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Ministry of Health

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African Population and Health Research Center

Countdown to 2030
Women's Children's & Adolescent's Health

Analysis of reproductive, maternal, newborn, child and adolescent health indicators

2019-2023

chartbook with main results and interpretations

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TABLE OF CONTENTS

General Introduction

This Chartbook summarizes the results for key indicators of reproductive, maternal, newborn, child and adolescent health (RMNCAH) that were produced by the country team at a Countdown analysis workshop in Kigali, April 22-26, 2024.

The analysis is based on routine district health facility data for 2019-2023, recent national surveys, health system data and global estimates, much attention is paid to data quality.

This Chartbook describes and interprets the results, which should be a critical input for the monitoring of country RMNCAH and health sector plans.

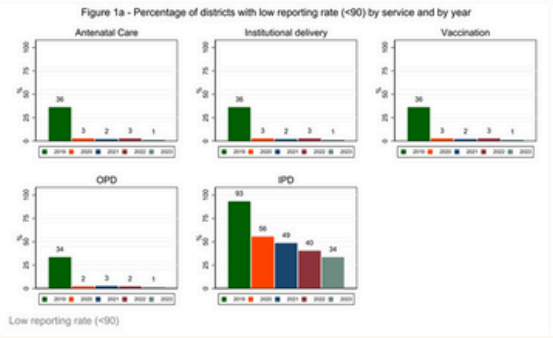
For each of the sections there are selected graphs and tables on key indicators with interpretations made by the country team during the workshop.

1 Facility data quality assessment: numerators 1

BACKGROUND: Routinely reported health facility data are an important data source for health indicators. The data are reported by health facilities on events such as immunizations given, or live births attended. As with any data, quality is an issue. Data are checked to consider completeness of reporting by health facilities, identify extreme outliers and internal consistency.

Table 1: Summary of reported health facility data quality, DHIS2, 2019-2023

	Data quality metrics	2019	2020	2021	2022	2023
1	**Completeness of monthly facility reporting (mean of ANC, delivery, immunization, OPD)**					
1a	% of expected monthly facility reports (national)	78	95	96	97	97
1b	% of districts with completeness of facility reporting >= 90%	53	87	88	90	92
2	**Extreme outliers (mean of ANC, delivery, immunization, OPD)**					
2a	% of monthly values that are not extreme outliers (national)	95.4	98.7	99	98.7	98.4
2b	% of districts with no extreme outliers in the year	90.3	91	93.4	92.7	91.6
3	**Consistency of annual reporting**					
3a	ANC1 to penta1 ratio in the reported data (national)	1.04	1.11	1.08	1.08	1.08
3b	Penta1 to penta3 ratio in the reported data (national)	1.08	1.06	1.06	1.05	1.04
3c	% of districts with ANC1-penta1 ratio in expected range	55.5	78.8	70.5	68.5	67.8
3d	% of districts with penta1-penta3 ratio in expected range	84.9	85.6	87.7	85.6	80.1
4	**Annual data quality score (mean 1a, 1b, 2a,2b, 3c,3d)**	76.2	88.4	88.1	87.7	86.9

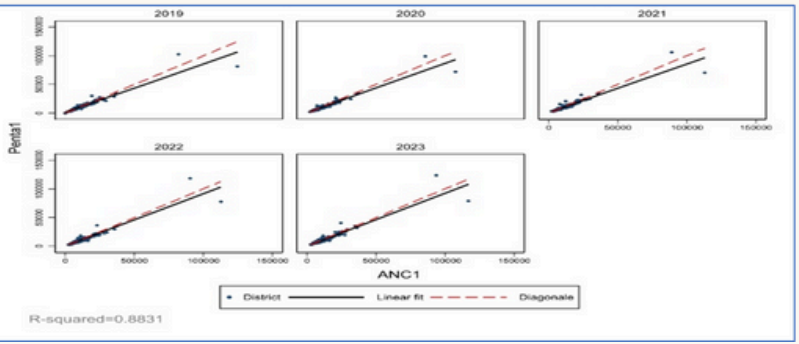


- Overall, the data quality score has shown improvement, though with a slight decline in the past two years. However, it remains relatively good, reflecting a generally positive trend.
- The completeness of reporting data has consistently increased, indicating a positive trend and good performance in ensuring comprehensive reporting across districts.
- The data on extreme outliers has shown a positive trend, with a high percentage of monthly values not being extreme outliers.
- Regarding the consistency of reported data for ANC1 to penta1 and penta1 to penta3 ratios at the national level, there has been slight fluctuation but generally stable ratios within acceptable ranges over the period. This indicates a satisfactory level of consistency in reporting these key indicators.
- The percentage of districts with ANC1 to penta1 ratios within the expected range has shown a decline since 2020, indicating potential issues in maintaining expected ratios in some districts.
- Similarly, while the percent of districts with penta1 to penta3 ratios within the expected range has shown variability, it has seen a decrease in recent years, suggesting challenges in maintaining consistent ratios.

1 Facility data quality assessment: numerators 2

Figure 1b: Ratio of number of facility reported ANC1 to penta1, and penta1 to penta3, compared to expected ratios

Figure 1c: Comparison of numbers of ANC1 and penta1 reported by health facility, by year



BACKGROUND: Routinely reported health facility data are an important data source for health indicators. The data are reported by health facilities on events such as immunizations given, or live births attended. As with any data, quality is an issue. Data are checked to consider completeness of reporting by health facilities, identify extreme outliers and internal consistency.

Interpretation

- The consistency of reported data for ANC1 to penta1 and penta1 to penta3 ratios at the national level has been slight fluctuation but generally stable ratios within acceptable ranges over the period. This indicates a satisfactory level of consistency in reporting.
- The percentage of districts with ANC1 to penta1 ratios within the expected range has declined over the years, indicating potential issues in maintaining expected ratios in some districts.
- Similarly, while the percent of districts with penta1 to penta3 ratios within the expected range has shown variability, it has decreased in recent years, suggesting challenges in maintaining consistent ratios.

Health facility data adjustment: numerators

Figure 1b: Comparison of live births before and after adjustment for completeness and outliers

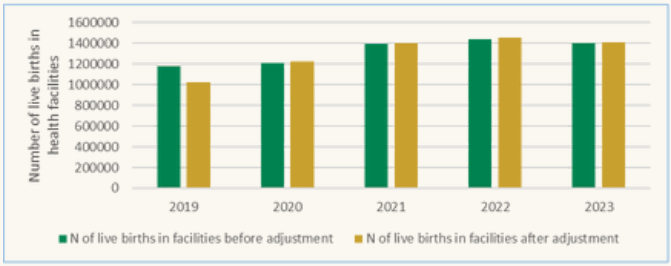
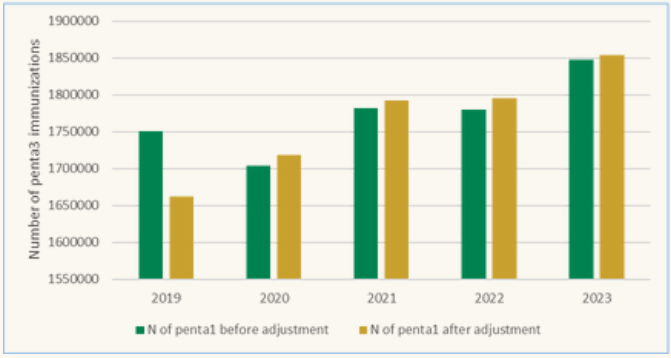


Figure 1c: Comparison of penta1 vaccination before/after adjustment for completeness and outliers



BACKGROUND: Completeness of reporting affects analysis, especially if it is low or varies between years. Extreme outliers can have a large impact, especially on subnational numbers. Several steps are necessary to obtain a clean data set for annual analysis, including adjusting for incomplete reporting and correcting for extreme outliers. These graphs show the impact on the numbers.

Live births

- The adjustment had varying effects on live births in health facilities over the years. Overall, the impact of adjustment appears to be relatively small, as the differences in the number of live births before and after adjustment is minimal.
- In 2023, the absolute difference in the number of live births before and after adjustment was 9013, representing a 0.6% increase from the unadjusted number.
- The year 2019 experienced the greatest impact, with an absolute difference of -150978, indicating a decrease of 12.8% in live births due to the adjustment.

Penta 1

- The adjustment of the number of penta1 vaccinations also had varying effects.
- In 2023, the absolute difference between the number of penta1 vaccinations before and after adjustment was 7077, representing only 0.4% increase from the unadjusted count.
- While the year 2019 experienced the greatest impact, with an absolute difference of -88399, indicating a decrease of 5.0% in penta1 vaccinations due to the adjustment, the overall impact on coverage rates appears relatively small.

2 Health facility data denominator assessment 1

Figure 2a: Annual population, DHIS2 and UN

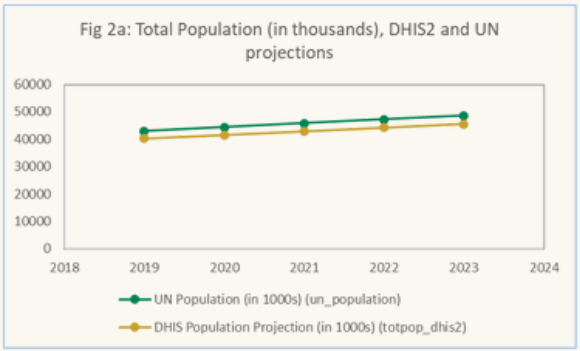
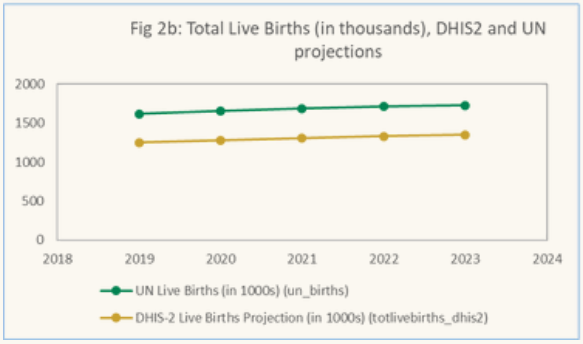


Figure 2b: Live births, DHIS2 and UN



BACKGROUND: Service coverage is defined as the population who received the service divided by the population who need the services: the denominator. The quality of the population projections in DHIS2 is assessed through consistency over time and comparison with the UN projections.

Interpretations

1. The DHIS2 total population projections demonstrate a consistent trend over the study period, showing a steady increase in population size in line with regular population growth.
2. The DHIS2 total live birth projections also exhibit a consistent trend, reflecting a regular pattern of live births within the population.
3. The DHIS2 population projections for both total population and live births closely align with the UN population projections, indicating a degree of accuracy and reliability in the DHIS2 estimates.
4. The DHIS2 population projections demonstrate consistency with UN estimates for both crude birth rate (CBR) and crude death rate (CDR), further affirming the reliability of the DHIS2 projections.

Overall conclusion: The quality of the DHIS2 projections, especially regarding live births, appears to be robust. The projections consistently align with regular population growth, exhibit a regular trend in live births, closely match UN population projections, and maintain consistency with UN estimates for crude birth and death rates. These collectively suggest a high level of reliability and accuracy in the DHIS2 projections, particularly in forecasting live births.

2 Health facility data denominator selection

Fig 2c: Institutional birth coverage, DHIS2-based with different denominators, and survey coverage

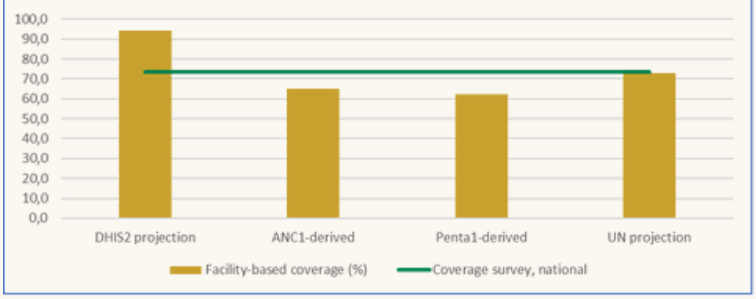
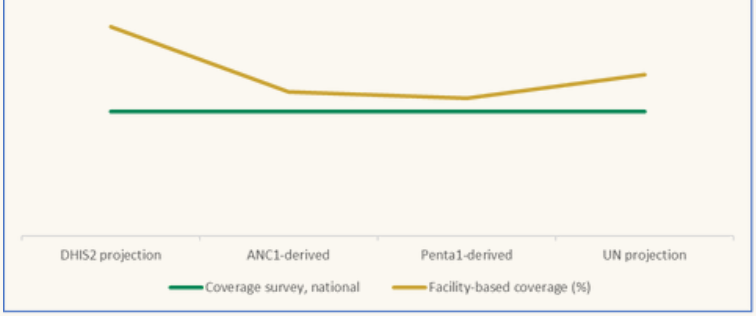


Fig 2d: Penta3 coverage, DHIS2-based with different denominators, and survey coverage



BACKGROUND: The best performing denominator for coverage analysis with facility data is selected by comparing how close the different denominator methods are to survey coverage for a nearby year. This is done at the national and subnational levels (using the median difference with the survey).

Interpretation

At national level,

- UN projection shows the smallest absolute difference between survey and facility data coverage, indicating its better performance compared to ANC1-derived and Penta1-derived methods.
- Penta3 coverage, penta 1 exhibits the smallest absolute difference, suggesting its superior performance.

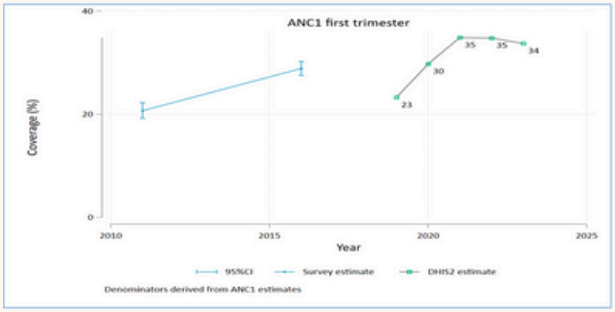
At subnational level

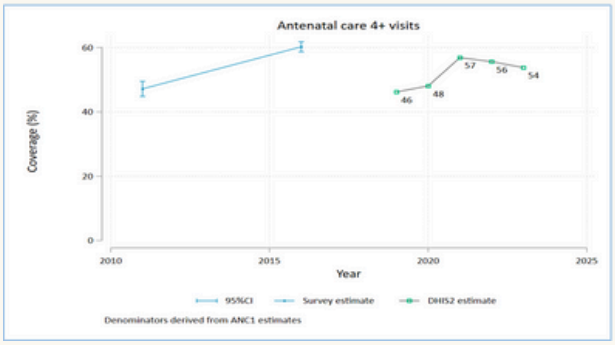
- For institutional live birth coverage, ANC 1 shows the smallest median gap, indicating its better performance compared to other denominators.
- For Penta3 coverage, penta 1 again is a better denominator.

The indicators selected for the coverage analyses, namely ANC1 for estimating institutional live births and Penta1 for estimating Penta3 coverage, are chosen due to their close alignment with survey data in coverage estimates.

3 National coverage trends: Antenatal Care

Figures 3a and 3b: Coverage trends in selected antenatal Care indicators





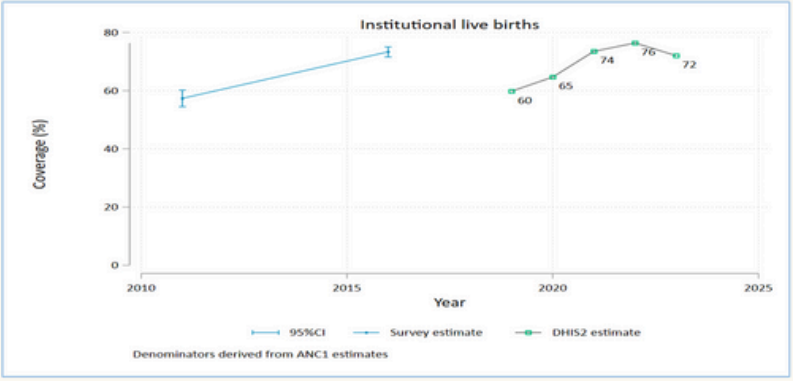
BACKGROUND: Monitoring the coverage of interventions is a critical and direct output of health systems. It is most useful if the national plan has meaningful targets. Both health facility and survey data need to be used.

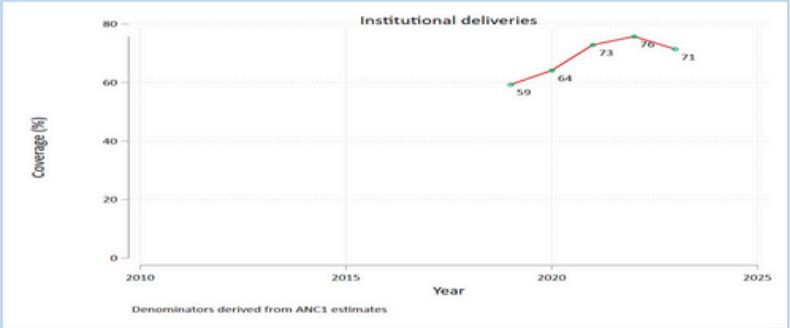
Interpretations

- The levels and trends of ANC4+ visits and ANC 1 first trimester seem plausible, and the values seem relatively consistent between the DHIS2 and survey data.
- There is consistency between the facility and survey data, as indicated by the alignment of DHIS2 estimates with survey estimates.
- The coverage of ANC4+ visits and ANC 1 first trimester show a positive trend until 2021 and then a slight decrease.
- In 2023, the DHIS2 estimates for both indicators fall within the confidence interval of the survey estimate, indicating reliable data.
- Coverage of ANC4+ of 54% in 2023 is close to the national target of 56%. In contrast, 34% registered for a first visit in 2023 is still lower than the national target of 60% ANC 1 first trimester.
- Possible explanations for the observed levels and trends could include improved access to healthcare services, increased awareness among pregnant women, and enhancements in healthcare infrastructure and delivery systems.

3 National coverage trends: delivery care

Figures 3c and 3d: Coverage trends in selected delivery care indicators





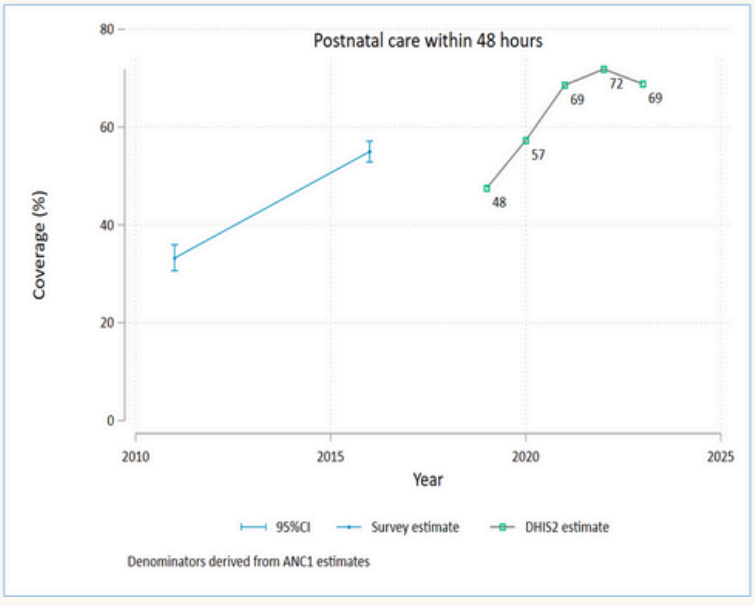
BACKGROUND: Monitoring the coverage of interventions is a critical and direct output of health systems. It is most useful if the national plan has meaningful targets. Both health facility and survey data need to be used.

Interpretations

- The levels and trends of Institutional delivery and institutional live births from DHIS2 seem plausible between 2019 and 2023. The facility data are also close and consistent with the survey estimates despite using 2016 estimates for comparison.
- Institutional delivery for 2016 survey was 73%.
- While the estimates are slightly below the national target of 100% institutional delivery and 90% institutional live births, there is a positive trend observed albeit with a slight dip in coverage in 2023.
- Possible explanations for the observed level and trends could include improved access to healthcare services, and enhancements in healthcare infrastructure and delivery systems.

3 National coverage trends: postnatal care and low birth weight

Figures 3e and 3f: Coverage trends in postnatal care, and percent of newborns with low birthweight



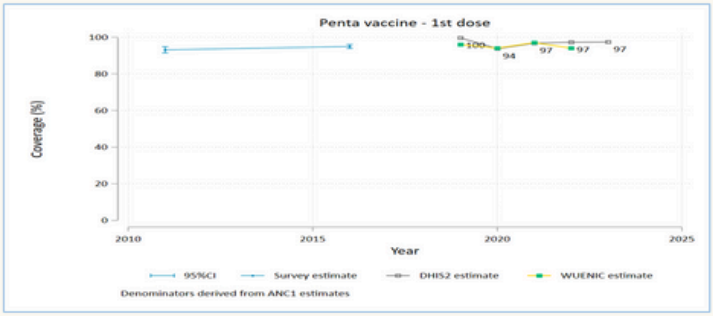
BACKGROUND: Monitoring the coverage of interventions is a critical and direct output of health systems. It is most useful if the national plan has meaningful targets. Both health facility and survey data need to be used.

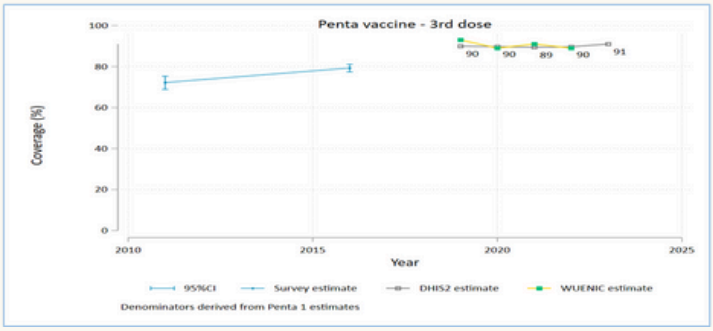
Interpretations

- The levels and trends of PNC seem plausible, with gradual increases observed over the years according to both survey and DHIS2 estimates.
- There is consistency between the facility and survey data, as indicated by the alignment of DHIS2 estimates with survey estimates.
- The coverage of PNC shows a positive trend until the most recent year, with DHIS2 estimates consistently aligning closely with survey estimates.
- In 2023, the DHIS2 estimates falls within the confidence interval of the survey estimate, indicating reliable data.
- The estimates are still lower than the national target. For instance, coverage of PNC of 69% in 2023 is far from the national target of 90%.
- Possible explanations for the observed levels and trends could include improved access to healthcare services, increased awareness among pregnant women, and enhancements in healthcare infrastructure and delivery systems.

3 National coverage trends: immunization indicators

Figures 3g and 3h: Coverage trends in selected child immunization indicators





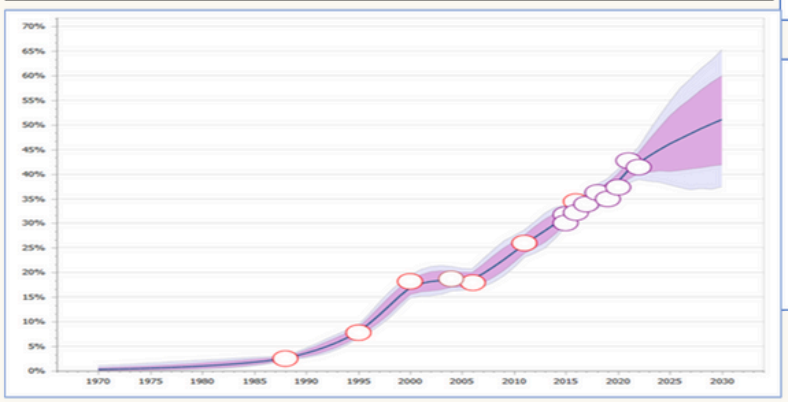
BACKGROUND: Monitoring the coverage of interventions is a critical and direct output of health systems. It is most useful if the national plan has meaningful targets. Both health facility and survey data need to be used.

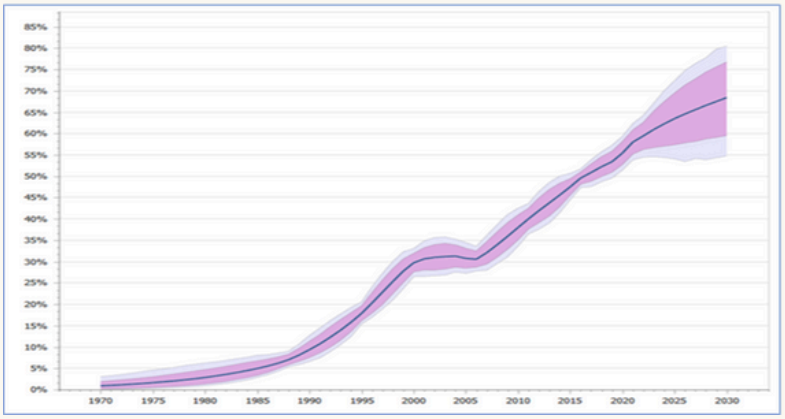
Interpretations

- The levels of Penta vaccine coverage as estimated by the different methods (Survey, WUENIC, DHIS2) seem plausible and within expected ranges for vaccination coverage. The data shows an increasing trend over time for both the 1st and 3rd doses, which aligns with expectations for vaccination programs.
- There is consistency between the DHIS2 and survey estimates for most years, although there are some discrepancies in certain years. For instance, in 2020, the DHIS2 estimates for the 1st dose are notably higher than the survey estimates, while for the 3rd dose, the DHIS2 estimates are slightly higher than the survey estimates.
- Overall, the UN estimates seem to be consistent and close to the facility estimates for both indicators.
- The estimates are also close to the national target.
- The observed levels and trends could be attributed to various factors, including but not limited to:
- Strengthening of immunization programs and health systems infrastructure, increased awareness and education about the importance of vaccination, and implementation of targeted interventions to reach underserved populations.

3 National coverage trends: family planning

Figures 3i and 3j: Trends in modern contraceptive use and in the FP coverage (demand satisfied for modern methods of family planning)





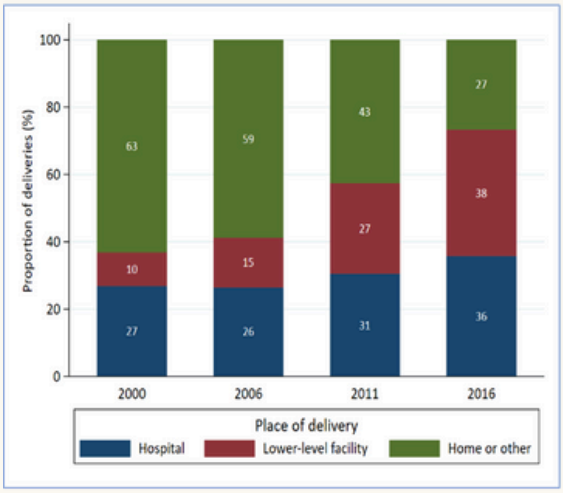
BACKGROUND: Monitoring the coverage of interventions is a critical and direct output of health systems. It is most useful if the national plan has meaningful targets. Both health facility and survey data need to be used.

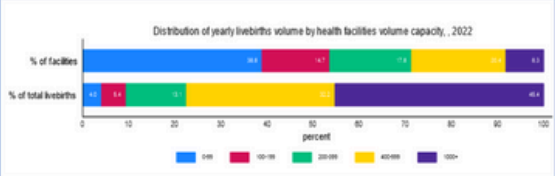
Interpretations

- The levels of modern family planning use and demand satisfied estimated are plausible and within expected ranges when compared to the survey estimates.
- Prevalence of modern contraceptive use has been increasing at a steady rate over the past five decades.

3 National coverage trends: delivery care by place and volume

Table 3e: Key characteristics of delivery care by place of delivery, and volume of births by facility in 2022





BACKGROUND: Monitoring the coverage of interventions is a critical and direct output of health systems. It is most useful if the national plan has meaningful targets. Both health facility and survey data need to be used. Data on whether deliveries increased more at hospitals or lower-level facilities and in the public or private sector can be used to inform MNH service delivery strategies in the context of the SDG 2030 targets for maternal mortality, stillbirth and neonatal mortality.

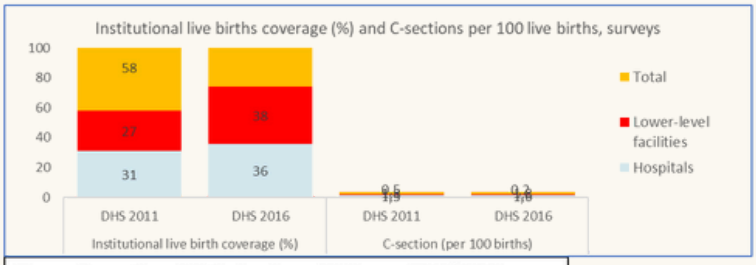


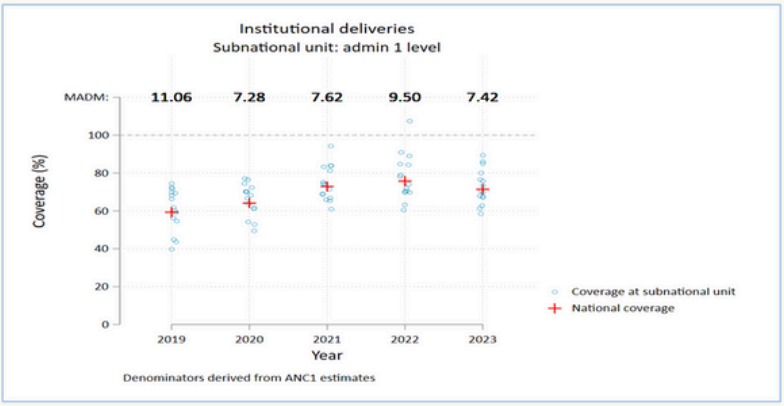
Figure : Proportion of births by place of delivery... (DHS/MICS)

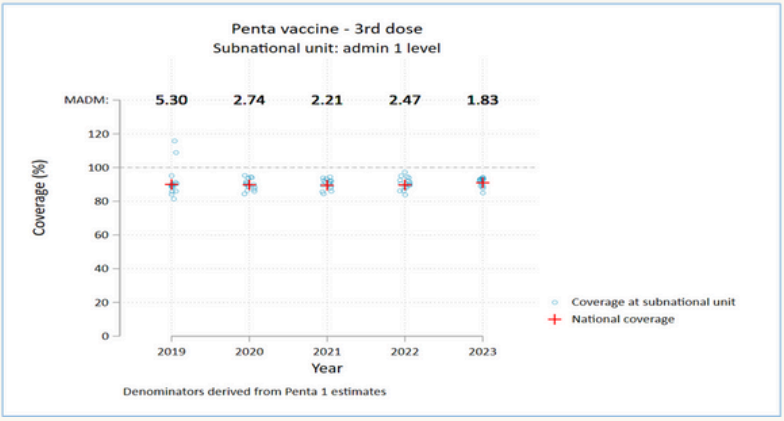
Interpretations

The proportion of health facility delivery continues to improve from 37% in 2000 to 73% in 2016. The proportion of delivery from lower-level facilities is approximately equal to that at hospitals. The lower-level facilities are many in number and closer to the end users. The cesarean section rate is above WHO recommended threshold (10%) in both public and private health facilities but with notable higher rates in private health facilities. This could be attribute to the low use of assisted vaginal delivery technology such as vacuum extractions and forceps delivery.

4 Equity: subnational coverage trends: subnational coverage trends: delivery care and penta3 coverage by admin1 (region), 2019-2023

Fig 4a: Regional coverage distribution: Institutional deliveries by admin1
Fig4b: Regional coverage distribution: Penta3 coverage by admin1





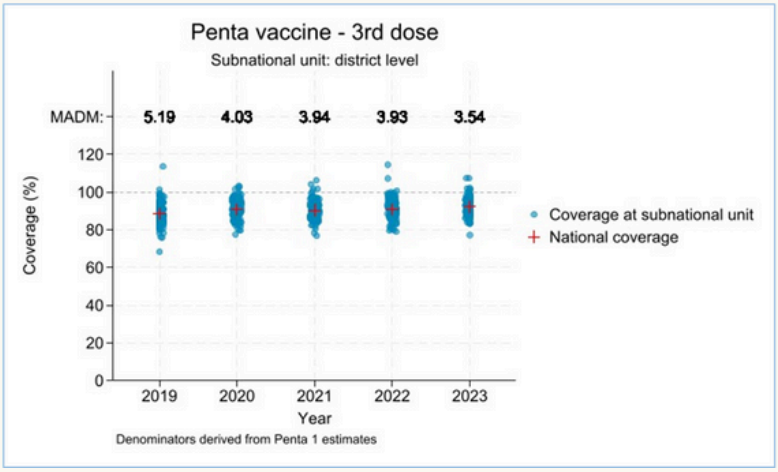
BACKGROUND: Monitoring the coverage of interventions is a critical and direct output of health systems. It is most useful if the national plan has meaningful targets. Both health facility and survey data need to be used.

Interpretations

- Reporting of institutional delivery and penta 3 has improved. One region was noted to over-report institutional deliveries in the year 2022.
- In general, the subnational trends are consistent with the national survey estimates.
- The coverage for institutional delivery has increased across all regions.
- The coverage gap has also narrowed over time with most regions having above 80% coverage across all years. There is also a reduction in inequalities across regions.
- Results show that the national coverage for penta 3 is above 80% and consistently high across all regions and years. There is also a reduction in inequalities across regions over time.
- Meeting global targets: The National coverage for penta 3 coverage has reached the global target of 90%. All regions have also surpassed the global target of 80%.
- For institutional delivery, the nation is still below the global target of 80%. However, by 2021, a number of regions had met the global target on institutional delivery (80%).

4 Equity- Subnational coverage trends: delivery care and penta3 coverage by district, 2019-2023

Fig 4c: Institutional deliveries by district
Fig4b: Penta3 coverage by district



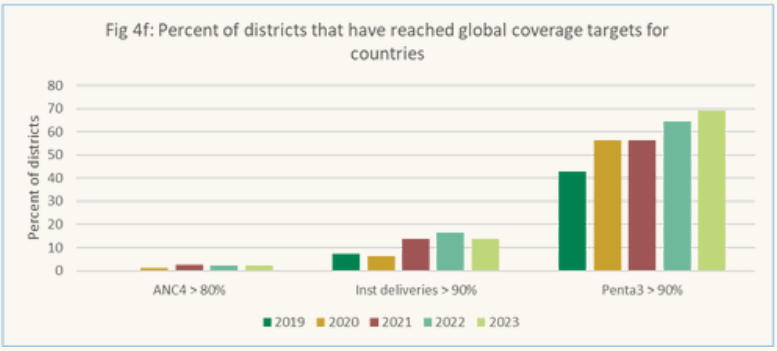
BACKGROUND: Monitoring the coverage of interventions is a critical and direct output of health systems. It is most useful if the national plan has meaningful targets. Both health facility and survey data need to be used.

Interpretations

- Reporting of penta 3 has improved across districts.
- Over-reporting was noted in a few districts (with proportions above 100%).
- However, the general DHIS2 national trends are consistent with the survey estimates.
- The inequality gap has also narrowed over time, with a reduction in inequalities across districts.
- Most districts have at least 80% coverage in all years.
- Meeting global targets: By 2023, all districts had surpassed the global target of 80%.

4 Equity- Subnational coverage trends: assessment of percent of regions that have reached international targets

Fig 4e: Percentage of regions reaching targets
Fig4f: Percentage of districts reaching targets



BACKGROUND: Monitoring the coverage of interventions is a critical and direct output of health systems. It is most useful if the national plan has meaningful targets. Both health facility and survey data need to be used.

Interpretations

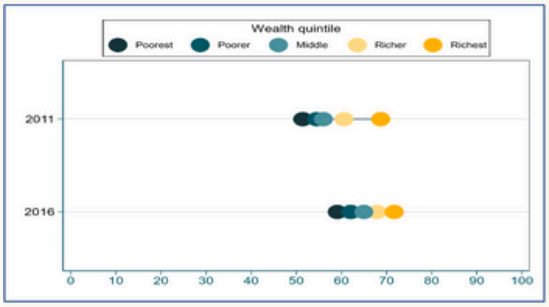
- The trends suggest progress over time, particularly for Penta3 vaccination, which shows a steady increase in the percentage of regions and districts reaching global coverage targets.
- There is also some improvement in reaching international targets for institutional deliveries.
- These improvements suggest a reduction in inequalities, as more regions and districts achieve the desired coverage levels.

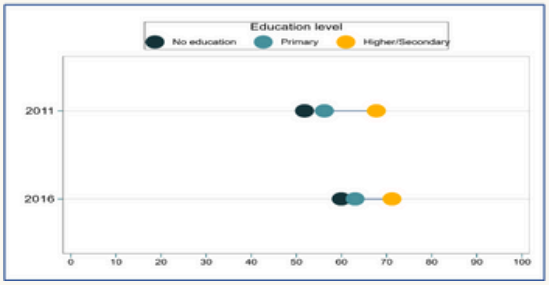
Global targets for subnational coverage

- ANC4 (>80%): Unfortunately, no region has reached the target of ANC4 coverage exceeding 80% in any of the years.
- Institutional Deliveries (>90%): While no regions achieved this target in 2019 and 2020, there has been a positive trend with 6.7% of regions meeting the target in 2021 and 2022. However, this progress seems to have stalled, with no regions meeting the target again in 2023.
- Penta3 (>90%): There has been significant progress in meeting the Penta3 vaccination target, with an increasing number of regions and districts surpassing the 90% threshold over the years. By 2023, the majority of regions (86.7%) and districts (69%) had achieved this target, indicating substantial progress in vaccination coverage.

4 Equity- Subnational coverage trends: wealth quintiles and female education from survey data

Fig 4g: Equiplot of the Composite Coverage Index (CCI) by wealth, recent surveys
Fig4h: Equiplot of the CCI by level of education of the mother, recent surveys





BACKGROUND: Household surveys provide critical information on inequalities. The focus is on two major dimensions of inequality: household wealth quintile and education of the mother. Equiplots are used to assess whether the country has made progress since 2010 in reducing the poor rich gap or the gap between women with no education or low education and women with higher education.

Interpretations

- The Countdown Composite Coverage Index (CCI) is used to provide a broad overview of inequalities. The CCI combines 9 indicators in the program areas of family planning, maternal and newborn care, immunization and treatment of sick children.
- In 2011, the CCI for the wealthiest quintile was substantially higher than that of the poorest quintile, indicating a significant gap in healthcare coverage between the rich and poor. However, by 2016, while the CCI for both quintiles had increased, the gap between them had narrowed. This suggests that although disparities in healthcare coverage persist, there has been improvement over time.
- The pattern of inequality appears to be linear, with each successive wealth quintile experiencing higher healthcare coverage compared to the previous quintile. This indicates a gradient effect where healthcare coverage increases progressively with increasing wealth, but at a diminishing rate.
- In 2011, there was a notable gap in CCI between mothers with no education and those with secondary/higher education. However, by 2016, the gap had decreased, suggesting an improvement in healthcare coverage across all levels of education. This decrease in the gap over time indicates progress towards reducing disparities in healthcare coverage based on maternal education. It suggests that increasing levels of female education contributes to improved healthcare outcomes. Mothers with higher education levels are likely to have better access to healthcare services and may be more knowledgeable about healthcare practices for themselves and their children.

5 Maternal mortality in health facilities

Figure 5a: Maternal mortality per 100,000 live births in health facilities, based on the reported data in DHIS2, 2019-2023, national (red line) and regions (blue dots)

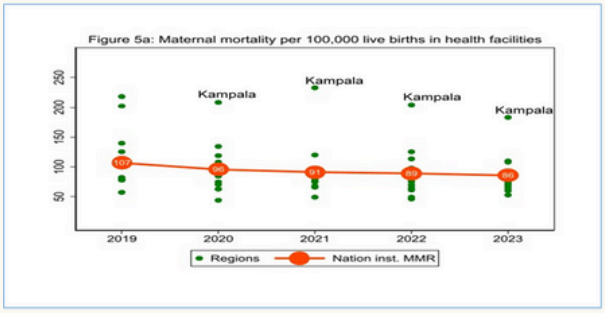
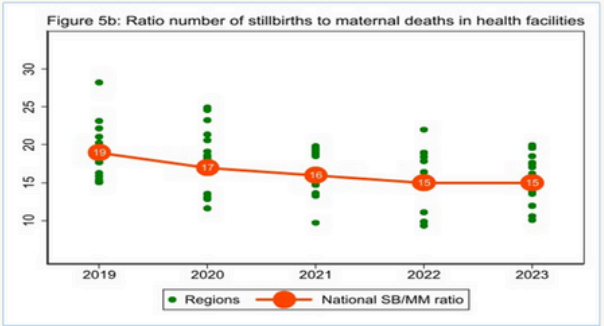


Figure 5b: Ratio of stillbirths to maternal deaths in health facilities, based on the reported data in DHIS2, 2019-2023, national (red line) and regions (blue dots)



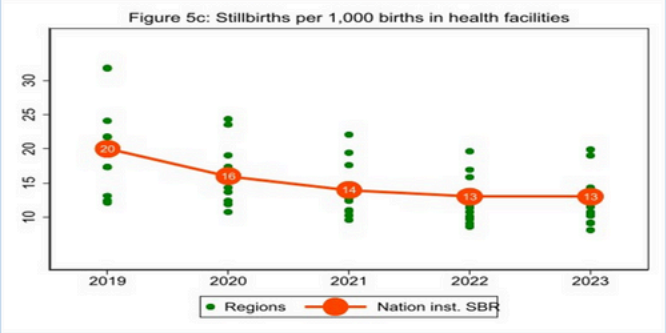
BACKGROUND: The main challenge with mortality data from health facilities is underreporting of deaths. Deaths may not be recorded in the maternity register, or not reported. Also, maternal deaths in other hospital wards are more likely to be missed, e.g., deaths associated with abortion or sepsis. The main aim is to estimate the level of underreporting in DHIS2 or MPDSR.

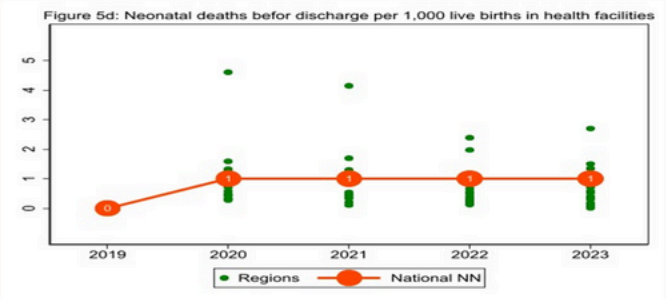
INTERPRETATION

- The level of MMR from the facility data shows a declining trend from 2019 to 2023, which is generally expected due to improvements in availability of healthcare services and interventions.
- Regional variation in MMR is evident, with some regions consistently reporting lower MMR compared to others. For example, Kampala exhibit relatively higher MMR compared to regions.
- The percentage of regions with low MMR (< 25) has increased from 27% (4 out of 15) in 2019 to 73% (11 out of 15) in 2016. in addition, the percentage of districts with very low SBR (<6) has increased from 0% in 2019 to 27% in 2023. However, the reporting of maternal deaths is not close to the survey estimates confirming some possible issues of under-reporting.
- For 2022 and 2023, the ratio of ratio stillbirth to maternal deaths was within the recommended range indicating a balanced reporting of maternal deaths and stillbirths. For 2019 and 2021, maternal deaths were under-reported.

5 Stillbirth rates in health facilities

Figure 5c: Stillbirths per 1,000 births in health facilities, based on the reported data in DHIS2, 2019-2023, national (red line) and regions (green dots)





BACKGROUND: The main challenge with health facility data on stillbirths and neonatal deaths is underreporting. We can estimate the level of underreporting of stillbirths based on different assumptions. For neonatal deaths, DHIS2 reporting systems based on labour and delivery ward are limited to neonatal deaths before discharge in the reporting system. Therefore, they are only an indicator of mortality during the first 24-48 hours.

Interpretations

- The level of stillbirths from facility data shows a consistent decline from 2019 to 2023, which aligns with expectations and indicates potential improvements in maternal healthcare. However, there are also large variations across regions.
- The estimated level of completeness of reporting of stillbirths is improving over the years. The assumption of using the lower bound from UN estimates for population-level stillbirth rates seems to provide a reasonable estimate. The decreasing trend in stillbirth rates from 2019 to 2023 suggests more comprehensive reporting and better data quality.
- The neonatal mortality rate (before discharge) nationally is consistently low, with 1 reported neonatal death per 1,000 live births from 2020 to 2023. However, these rates do not align with the national estimate of neonatal mortality indicating issues in reporting and completeness of data.

5 Underreporting of maternal deaths and stillbirths

Fig 5e: Completeness of facility maternal death reporting (%), based on UN MMR estimates and community to institutional ratio

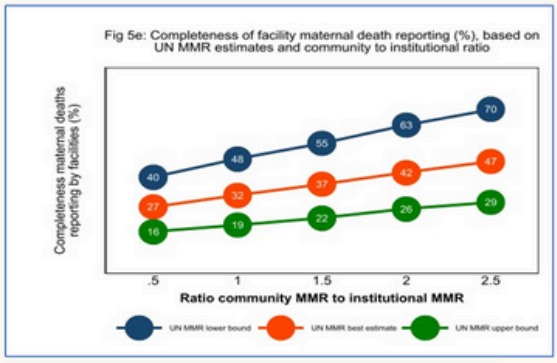
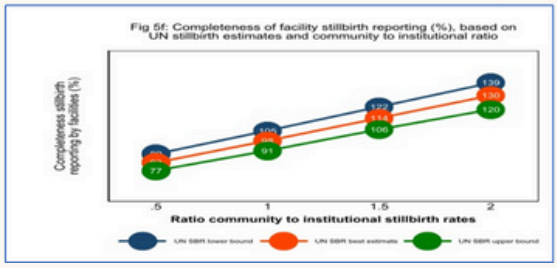


Fig 5f: Completeness of facility stillbirth reporting (%), based on UN stillbirth estimates and community to institutional ratio



BACKGROUND: The main challenge with health facility data on stillbirths and neonatal deaths is underreporting. We can estimate the level of underreporting of stillbirths based on different assumptions: 1) using population mortality estimates from the UN: lower bound, best estimate and upper bound 2) community to institutional mortality ratio: assumptions ranging from half as low to at least 2 times higher community mortality.

Interpretation

- Estimated level of completeness of reporting of maternal deaths seems plausible – *40%. Issues of underreporting still exist although reporting is improving*
- Most plausible assumptions are – lower bound population MMR estimate and a CI ratio of 0.5
- Estimated level of completeness of reporting of stillbirths is impressively high
- However, all assumptions for SBR population level, within the probable CI ratio of 0.5 to 2, inadequately support this level of reporting completeness as levels are more than twice the expected.
- Completeness of reporting of stillbirths is more than twice that of maternal deaths – *maternal deaths rarer than stillbirths, including some neonatal deaths in stillbirths/perinatal deaths*

6 Health system performance assessment: indicators 1

Figure 7a: Number of hospital beds per 10,000 population by region, year

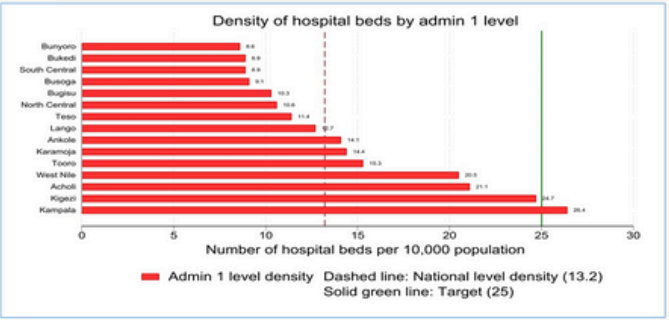
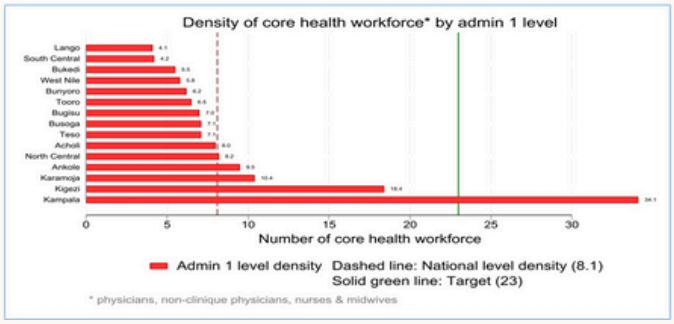


Figure 7b : Number of core health professionals per 10,000 population by year



BACKGROUND

Subnational analyses of health system inputs and service outputs are critical: districts and regions are key units of the health systems and their service delivery. This includes assessment of system inputs (health workforce, infrastructure) and outputs (use, coverage).

MAIN FINDINGS

- Overall, the country is below the WHO target of 25 beds per 10,000 and the WHO target on the density of core health workforce. We suspect issues of under-reporting especially on facility beds.
- Only Kampala has met the WHO standards for hospital bed density and has even exceeded those for core health workforce. This is not unsurprising, given the higher concentration of health facilities, including private ones, in the region. In addition, the conducive working environment, notably as the capital city, contributes to these achievements.

6 Health system performance assessment: indicators 2

Figure 7c: Scatter plot of service utilization by health system inputs for regions, year (e.g. OPD use among under 5 and health workforce density, or admission rates among under-5 and beds density)

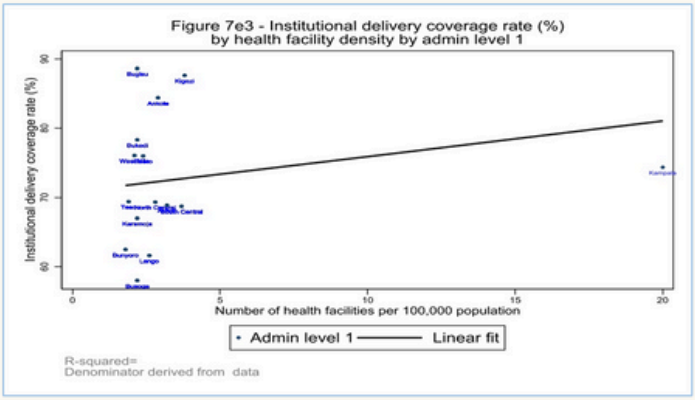
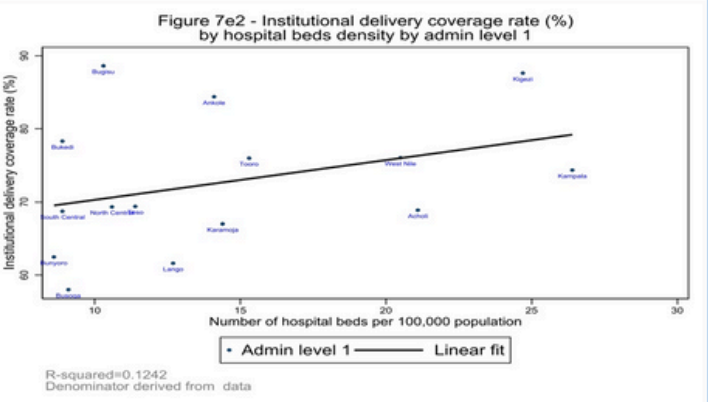


Figure 7d: Scatter plot of service utilization by health system inputs for regions, year (e.g., institutional live birth coverage rate and health workforce density)



BACKGROUND

Subnational analyses of health system inputs and service outputs are critical: districts and regions are key units of the health systems and their service delivery. This includes assessment of system inputs (health workforce, infrastructure) and outputs (use, coverage).

MAIN FINDINGS

- The results to some extent confirm that Kampala which also doubles as the capital city is expected to have better services (including the number of health facilities). However, the large disparity observed between Kampala and other regions was not expected.

Poor performing regions:

- Bunyoro, South Central, and Bukedi have the lowest number of hospital beds per 100,000 population despite the high proportion of institutional delivery.

Good performing regions

- Kampala stands out with the highest percentage of health facilities per 1000,000 population despite its institutional delivery being below 80%. The same region with Kigezi are also performing well on the number of hospital beds per 100,000 population.

Analysis of reproductive, maternal, newborn, child and adolescent health indicators

2019-2023

About Countdown 2030 in Uganda

The Countdown to 2030 country collaboration in Uganda includes Makerere University, the Uganda Ministry of Health, the London School of Hygiene and Tropical Medicine, the Centre for Global Child Health at the Hospital for Sick Children, and the Institute for Global Health at the University of Manitoba. It aims to strengthen the analysis and synthesis of health data to inform national and local reviews of progress and performance in the context of the national health plans and Global Financing Facility (GFF) investment case for reproductive, maternal, newborn, child and adolescent health and nutrition.

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