine treatment of STIs is reported in 79 percent of in FP service areas However, government FP facilities are more likely to treat STIs than private facilities. Of the facilities providing FP and where FP providers routinely treat and STIs, 85 percent have at least one medication to treat syphilis, 69 percent have at least one medication to treat Chlamydia, and 63 percent can treat trichomoniasis. Only about half (53 percent) have at least one medication to treat gonorrhea. Only 42 percent have at least one medication to treat all four STIs.

Observation of Client Visits

The USPA observed family planning client visits to assess how closely providers adhere to internationally recognised standards for quality service provision. Trained interviewers observed 85 clients of family planning services; 32 percent of these clients were visiting the family planning facility for the first time, and 68 percent of the clients came for follow-up visits. Almost all of the clients left the facility with a family planning method; 70 percent of clients received the progestin-only injectable, 20% received the combined pill, and about 25 percent received condoms.

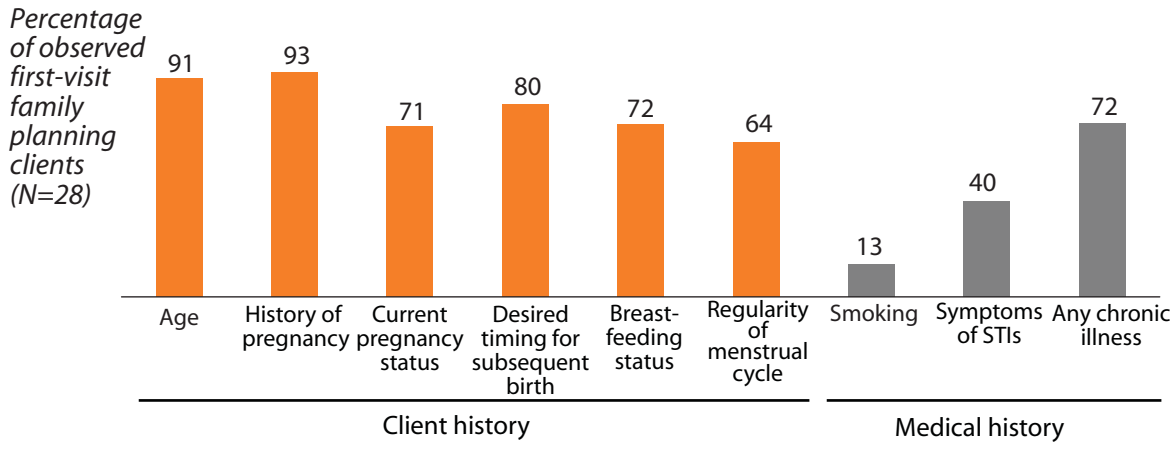
Observed Conditions and Content for Family Planning Counseling



Over 80 percent of the family planning consultations took place under appropriately private conditions. Four in five clients were asked by providers if they had any concerns about their methods. This is a fairly large percentage considering that many of the clients were repeat visitors to the facilities. Return/follow-up visits were discussed with almost all clients (93 percent). Visual aids were used during only 31 percent of the consultations, even though these aids are available in 84 percent of family planning facilities.

Observations of consultations with first-visit family planning clients indicate that most recommended assessments are routinely carried out. For example, over 70 percent of first-visit clients were asked about their breastfeeding status, desired timing for their next chid, and current pregnancy status. Only 40 percent, however, were asked about STI symptoms. While providers appear to be doing a good job of family planning and pregnancy-related screening, they may be missing an opportunity to provide preventive HIV and STI counselling.

Observed Elements of Client History for First-Visit Family Planning Clients



Management Practices and Training

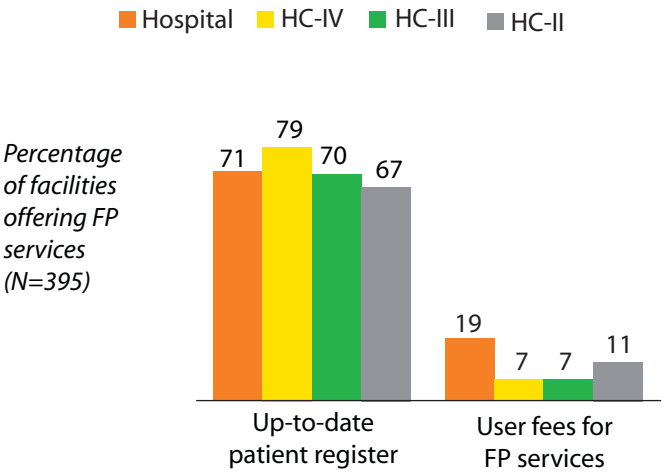
The 2007 USPA collected data about several important management practices: up-to-date client registers, user fees, and routine staff training and supervision. Results vary widely by facility type and region.

Just under 70 percent of facilities offering family planning have up-to-date client registers, essential tools for management information systems. Client registers are more common in government facilities than in private facilities (74 versus 44 percent)

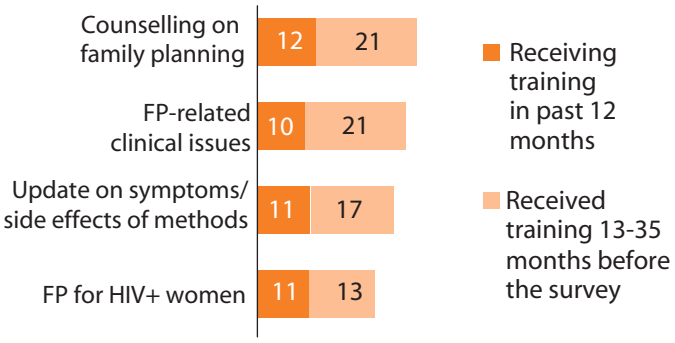
In Uganda, government facilities should not charge for family planning services, and government-supplied methods should be free, even in private facilities. According to the USPA, 2 percent of government and 51 percent of private FP facilities charge a fee. Private facilities often charge a consultation fee, for the FP method, and for tests. Overall, 19 percent of hospitals, 7 percent of HC-IV and HC-IIIs, and 11 percent of HC-IIs charge some user fees.

The USPA interviewed 997 family planning providers. Only 17 percent of interviewed service providers received any training during the 12 months preceding the survey. Another 19 percent received their most recent training during the 13-35 months prior to the survey. Providers in HC-IIIs are most likely to have received recent training. Provider training is consistently low across regions, except for North Central, where more than half of providers had received training during the 12 months preceding the survey. The training provided covered a range of topics including family planning counselling, update on contraceptive methods, and FP for women infected with HIV.

Management Practices for Family Planning Services: Patient Register and User Fees



In-Service Training Received by Interviewed Family Planning Service Providers



Percent of interviewed family planning service providers (N=997)

2007 USPA Results: Maternal Health Services

Maternal health services are not consistently available throughout Uganda. Nationwide, 71 percent of health care facilities provide antenatal care (ANC) services, mostly hospitals (95 percent), HC-IVs (100 percent) and HC-IIIs (96 percent). Only 52 percent of HC-IIs, the most common source of health care for Ugandans, provide ANC. Sixty-three percent of all facilities provide tetanus toxoid vaccines. Normal delivery services are available in about half (53 percent) of facilities, while only one third (31 percent) of facilities offer postnatal (or postpartum) care.

(c) 2001 Hugh Rigby/CCP, Courtesy of Photoshare

Emergency services are not widely available. Only 47 percent of all facilities have a system in place to provide transport to a referral site for maternal emergencies. Ironically, the lowest level health centres are least likely to have transportation support for emergencies (only 33 percent), although these centres are also least able to treat emergencies. Only 5 percent of facilities nationwide can perform a Caesarean section.

Malaria during pregnancy can have serious adverse effects on both the mother and the foetus. For more malaria findings, see the Malaria section, page 23.

Availability of Maternal Health Services

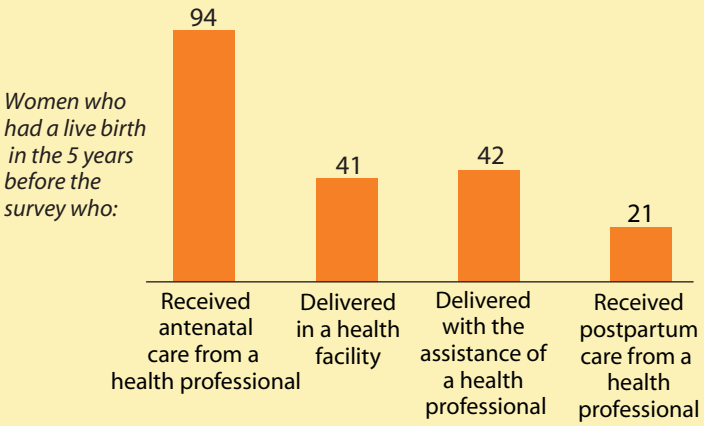
Percentage of facilities offering specific services, by region (N=491)

Region	ANC	Normal delivery	C-section	Transportation support for maternity emergencies	Postnatal or Postpartum care
Central	93	65	5	41	39
Kampala	76	63	26	69	67
East Central	72	58	4	51	31
Eastern	66	52	7	29	19
Northeast	51	46	4	46	33
North Central	67	60	6	80	39
West Nile	78	56	5	85	34
Western	59	43	6	34	21
Southwest	61	39	4	38	27
TOTAL	**71**	**53**	**5**	**47**	**31**

Putting the USPA into Context: Maternal Health in the UDHS

According to the 2006 UDHS, 95 percent of pregnant women make at least one antenatal care visit; 42 percent make two or three visits; and 47 percent make four or more. However, most women seek care well after the first trimester of pregnancy. Three-quarters of births are protected against neonatal tetanus.

Antenatal, Delivery and Postpartum Care



Far fewer women go to health care facilities to give birth. Nationwide, only 41 percent of women give birth in a health care facility. Women staying at home are more likely to be assisted by a traditional birth attendant or a friend or relative than by a trained provider. Delivery assistance from a health professional, though still low, has increased slightly since 2000/01 (43 percent versus 39 percent). Only 21 percent of women received any postnatal care from a skilled health provider.

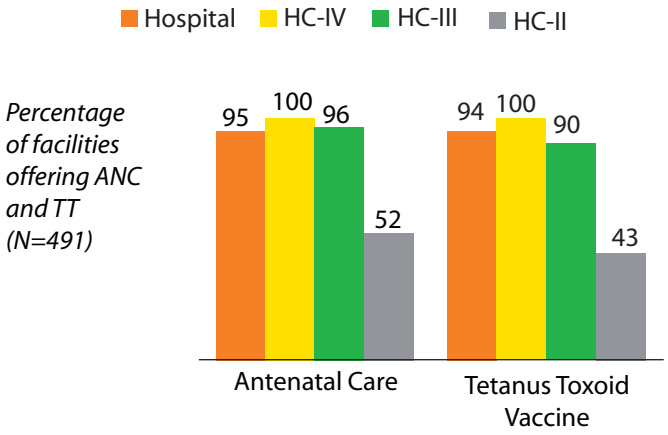
There are approximately 435 maternal deaths per 100,000 live births. Many of these deaths are related to obstetric complications, including unsafe abortions, haemorrhage, and high blood pressure.

Antenatal Care and Postpartum Care

Nationwide, 71 percent of facilities offer antenatal care services, ranging from only 51 percent of facilities in Northeast to 93 percent of facilities in Central Region. Most hospitals and HC-IVs offer ANC services five days a week, while lower level health centres often offer these services only once or twice a week. Similarly, tetanus toxoid vaccines are available five days a week at most hospitals and HC-IVs, but less often at other facilities. In seven out of every ten facilities, tetanus toxoid vaccination is always offered on the same days that antenatal care is offered.

Postpartum care is available at only 31 percent of facilities, most commonly hospitals and health centres.

Availability of Antenatal Care and Tetanus Toxoid Vaccine



Items to Support Quality ANC Services

The availability of basic items for ANC varies throughout Uganda. Only 22 percent of facilities that offer ANC have all the essential supplies for basic ANC—iron and folic acid tablets, tetanus toxoid vaccine, blood pressure apparatus, and fetoscope. Availability of these basic items ranges from 7 percent in Eastern Region to around 50 percent in Northeast and North Central regions. Items needed for physical exams are even less available. For example, only 8 percent of facilities have an exam light. Approximately eight in ten facilities providing ANC do have visual and auditory privacy, and almost nine in ten have an exam bed. One-third of ANC facilities have visual aids for health education and half have blank individual client health cards. Just over 60 percent have ANC guidelines on site.

Laboratory testing capacity for anaemia, urine protein, urine glucose, Rh factor, and syphilis vary in availability. Hospitals are most likely to have these tests. Few facilities have a standard or routine to screen ANC clients for any of these conditions.

Availability of Diagnostic Tests

Percentage of facilities providing ANC with capacity for conducting the indicated diagnostic test (N=347)

Zone	Anaemia	Urine protein	Urine glucose	Rh factor	Syphilis
Central	17	26	26	1	18
Kampala	76	85	82	12	84
East Central	23	18	18	3	21
Eastern	11	14	14	1	13
Northeast	35	26	31	1	16
North Central	18	37	37	0	26
West Nile	32	50	44	1	20
Western	26	37	39	1	29
Southwest	14	27	31	1	25
TOTAL	**21**	**29**	**29**	**1**	**22**

Photo by Paul Ametepi, Macro International

Availability of Medicines

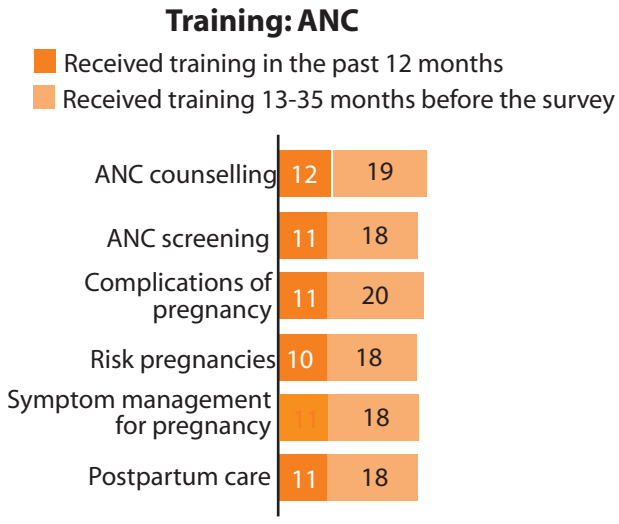
ANC facilities also vary in their capacity to treat common problems of pregnancy. About three in four ANC facilities have an antibiotic and almost all have an antimalarial drug. However, only 10 percent of these facilities have methyldopa (aldomet), used for treating high blood pressure, a common complication of pregnancy. Most facilities have at least one medication for treating syphilis (86 percent), but fewer are able to treat other STIs—trichomoniasis (68 percent), chlamydia (73 percent) or gonorrhea (57 percent). Overall, only 6 percent of all facilities providing ANC have medications on hand for treating all of these common complications and infections in pregnancy.

Management Support for ANC and PPC

Four in five facilities have up-to-date client registers for ANC. Far fewer, only 5 percent, have registers for postpartum care.

The USPA determines that a facility has routine staff training if at least half of interviewed providers in that facility report that they received structured pre- or in-service training within the year preceding the survey. Approximately two-thirds of facilities providing ANC offer their staff routine training. Of all ANC providers interviewed, less than 15 percent had received training in ANC counselling, screening, complications of pregnancy, or postpartum care in the year before the survey.

Similarly, a facility is considered as having routine staff supervision if at least half of interviewed providers report they have been personally supervised in the six



Percent of interviewed ANC providers with training in specified topics (N=756)

months preceding the survey. Facilities were more likely to provide personal supervision: in 92 percent of facilities, at least half of interviewed providers had received personal supervision once or more in the six months preceding the survey.

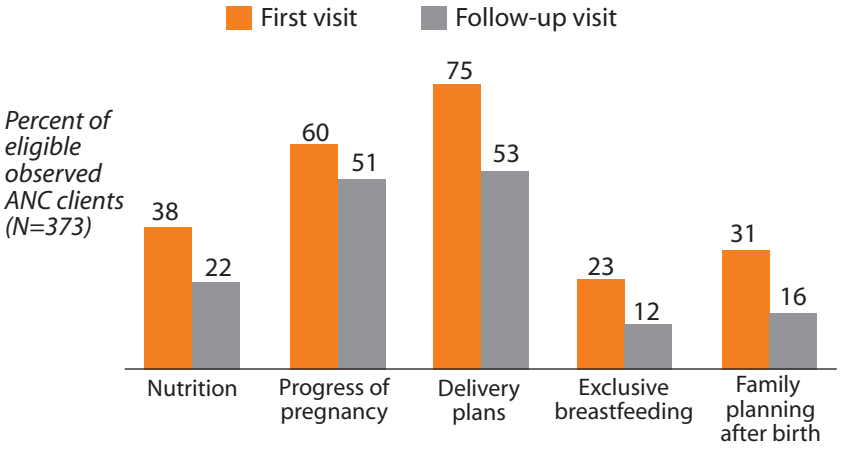
ANC should be free in all government facilities. Overall, one-fifth of facilities, mostly private, charge user fees for ANC services. Seventy percent of private facilities charge user fees, compared to 4 percent of government facilities.

Adherence to Standards in ANC

USPA interviewers observed the client-provider interactions of 373 ANC clients. About half of the clients observed were visiting for the first time in their pregnancy, while the other half were coming for a follow-up visit.

The USPA findings suggest that health care providers do well with routine activities for monitoring pregnancies but are less alert to complications of pregnancy or to related health concerns. For example, over 80 percent of eligible pregnant clients were weighed and had their blood pressure checked, but only 8 percent had their urine tested for protein even though almost 30 percent of facilities have the capacity to provide this service. About three-quarters of observed clients were given iron tablets and half received the tetanus toxoid vaccine.

Counselling Topics Discussed During ANC Visits

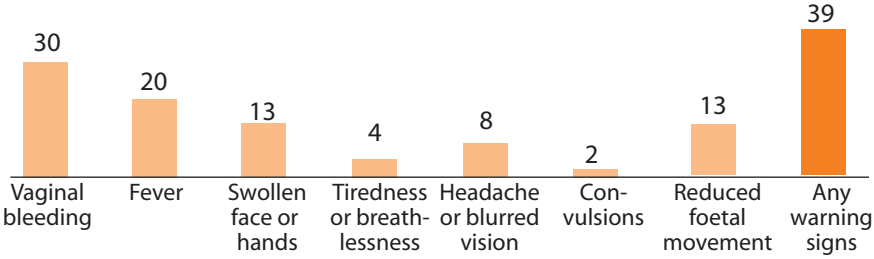


ANC providers did not take client history or counsel clients consistently. Only one-third of first-visit clients were asked about any medications they were currently taking, and only 59 percent of first clients with previous births were asked about complications of previous pregnancies. Delivery plans were discussed with only 56 percent of late-term (at least eight months pregnant) clients. Less than one quarter of all ANC clients were counselled about postpartum family planning or exclusive breastfeeding.

Counselling and education on specific warning signs of pregnancy are not regularly carried out. Among clients who were interviewed as they left the facility after receiving services, only 39 percent said that their providers had talked with them about any warning sign of pregnancy during the current visit or any prior visits. These results are similar to those found in the 2006 UDHS, which reported that 35 percent of women who received ANC said that their provider had told them about signs of pregnancy complications.

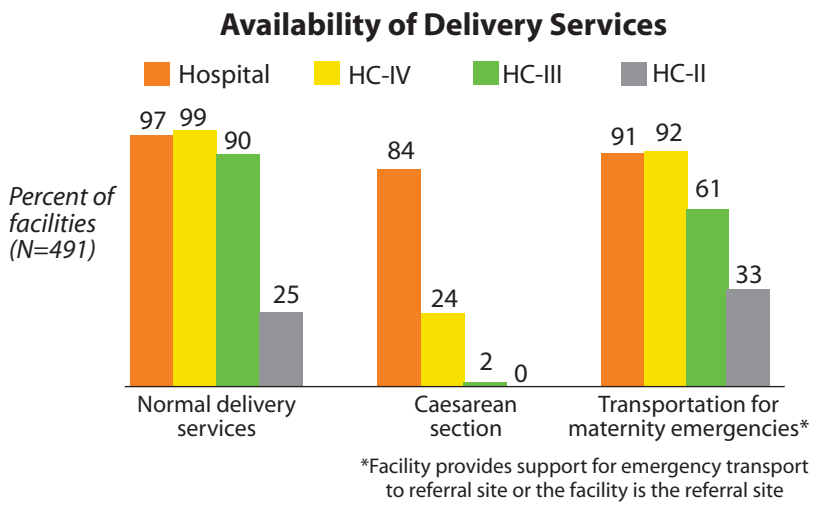
Health Education Received as Reported by ANC Clients

Percent of interviewed ANC clients who said provider counselled them on specific warning signs (N=373)



Delivery Services

As noted on page 9, only 53 percent of all facilities provide normal delivery services. Availability of these services ranges from only 39 percent of facilities in Southwest to 65 percent of facilities in Central Region. The median monthly number of deliveries for the 12 months preceding the survey was 103 for hospitals and 28 for HC-IVs. Hospitals had a median of 24 C-sections per month in the 12 months preceding the survey.



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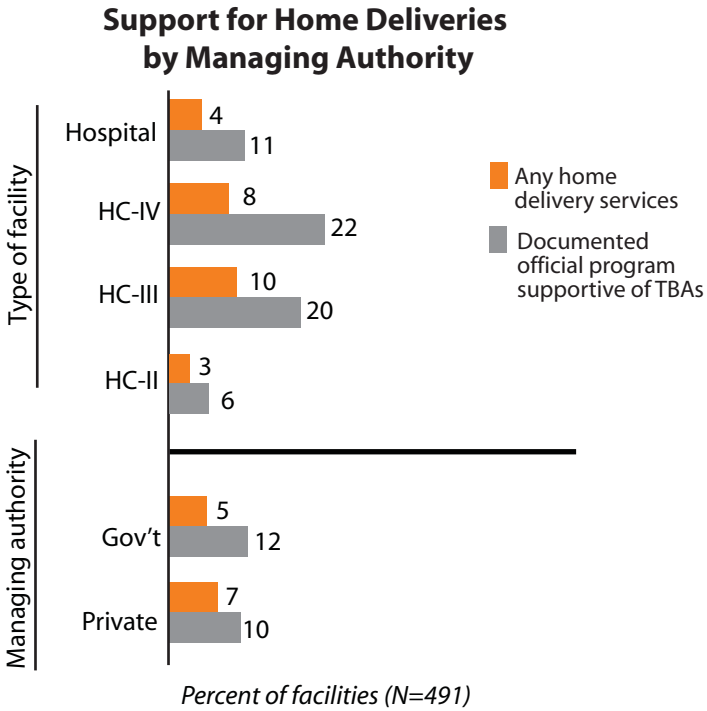
Domiciliary Care Practices

According to the 2006 UDHS, almost six in ten pregnant women deliver at home, most without assistance from a trained provider. The USPA findings show, however, that only 6 percent of all facilities have services supporting home delivery, either for routine cases or emergencies. Twelve percent of facilities have programmes with traditional birth assistants.



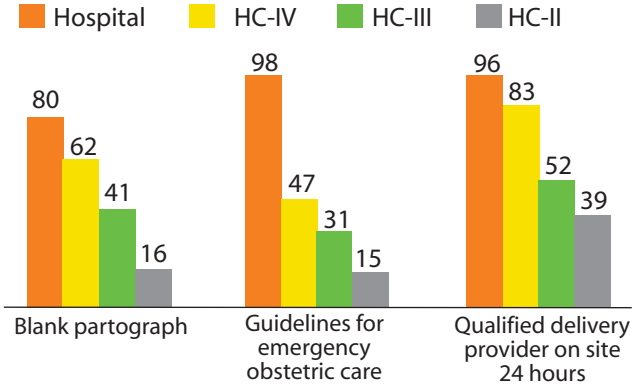
Elements and Practices to Support Normal Deliveries

Most facilities providing delivery services have delivery beds and privacy for delivery (78 percent each). Only 13 percent of facilities have an examination light, however. Fewer facilities have other necessary items, especially guidelines for both normal and emergency deliveries. The partograph, a standard tool used for monitoring the progress of labour, is available in only 39 percent of facilities. Less than half of facilities (44 percent) have all of the items needed for infection control.

A total of 55 percent of facilities offering deliveries have a trained provider on site 24 hours a day, while another 1 percent have a provider on call 24 hours a day.

Items to Support Quality Delivery Services

Percent of facilities offering delivery services (N=261)

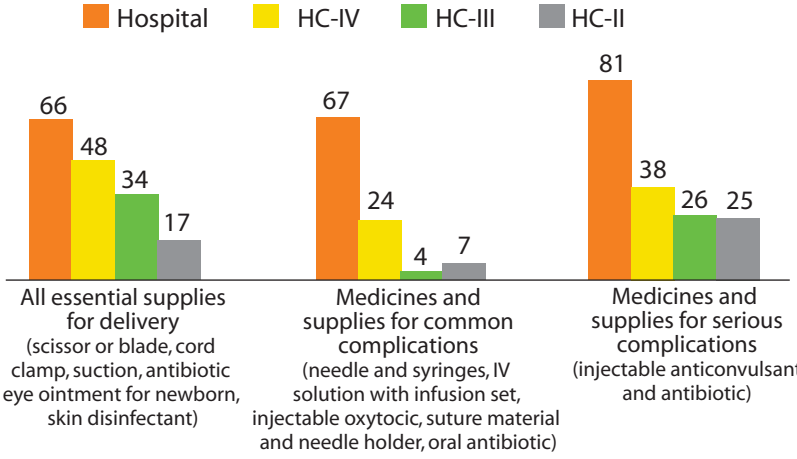


Supplies for Normal and Complicated Deliveries

Only one-third of facilities have all the necessary supplies for normal deliveries in the delivery area: scissors or a blade; cord clamp or tie; suction apparatus; and skin disinfectant. Very few facilities that offer delivery services (11 percent) have all the supplies needed to handle common complications (see figure at right). Interestingly, more facilities (31 percent) have the medicines needed to treat serious complications. In both cases, hospitals and private institutions are most likely to have all the necessary items.

Availability of Medicines and Supplies for Delivery

Percent of facilities offering delivery services (N=261)



Of most concern, however, is that equipment for life-threatening emergencies is in such short supply. Hospitals and HC-IVs are expected to provide comprehensive emergency obstetric care, including C-sections. Nationwide, only 5 percent of facilities have a vacuum extractor (used for assisted vaginal delivery), and only 10 percent have a dilation and curettage (D&C) kit (needed to remove retained placenta). Injectable oxytocin to prevent haemorrhage is available in the delivery area in only 17 percent of facilities that offer delivery services, although 73 percent of facilities have ergometrine or methegrine. Only 12 percent have blood transfusion services (although 90 percent of hospitals have this ability) and 37 percent have newborn respiratory support services.

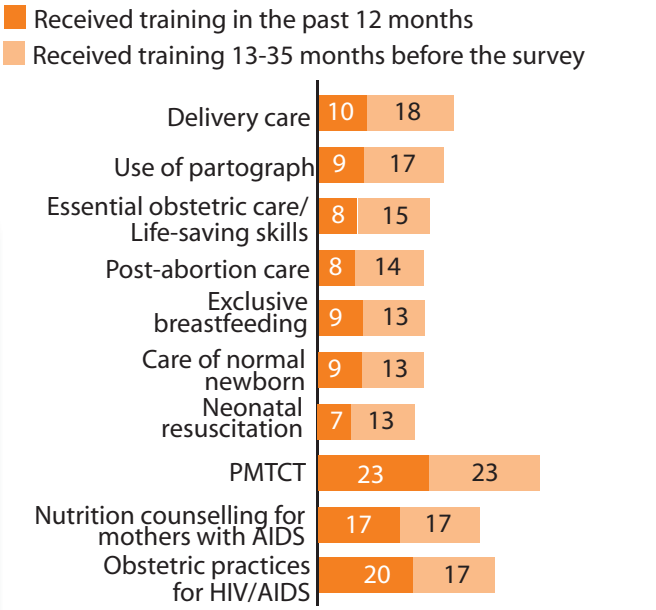
Almost 80 percent of hospitals and HC-IVs offering delivery services had used oxytocics in the three months preceding the survey, and 62 percent had carried out manual removal of placenta. Use of anticonvulsants (35 percent), blood transfusions (43 percent), and C-sections (41 percent) were less common.

Management Practices and Training

The USPA interviewed 579 delivery service providers. Only one-third of these providers reported receiving any training (pre- or in-service) during the year preceding the survey. Only 7 to 10 percent had been trained in any basic obstetric topic (see chart at right). Twice as many providers received training related to HIV/AIDS.

Photo by Paul Ametepi, Macro International

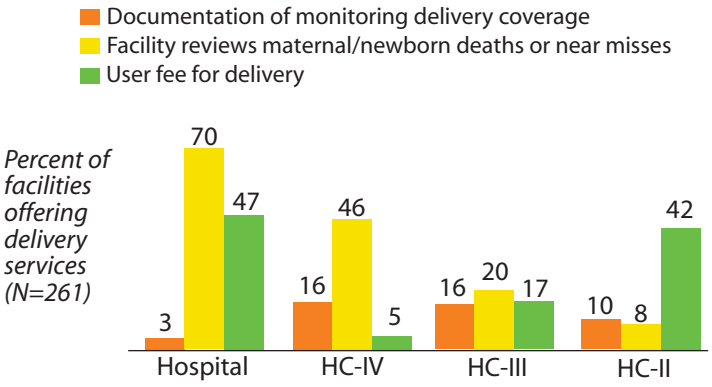
In-Service Training: Delivery



Percent of interviewed delivery-service providers with training in specified topics (N=579)

Only 13 percent of facilities offering delivery services document monitoring of delivery coverage in their catchment area. Monitoring of delivery coverage is highest in HC-IVs and HC-IIIs (16 percent each) and government facilities (15 percent). No facilities in East Central or Southwest monitor delivery coverage, compared to more than 30 percent of facilities in West Nile and Western regions.

Management Practices



Careful reviews of maternal or newborn deaths or near-misses help providers recognize problems and prevent future deaths. Nationwide, only 23 percent of facilities providing delivery services conduct these reviews. Hospitals are most likely to conduct reviews of maternal and/or newborn deaths or near misses (70 percent) compared to only 46 percent of HC-IVs and 20 percent of HC-IIIs that offer delivery services.

Very few (4 percent) government facilities charge user fees for delivery, while the majority of private and facilities (90 percent) charge fees. Nationally, 25 percent of facilities charge delivery fees.

Infection Control

Only one-third of all facilities offering ANC and 44 percent of facilities offering delivery services are fully equipped with soap and running water, clean latex gloves, disinfecting solution, and a sharps box. Running water is available in only 65 percent of ANC sites and 69 percent of delivery sites.

While 92 percent of facilities offering delivery services report sterilisation of equipment for reuse, only 9 percent have all of the equipment and knowledge needed to sterilise or disinfect using dry heat/autoclave or boil/steam or chemical high-level disinfection (HLD). Only 5 percent of facilities have written guidelines for sterilisation or HLD procedures at the processing site.

Infection Control in Delivery Services

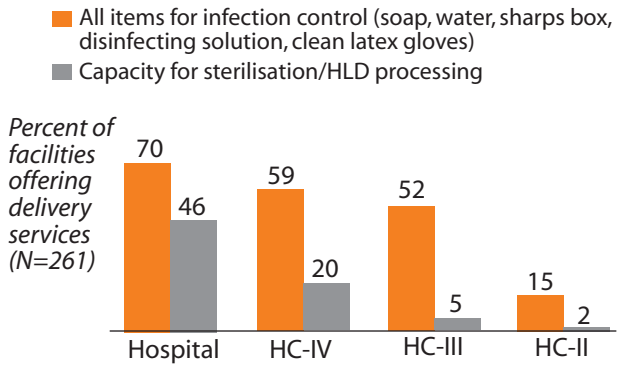


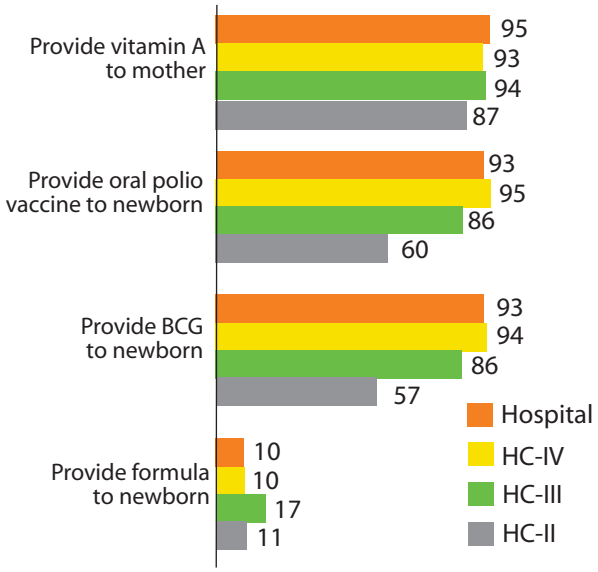
Photo by Paul Ametepi, Macro International

Newborn Care

Several routine practises can increase newborn and infant survival. Vitamin A supplementation to breastfeeding mothers, for example, is beneficial to both mother and newborn. Nine in ten facilities (92 percent) that offer delivery services routinely provide vitamin A to new mothers, and 93 percent of facilities have vitamin A either in the delivery room or in the pharmacy. Other recommended practices, such as providing BCG and oral polio vaccines are almost universal. Fourteen percent of facilities still provide formula or other liquids to newborns before breastfeeding is established.

(c) 2001 Hugh Rigby/CCP, Courtesy of Photoshare

Newborn Care Practices



Percent of facilities offering delivery services (N=261)

2007 USPA Results: Child Health Services

Photo by Paul Ametepi, Macro International

The USPA assessed the availability of three basic child health services: curative care for sick children; immunisations; and growth monitoring. The USPA also evaluates health care providers' adherence to the World Health Organization's Integrated Management of Childhood Illness (IMCI) strategy, adopted by the Ministry of Health (MOH) in 1996 and the MOH's Expanded Programme of Immunisations (EPI).

Almost all facilities (98 percent) provide curative care for sick children, 88 percent provide childhood immunisations, and 65 percent provide growth monitoring. Nationally, about two-thirds of facilities provide all three services. Over 80 percent of hospitals and HC-IVs provide all three services. Availability varies markedly by region, from only 31 percent of facilities offering all three child health services in East Central to 89 percent in Central Region. Curative care for sick children is available in most facilities five days a week, while immunisation and growth monitoring services are often available only once or twice a week.

Immunisation services are available in 81 percent of private facilities, while 90 percent of government facilities provide childhood immunisations. More than 70 percent of facilities in all regions provide immunisation.

Availability of Child Health Services

Percentage of facilities providing the indicated services at the facility, by type of facility (N= 491)

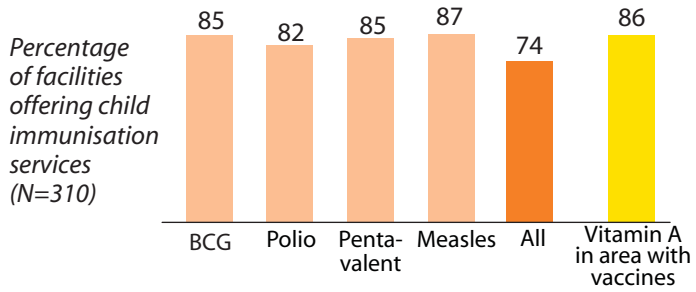
Facility type	Curative care for sick children	Growth monitoring	Immunisation	All 3 basic child health services
Hospital	97	82	98	81
HC-IV	100	83	100	83
HC-III	100	76	96	76
HC-II	97	57	82	55
Total	**98**	**65**	**88**	**64**

Immunisations

The basic EPI vaccines (BCG, polio, pentavalent, measles) are available in three out of four facilities that provide childhood immunisation services. No vaccine is universally available.

According to the EPI, vitamin A should be stored with vaccines in order to increase provision of vitamin A. Most facilities (86 percent) that offer child immunisation in Uganda follow this recommendation.

Availability of Vaccines and Vitamin A for EPI



Several supplies are needed to provide the best vaccine services. Among the facilities providing child immunisation services, 90 percent have blank immunisation records, 79 percent have syringes and needles, and 90 percent have vaccine carriers with ice packs. About half of facilities offering child immunisation have all items needed for infection control.

Certain administrative components are also needed. While about nine in ten facilities have a client register and tally sheet, only 19 percent monitor measles coverage or DPT/pentavalent dropout rates in their catchment areas. Thus, only 18 percent of facilities offering immunisation have all of the necessary administrative components.

According to the USPA, quality child immunisation includes:

***1**-Availability of all EPI vaccines (74%) and vitamin A (86%)*

***2**-Equipment: immunisation cards, syringes and needles and vaccine carriers (65%)*

***3**-All items for infection control (48%)*

***4**-Client register or tally sheet, documentation of measles coverage or DPT/pentavalent dropout rate (18%)*

Only 9% of facilities have all these components

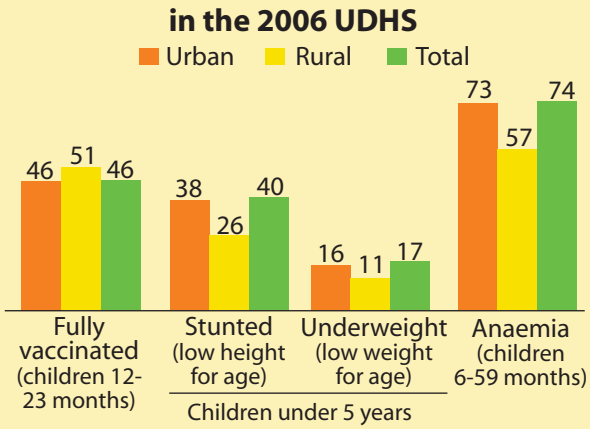
Growth Monitoring

Two in three facilities provide growth monitoring for children. However, only half of these facilities offer growth monitoring five days a week. Furthermore, only 38 percent of facilities that offer curative care for sick children have a scale to weigh infants, and three-quarters have a scale to weigh older children (see page 18).

Putting the USPA into Context: Child Health in Uganda

Child mortality has declined since 2000-01. As of the 2006 UDHS, the infant mortality rate was 75 per 1,000 live births, down from 89 deaths per 1,000 in 2000-01. The under-five mortality rate was 137 deaths per 1,000 live births compared to 158 in 2000-01. Still, one in every eight children in Uganda dies before his or her fifth birthday.

In 2006, less than half (46 percent) of Ugandan children had received all of the recommended EPI vaccines (BCG, three doses each of DPT/THB and polio, and one dose of measles). Seven percent of children had no vaccinations. Immunisation coverage has improved in recent years, as only 37 percent of children were fully immunised in 2000-01.



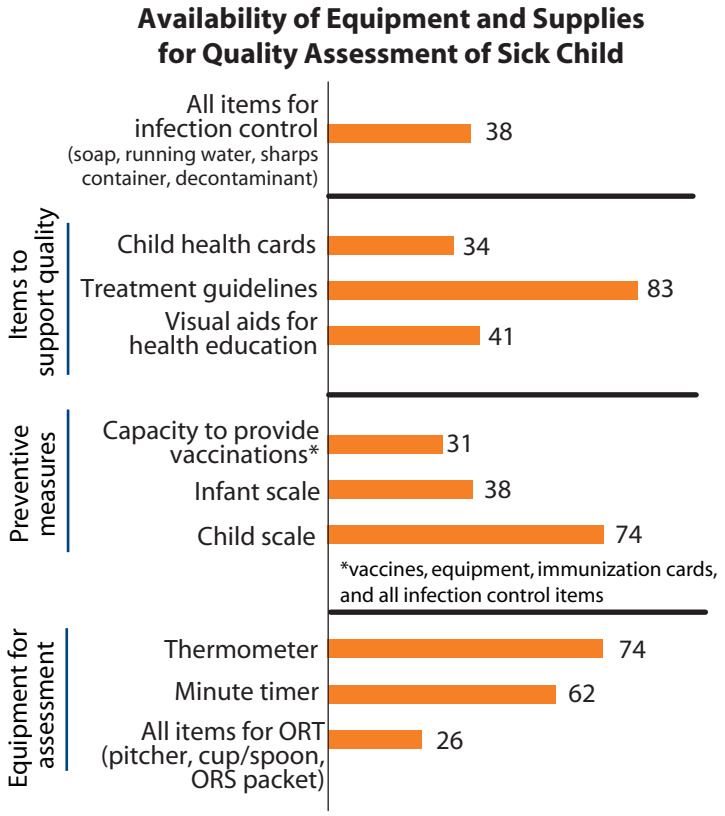
Among children with acute respiratory infection (ARI) or fever in the two weeks before the DHS, 73 percent were taken to a health facility for treatment. Only 40 percent of children with diarrhoea were treated with oral rehydration salts (ORS), although almost all mothers know about ORS packets. Only one-fifth of children with diarrhoea were given increased fluids, a critical intervention to prevent dehydration. About 70 percent were taken to a health provider. Almost one-third were given antibiotics, which are usually unnecessary.

Malnutrition is a serious problem in Uganda. Almost four in ten children under age five are stunted, or too short for their age. Stunting is a sign of chronic malnutrition. One in six children is underweight, or too thin for their age. Almost three in four children are anaemic, while more than half are moderately or severely anaemic.

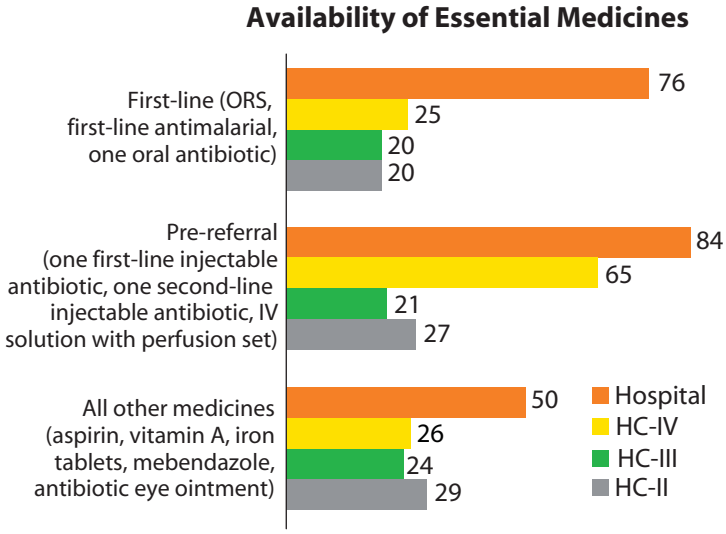
Care for the Sick Child

While almost all facilities provide curative care for sick children, only 10% of these facilities have all of the items needed to provide quality services including individual health cards, treatment guidelines and visual aids. Many essential items needed for treating sick children are not available in all facilities. For example, only 34 percent of facilities have child health cards, and only 41 percent have visual aids. Only about one in four facilities have the items necessary to provide oral rehydration therapy (cup, spoon, and ORS).

The IMCI guidelines were created both to improve quality of care for sick children as well as to improve preventive care. In Uganda, however, only one-third of facilities offer EPI services on every day that sick child services are available. This is a missed opportunity, as parents may not bring their children back to the facility later for immunisations.



Percentage of facilities offering outpatient care for sick children (N=481)



Percent of facilities offering sick child services that have each item (N= 481)

Essential Medicines for Treating Sick Children

Only one in four facilities that offer curative care for sick children has all three first-line medicines identified by the IMCI guidelines—ORS, first-line antimalarial, and at least one antibiotic. Hospitals are most likely to have these three items. Pre-referral medications—one first-line injectable antibiotic, one second-line injectable antibiotic, and IV solution with perfusion set and sterile syringes—are available in four in ten facilities. Hospitals and private facilities are more likely than other level or government-run facilities to have all types of medicines.

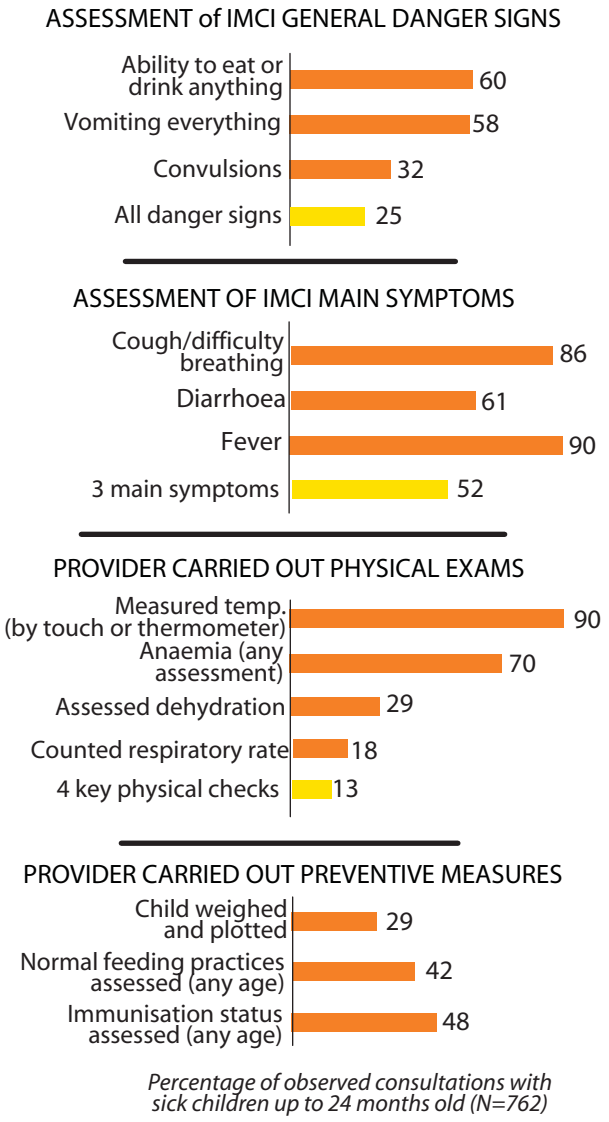
Observation of Sick Child Consultations

USPA interviewers observed sick child consultations to check if providers followed IMCI guidelines. Only during one in four consultations did providers check for all three major danger signs: ability to eat or drink anything (60 percent); vomiting (58 percent); and convulsions (32 percent). Various aspects of the physical examination were also missing—30 percent did not check for anaemia, only 29 percent assessed dehydration, and only 18 percent counted respiratory rates.

IMCI guidelines state that sick child services should also be able to provide vaccines and growth monitoring. However, children's weights were plotted in only 29 percent of observed sick child consultations, feeding practices were assessed in only 42 percent of observations, and immunisation status in 48 percent. These are clear missed opportunities for prevention.

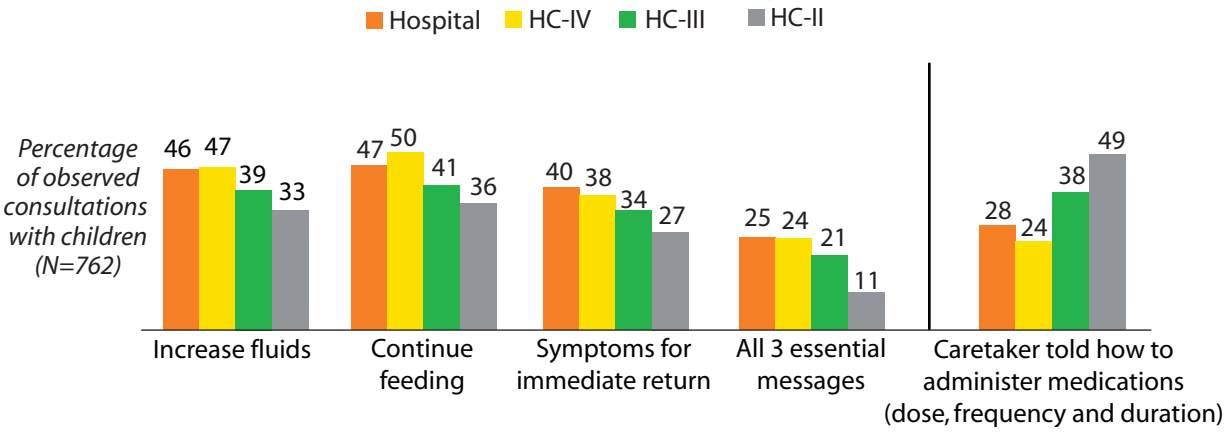
Providers should tell caregivers how to care for their sick children. While 57 percent of caregivers were told what illness their child had, far fewer received the three essential messages about treatment. Only two in five caregivers were told to increase fluids or to continue feeding. One-third were told what symptoms required a return visit. In all, these three essential messages were given in only 18 percent of observed visits. Only 40 percent of caregivers were fully instructed about giving medications.

Observed Assessments and Examinations



Percentage of observed consultations with sick children up to 24 months old (N=762)

Essential Advice Given to Caregivers



Treatment by Diagnosis

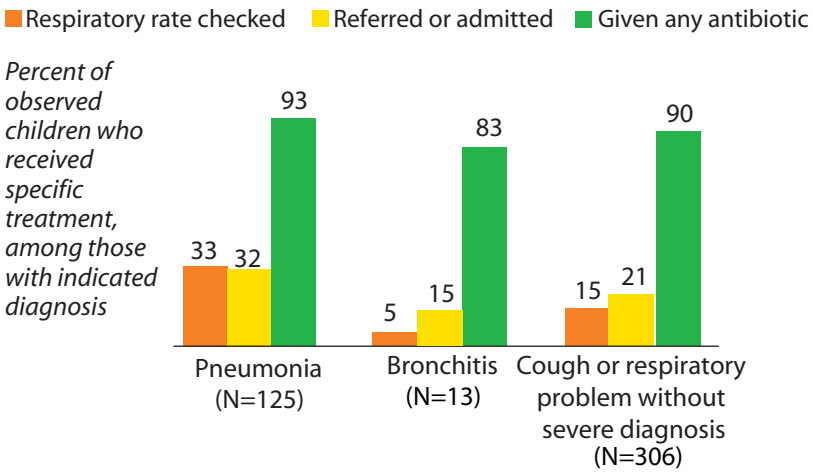
Providers often do not follow IMCI guidelines for diagnosis and treatment for specific illnesses. Only one-third of children with respiratory illness, for example, had their respiratory rate checked, as recommended. Almost all children with pneumonia or severe respiratory illnesses were given antibiotics, including 90 percent of children with non-severe respiratory problems which is against IMCI guidelines.

According to the IMCI and MOH policy and national treatment protocol, children with fever or history of fever should receive an antimalarial and a fever-reducing medication such as aspirin. More than half of children with severe fever received an antibiotic and only 50 percent received a first-line antimalarial. About three-quarters of these children received medication for symptoms, such as aspirin or cough medicine. Ninety-six percent of children who were diagnosed with malaria received an antimalarial drug, only 69 percent received the first-line antimalarial drug, and 70 percent also received an antibiotic.

About three in ten children diagnosed with severe diarrhoea were referred or admitted; this is about the same percentage of non-severe diarrhoea cases that were referred or admitted. Antibiotics should not be prescribed for non-dysentery related diarrhoea; however, 67 percent of children with any type of non-dysentery diarrhoea were given antibiotics. ORS was prescribed for 83 percent of those with severe diarrhoea and 73 percent of those with less severe cases.

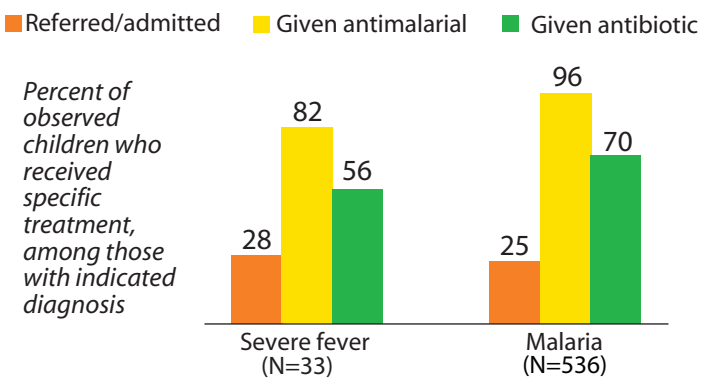
For all diagnoses, providers failed to assess for many of the IMCI main symptoms and danger signs, and did not consistently provide the basic physical exams. Antibiotics were prescribed for a wide range of diagnoses, signalling a possible overuse.

Treatment of Children with Respiratory Illnesses



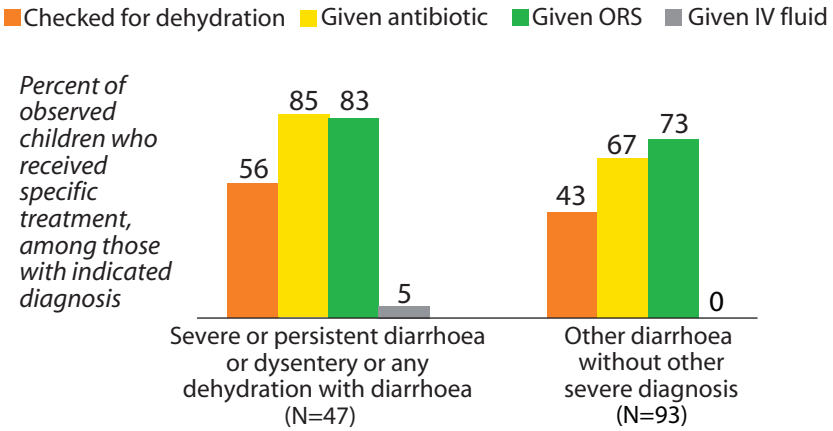
**Diagnoses of children made by the providers*

Treatment of Children with Fever or Malaria



**Diagnoses of children made by the providers*

Treatment of Children with Diarrhoeal Diseases



**Diagnoses of children made by the providers*

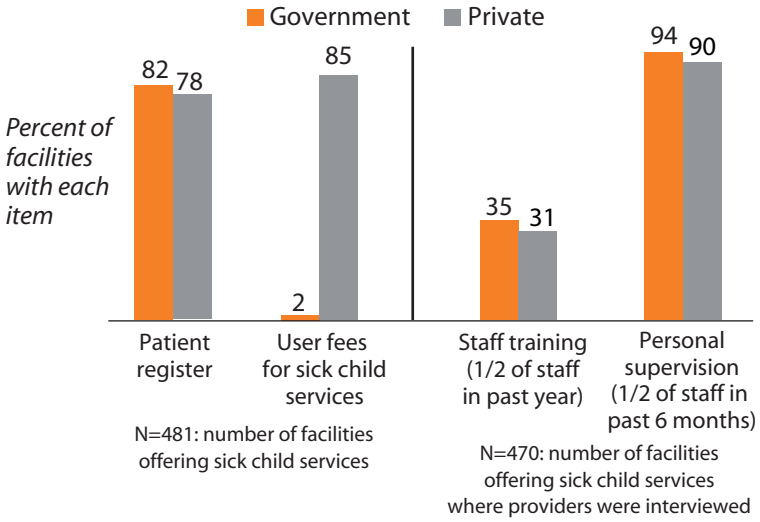
Management Practises Supporting Sick Child Care

Most facilities (81 percent) offering curative care for sick children have an up-to-date patient register. One-third of facilities provide routine staff training, meaning that half of staff interviewed in that facility have been trained in the year before the survey. Of the 1,360 child health service providers interviewed, 31 percent reported receiving training within the 12 months before the survey. Less than 15 percent of providers received training in most topics, including EPI/cold chain, ARI and diarrhoea treatment, nutrition/micronutrient deficiencies, and IMCI during this period. Training in malaria treatment was more common (21 percent). Only 5 percent of providers received any training in paediatric AIDS management in the three years prior to the survey.

Almost nine in ten child health providers interviewed for the USPA reported that they had been supervised in the six months before the survey. During this supervision, supervisors usually checked records, observed work, and discussed problems.

According to MOH policy, child health services should be free to all children under age five. However, 22 percent of facilities that offer sick child services charge some fees for sick child services. This is most common in private (85 percent) facilities and in hospitals (44 percent). Only 31 percent of the facilities that charge fees post any fees.

Management Practices Supportive of Quality Child Health Services by Managing Authority



Caretakers' opinions

Caretakers had some complaints about the health care services their children received. One in four caretakers complained about the availability of medicines, while 22 percent complained about waiting time to see provider. Ten percent had problems with the hours the facility was open.

(c) 2007 Bonnie Gillespie, Courtesy of Photoshare

2007 USPA Results: Malaria

Almost all facilities (99 percent) offer malaria diagnosis and/or treatment services. Only 79 percent of these facilities, however, had first-line antimalarials in the facility. Most facilities offering malaria diagnosis or treatment (about 80 percent) had stockouts of first-line antimalarials in the six months before the survey. Hospitals and HC-IVs are most likely to have antimalarials and least likely to have had stockouts.

Treatment protocols are available in all relevant units in two-thirds of facilities offering malaria treatment or diagnosis services.

Laboratory capacity for diagnosing malaria is available in only 26 percent of facilities. Most hospitals can test for malaria with a blood smear (81 percent), compared to only one-third of health centre IIIs and 11 percent of health centre IIs. Only 2 percent of facilities offering malaria diagnosis and/or treatment, and 10 percent of all hospitals have the rapid test for malaria.

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Putting the USPA into Context: Malaria in Uganda

Malaria is the number one cause of morbidity and mortality in Uganda. Approximately 25 to 30 percent of childhood deaths are due to malaria, resulting in 70,000 to 100,000 deaths nationwide.

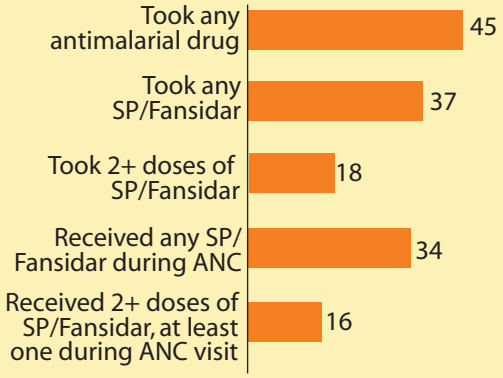
The Uganda Malaria Control Programme, following the recommendations of the international Roll Back Malaria Initiative, aims to reduce cost of insecticides and mosquito nets, increase their use, and launch home-based treatment programmes. Due to growing antimalarial resistance, the recommended treatment for malaria has changed several times in the last five years. In 2006, the Government of Uganda introduced artemisinin-based combination therapy (ACT) as the recommended malaria treatment. The recommended treatment is a brand of artemether/lumefantrine called Coartem.

According to the 2006 UDHS, 34 percent of households had at least one mosquito net, but only 16 percent had an insecticide-treated net (ITN). Young children and pregnant women are most vulnerable to malaria, but only 10 percent of children under five and pregnant women slept under an ITN the night before the survey.

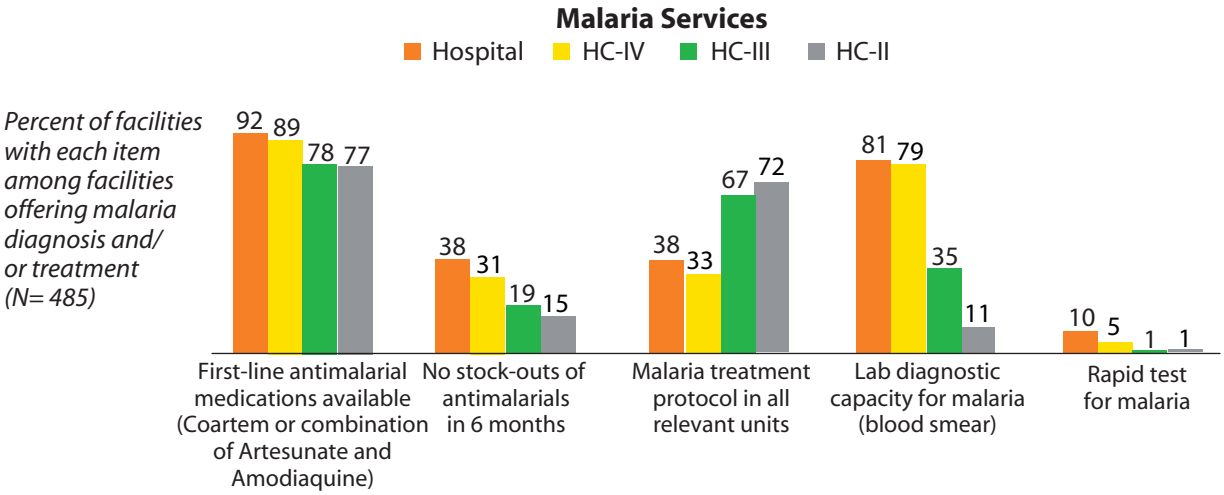
Thirty-four percent of women received IPT during an ANC visit according to the DHS, but only 18 percent of pregnant women took the two recommended doses of SP during their last pregnancy.

Fever is the primary symptom of malaria in children. Among children under five with a fever, 61 percent took an antimalarial drug. Anaemia is also a major sign of malaria in children. Almost three in four children have some form of anaemia, while 50 percent have moderate or severe anaemia.

IPT for Pregnant Women



Percent of women 15-49 with a live birth in the 2 years before the survey



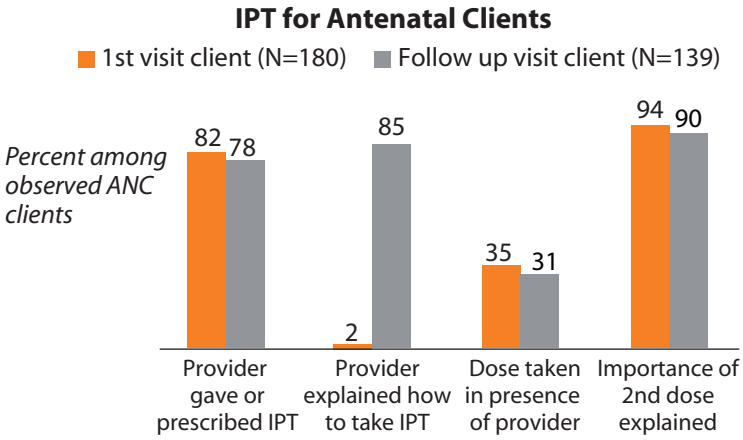
Treatment of Children

Among the observed children diagnosed with malaria, almost all were given an antimalarial, but only 69 percent were given a first-line antimalarial. Seven in ten were given an antibiotic. Anemia was checked in 71 percent of children diagnosed with malaria. The three general danger signs (ability to eat/drink, vomiting everything, and febrile convulsions) were assessed in only 27 percent of malaria diagnosis cases.

Training

Fifteen percent of facilities have at least one clinician provider of malaria services trained within the 12 months preceding the survey, while 38 percent of facilities have at least one nurse-provider of malaria services trained in the year preceding the survey. An additional 8 percent and 26 percent, respectively, received this training two to three years prior to the survey.

Antenatal Care and Malaria



According to government policy, ITNs should be offered free, or at a subsidized price, to all women during ANC visits. The USPA found that only 5 percent of facilities offering malaria services provided a free ITN to antenatal care clients, although 76 percent had ITNs in the facility. Hospitals and facilities in North Central are most likely to provide ITNs to ANC clients (13 and 35 percent, respectively).

Providers are not promoting ITN use. Only about one-third of observed first-visit ANC clients were told of the importance of using an ITN. Women who came for follow-up visits were less likely to be given information about ITNs.

The Uganda National Malaria Control Programme calls for intermittent preventive treatment (IPT) of malaria by using SP/Fansidar twice during the pregnancy. Eight in ten first-visit ANC clients and four in ten follow-up clients were given IPT or prescribed IPT. Six in ten first-visit clients were given information on how to take the IPT medicine. Just under half of first-visit clients took their first dose in the facility under the supervision of a provider. The importance of the second dose was explained to only 24 percent of first-visit clients.

Conclusions

Uganda has experienced some significant health improvements in recent years. According to the 2006 UDHS, use of family planning has increased, childhood mortality has decreased, and more women are giving birth with the assistance of a skilled provider. Still, Uganda faces significant challenges. Fewer than half of children are fully immunised. Many children still suffer from malnutrition and anaemia. The majority of women give birth at home, and few women receive postnatal care. Most women and children still do not use insecticide-treated mosquito nets to prevent malaria, and many pregnant women do not receive intermittent preventive treatment.

What role do health facilities, policies, and personnel play in the health situation in Uganda? The USPA findings provide information to help answer this question. The results are very mixed. Key conclusions and recommendations are noted below:

General Patterns:

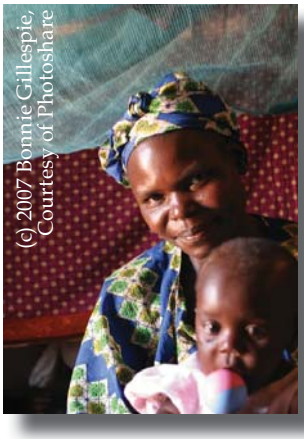
- Overall, health care workers are not providing prevention education and counselling to most clients. For example, ANC providers are not informing women about the danger signs of pregnancy or promoting the use of ITNs. Providers are also not advising caretakers how to give medicine and home treatments to their sick children. It is not clear whether the lack of client education occurs because providers are not properly trained or because they are stretched too thin, trying to see as many children as possible. Whatever the reasons, they need to be addressed immediately to improve patient care.
- Infection control is inadequate in all service areas. Running water, soap, and disinfecting solution are the most commonly missing items. Without running water, facilities will never be able to fully prevent infection or provide top quality care.
- Ugandan national policies and IMCI stress integration of services and a more holistic health care approach. Despite this, there are many missed opportunities in all service areas. Many facilities and providers caring for sick children do not also provide immunisations or growth monitoring at the same time. Integrated care maximizes use of scarce health resources and improves patient outcomes. Efforts are needed to improve integration and minimize missed opportunities.
- Routine, recent training of providers (within one year of the survey) ranges from only 16 percent of facilities in family planning service areas to about two-thirds in ANC service areas. Most providers are regularly supervised. It is not clear whether this training and supervision is effective since so many recommended practices are not being followed. A careful review of training and supervision programs is warranted.

Family Planning:

- Four in five facilities offer family planning services nationwide, but services vary by region. Only half of facilities in Northeast provide family planning and only 70 percent in West Nile. Services need to be widely available to promote use. Fewer Ugandan women use modern methods than women in Kenya, Tanzania, and Malawi.
- Most facilities can provide contraceptive pills, injectables, and condoms, although even these most popular methods are not always in stock. Far fewer provide permanent and long-term methods like sterilisation, IUDs, and implants. Increasing availability of these methods will help to reduce discontinuation and unmet need. Worldwide, the most successful FP programmes include a mix of short- and long-term methods.
- Family planning providers are educating clients about their methods and encouraging follow up. However, USPA findings suggest that new clients are not being consistently screened

for STIs. Furthermore, only 42 percent of FP facilities have at least one medication to treat four STIs. Less than four in ten FP facilities has STI guidelines, and only one in ten facilities has take-home information about STIs or HIV/AIDS for clients. This is a tremendous missed opportunity for prevention and education.

Maternal Health



- Only 53 percent of all facilities provide childbirth services. These services are not well equipped to handle routine deliveries, let alone emergencies. Basic supplies for delivery are generally unavailable. Although two-thirds of hospitals have scissors, only half of HC-IVs and one-third of HC-IIIs have a cord clamp, suction apparatus, skin disinfectant, and antibiotic eye ointment for newborns.
- Even fewer facilities can handle emergencies. Only 12 percent can transfuse blood, and only 5 percent can perform a Caesarean section. Less than half of facilities offering delivery services have equipment to resuscitate newborns. Why are there still so few services for such a common event as childbirth? Making safer delivery services more available should be a national priority in Uganda, demanding immediate attention from all levels of government.
- When serious health problems occur during pregnancy and childbirth, a few minutes can mean the difference between life and death. Yet only 47 percent of facilities have transport systems for maternal emergencies. Unless such systems are made more widely available, maternal mortality will continue at its current high rate.
- Currently more than half of births occur at home. Yet only 6 percent of facilities have services supporting home delivery, and only 12 percent have programmes with traditional birth attendants.
- ANC is widely available in Uganda, and almost all women seek care at least once during pregnancy. The quality of ANC services is not clear, however. Less than one-quarter of facilities providing ANC have the basic recommended equipment and supplies, and less than 30 percent can test for anaemia and gestational diabetes. Only about half of the observed first visit ANC clients received the tetanus toxoid vaccine. Thus, both facilities and health care workers are failing to provide good preventive care to pregnant women.

Child Health

- Almost nine in ten facilities provide immunisation services. However, not all facilities have all vaccines, and most facilities provide immunisation services only one or two days per week. Considering that only 46 percent of Ugandan children are fully immunised—a lower rate than in Rwanda, Tanzania, and Kenya—better access to immunisation services must be a priority. Caretakers should not have to bring their children to multiple facilities or return for multiple visits for such a basic prevention procedure.
- Less than one-quarter of facilities treating sick children have the three first-line treatments, simple, inexpensive, and essential drugs that should be available in all facilities. Facilities are also lacking pre-referral and basic medicines, including aspirin, vitamin A, and iron tablets. Stocking all facilities with these recommended and largely inexpensive medications should be a priority.
- Providers are not assessing danger signs or performing the expected basic exams on sick children. This may lead to incorrect diagnoses and could potentially endanger sick children.
- As in other countries, providers in Uganda appear to be overprescribing antibiotics for sick

children. While an antibiotic may be warranted in pneumonia or dysentery cases, it is not necessary for children with minor respiratory or diarrhoeal illnesses. Unnecessary use of antibiotics should be limited, as antibiotic resistance is growing worldwide. According to SPA surveys, providers in Uganda are using antibiotics for sick children more often than providers in Kenya (2003 KSPA) and Tanzania (2006TSPA).

Malaria

- First-line antimalarial medications are available in about 80 percent of facilities, but stock-outs are quite common. Eighty-two percent of facilities had stock-outs of first line antimalarials in the six months preceding the survey. This means that many sick children and adults are not receiving optimal care.
- Although treatment is crucial, providers also need to promote malaria prevention. Unfortunately, despite government support, provision of free mosquito nets and promotion of ITN use are rare. Four in five first-visit ANC clients were given or prescribed IPT, but counselling about the second dose is far less common. As noted above, providers in every type of health facility need to focus on prevention.

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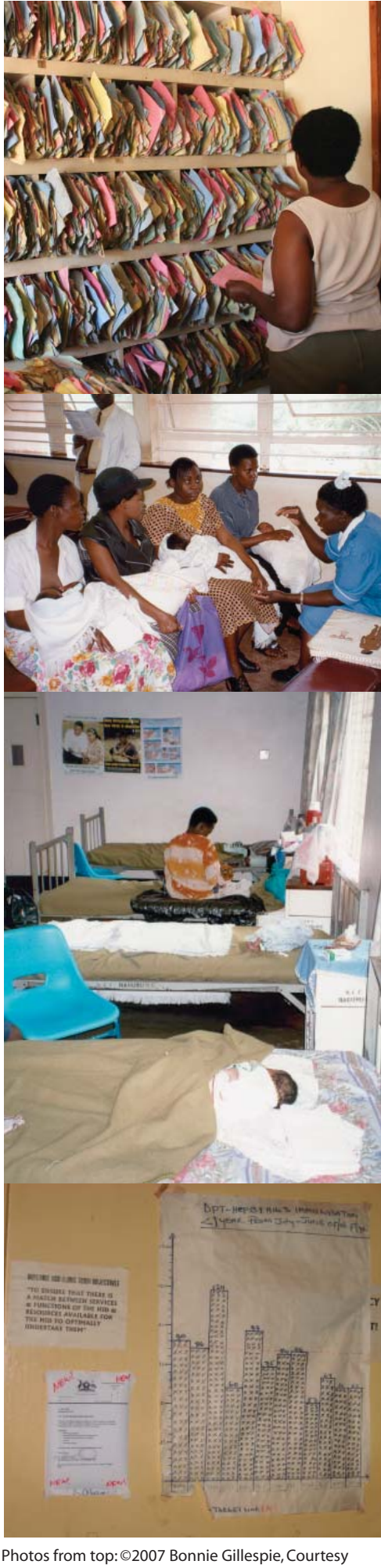
Key Indicators

	Type	
	Hospital	HC-IV
Family Planning Services		
Family planning services available 5 days a week (% of facilities)	81	86
Availability of any modern method (% of facilities)	71	99
All items for quality counselling[1] (% of facilities)	38	32
All items for infection control[2] (% of facilities)	52	42
Conditions for quality pelvic exam[3] (% of facilities)	12	1
STI treatment provided by FP providers (% of facilities)	66	80
User fees for FP services (% of facilities)	19	7
Maternal Health Services		
Facilities offering antenatal care (%)	95	100
Facilities offering postpartum care (%)	65	67
Facilities offering tetanus toxoid vaccine (%)	94	100
ANC facilities with all items for quality counselling[4] (%)	29	22
ANC facilities with all items for infection control[2] (%)	43	38
ANC facilities with all essential supplies for basic ANC[5] (%)	58	22
ANC facilities where STI treatment is provided by ANC providers (%)	73	89
ANC facilities with all medicines for treating pregnancy complications[6](%)	40	10
Facilities with user fee for ANC (%)	35	6
Facilities offering normal delivery services (%)	97	99
Facilities offering Caesarean section (%)	84	24
Facilities offering emergency transportation support for maternity emergencies (%)	91	92
Facilities offering any home delivery services (%)	4	8
Delivery facilities with all items for infection control[2] (%)	70	59
Facilities offering delivery services with all essential supplies for delivery[7] (%)	66	48
Facilities offering delivery services with user fee for delivery (%)	47	5
Child Health Services		
Facilities offering curative outpatient care for sick children (%)	97	100
Facilities offering growth monitoring (%)	82	83
Facilities offering childhood immunisation (%)	98	100
Immunisation facilities with all equipment for immunisations[8] (%)	90	78
Immunisation facilities with all basic child vaccines (BCG, DPT-HB, polio, measles) (%)	82	92
Facilities with all first line[9] /pre-referral medicines[10] (%)	76/84	25/65
Facilities with user fees for sick child services (%)	44	3
Malaria Services		
Facilities providing free ITNs to ANC clients (%)	13	8
Facilities offering malaria treatment with 1st line anti-malaria medicines in the facility (SP/Fansidar, Amodiaquine or Coartem) (%)	92	89
Facilities with lab diagnostic capacity for malaria (blood smear) (%)	81	79

1-Visual privacy, client cards, written guidelines, visual aids
2-Soap, running water, clean gloves, disinfecting solution, sharps box
3-Private room, exam bed, exam light, vaginal speculum
4-Visual aids for health education, guidelines, client card/record
5-Iron and folic acid, tetanus toxoid vaccine, blood pressure apparatus, fetoscope
6-Antibiotic, antimalarial, 4 STIs, and anti hypertensive

of Facility		Managing Authority		TOTAL
HC-III	HC-II	Govern-ment	Private	
79	73	81	53	77
86	74	89	49	79
31	15	25	11	23
42	24	32	38	33
0	1	0	4	1
82	78	81	68	79
7	11	2	51	10
96	52	69	74	71
53	13	32	30	31
90	43	64	60	63
19	7	16	13	15
43	24	33	39	34
25	14	18	32	22
87	86	86	88	86
4	4	2	19	6
14	28	4	70	20
90	25	53	54	53
2	0	4	10	5
61	33	45	54	47
10	3	5	7	6
52	15	44	45	44
34	17	28	49	33
17	42	4	90	25
100	97	99	96	98
76	57	66	63	65
96	82	90	81	88
75	55	65	64	65
72	72	74	78	74
20/51	20/27	12/29	59/72	23/39
19	24	2	85	22
8	2	5	3	5
78	77	78	80	79
35	11	18	51	26

7-Scissor/blade, cord clamp, suction apparatus, antibiotic eye ointment skin disinfectant
8-Blank immunisation cards, syringes and needles, cold box with ice packs
9-ORS, one antimalarial, one oral antibiotic
10-One 1st line injectable antibiotic, one 2nd line injectable antibiotic, and IV solution with perfusion set



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