

REPUBLIC OF UGANDA



VALUE FOR MONEY AUDIT REPORT ON THE MANAGEMENT OF
HEALTH PROGRAMMES IN THE HEALTH SECTOR
MINISTRY OF HEALTH

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
BEMOC	Basic Emergency Obstetric Care
BP	Blood Pressure
CDD	Control of Diarrhea Diseases
CEMOC	Comprehensive Emergency Obstetric Care
DDHS	District Director of Health Services
DSC	District Service Commission
EMOC	Emergency Obstetric Care
FB-PNFP	Facility Based Private Not for Profit
FDS	Fiscal Decentralization System
FY	Financial Year
GOU	Government of Uganda
HBMF	Home Based Management of Fever
HCs	Health Centers
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSC	Health Service Commission
HSD	Health Sub District
HSSP	Health Sector Strategic Plan
IDP	Internally Displaced People
IEC	Information, Education and Counseling
IMCI	Integrated Management of Childhood Illnesses

IMR	Infant Mortality Rate
ITNs	Insect Treated Nets
JRM	Joint Review Missions
MAAIF	Ministry of Agriculture, Animal Industry & Fisheries
MDG	Millennium Development Goals
MMR	Maternal Mortality Rate
MOD	Ministry of Defence
MOE	Ministry Of Energy
MOE&S	Ministry of Education & Sports
MOFA	Ministry of Foreign Affairs
MOFPED	Ministry of Finance Planning and Economic Development
MOH	Ministry of Health
MOLG	Ministry of Local Government
MOPS	Ministry Of Public Service
MOU	Memorandum of Understanding
MOW&E	Ministry of Water & Environment
NDA	National Drug Authority
NGO's	Non Governmental Organizations
NHP	National Health Policy
NMS	National Medical Stores
OAG	Office of The Auditor General
OPD	Outpatients Department
ORT	Oral Rehydration Therapy

PEAP	Poverty Eradication Action Plan
PFAA	Public Finance & Accountability Act
PHC	Public Health Care
PMTCT	Prevention of Mother to Child Transmission
PPDA	Public Procurement and Disposal of Public Assets
RH	Reproductive Health
SWAP	Sector Wide Approach
TBA	Traditional Birth Attendant
UBOS	Uganda Bureau of Statistics
Ug shs	Uganda Shillings
UIA	Uganda Investment Authority
UMHCP	Uganda Minimum Health Care Package
UNBS	Uganda National Bureau of Standards
UNCS&T	Uganda National Council for Science and Technology
UPHOLD	Uganda Programme for Human and Holistic Development
URA	Uganda Revenue Authority
US \$	United States Dollar
WHO	World Health Organization

1 EXECUTIVE SUMMARY

This is a Value for Money Audit report on the Health Sector with particular focus on health service delivery.

The findings are based on a sample of 81 randomly selected HCs and hospitals from 14 districts.

The audit was carried out in two phases namely: the pre-study and the main study.

In both phases we employed a number of methodologies including interviewing the various stakeholders, data collection and inspection of the HCs and their facilities.

In the campaign to implement the MDGs, GOU embarked on the strategy to reduce child and maternal mortality by two thirds and three quarters from 143/1,000 and 510/100,000 by 2015 respectively. This was to be achieved through the development of the health sector strategic plans I and II in 2000 and 2005 respectively by the MOH under the national PEAP.

The provision of health services is funded by the GOU and Development Partners. A big proportion of the population in Uganda lives below the poverty line with 31.1% (2006), 38.8% (2003) and 44% (2000) of the population living in absolute poverty. This therefore means that many people can not afford private medical services and therefore require free medical services provided by Government. In order to make health services accessible to the population, GoU decentralized health service delivery to districts and further lower to health sub districts (by re allocating resources to lower HCs).

GOU has spent US \$ 193.5 million (Ug Shs 354.16 billion) to finance PHC activities which was only 21.6% of the total health sector expenditure of US \$ 896.26 million (Ug Shs 1640.15 billion) over the 5 year period (2000-2005). This translates into health expenditure per capita of US \$ 7.28 which is far less than the HSSP I target of US \$ 28 and WHO's Commission for microeconomics and health of US \$ 30-40.

During the period under review, there was progress in some areas of the health sector against set targets as follows:-

- Polio has been eradicated and Uganda was declared polio free in November 2006.
- DPT3 Immunization coverage increased from 48% (2001) to 89% (2005) against 85% target.
- OPD utilization increased from 0.43 (2001) to 0.9 (2005) against 0.7 target.

- Dramatic decline in cases of guinea worm from 126,639 cases in 1992 to less than one case in 2006.

Like most other African countries, the rate at which Uganda is achieving the MDG under the health sector is very low, but progressively increasing.

SUMMARY OF FINDINGS

PROGRESS

- Polio has been eradicated and Uganda declared polio free in November 2006.
- DPT3 Immunization coverage increased from 48% (2001) to 89% (2005) against 85% target.
- OPD utilization increased from 0.43 (2001) to 0.9 (2005) against 0.7 target.
- Dramatic decline in cases of guinea worm from 126,639 cases in 1992 to less than one case in 2006.

FINANCING

- There are delays in disbursement of funds from MOFPED to districts and HSD usually in the 1st and 2nd quarters of the FYs.
- Lower HCs do not participate in the budgeting process
- Districts and HSDs do not use a standard guideline or formulae to allocate funds to lower health units.
- GoU Health policy of funding NGO hospitals to increase accessibility of health services to the poor has failed due to the user fees that they are charged.
- There are cases of diversion of PHC funds at HCs.
- HSDs do not utilize all the funds released to them leading to accumulation of balances at the end of FY.
- There is no clear and standard method of book keeping in the districts and HSDs and regular reviews of accounting records are not carried out in line with the health care financing strategy

EQUIPMENT

- Assets/inventory registers for equipment at health facilities are either poor or not maintained
- Equipment is not regularly maintained leading to constant break down
- Some equipment and medical facilities are not properly utilized
- Most HCs and hospitals lack essential medical equipment

DRUGS

- There is breakdown in information between the MOH, districts and HCs concerning drug allocation under the credit line method making it difficult to carry out reconciliation at all levels
- There is little or no compliance with the drug delivery procedures and delivery schedules issued by NMS leading to late delivery of drugs.
- Recording of drugs at lower HCs and HSDs is rarely done
- There are drug stock outs in HCs and Hospitals
- Expired drugs are not properly handled
- HCs have no proper drug storage facilities

INFORMATION, EDUCATION AND COUNSELLING MATERIALS

- There is little involvement of districts, HSDs and HCs in the development and designing of IEC materials
- There is a low geographical coverage of IEC materials

BUILDINGS

- Some completed medical structures are not utilized
- Some medical structures have taken too long to be completed
- Some medical structures are poorly constructed
- Buildings are not well maintained

STAFFING

- DSCs have found it difficult to attract and retain qualified medical personnel
- Districts do not have a clear policy on training while training by MOH is not tailored to district training needs
- Districts lack a clear policy on staff transfer and rotation leading to congestion of health workers in urban areas and acute staffing gaps in rural and remote areas
- Some districts do not regularly appraise and supervise staff
- There are staffing gaps in most of the HCs and hospitals

MONITORING EVALUATION SYSTEM

- Monitoring and evaluation is not regularly done leading to laxity by districts and

HCs in providing health services.

- Districts, HSDs and HCs do not use the existing HMIS to report their performance
- Some HMIS reports are not completed and submitted in time

ACCESSIBILITY OF HCs

- Some HCs are not located in accordance with existing guidelines
- There are inadequate out reach visits carried out by HCs

2 INTRODUCTION

I have reviewed the management of the health programmes with specific interest to child health and maternal health programmes of MOH which are run by the department of Community Health. The Department of Community Health is responsible for provision of health services to keep the population healthy to enable it to effectively contribute to economic development.

This report focuses on the delivery of health services within the child health and maternal health programmes. Provision of services to the general well being of children is conducted in a holistic approach under IMCI which handles the treatment of the major childhood disease symptoms and signs such as fever, cough, difficult breathing, diarrhea and malnutrition. It also handles the assessment of child immunization status and feeding practices of children under 2 years. These diseases accounted for about 70% of all child illness in Uganda (MOH- Annual Health Performance report 2001/2002).

The overall goal of IMCI is to reduce morbidity and mortality caused by common childhood illnesses in children under five years of age.

Maternal health interventions on the other hand are run under the general provision of sexual and reproductive health services such as Ante Natal Care, Family planning, Post Natal Care, Post Abortion Care, Essential and Surgical Obstetric Care and life skills development. The interventions are geared at reducing infant and under 5 mortality rates as well as maternal and peri-natal mortality and morbidity.

The primary objective of this audit was to evaluate the economy, efficiency and effectiveness of these programmes using the HSSP performance indicators of; ANC attendance, deliveries in health units, number of users of family planning methods, immunization rates, OPD utilization, GoU budget allocated to health sector, PHC funds released on time to the sector, health expenditure per capita, PHC funds that are expended, districts submitting complete HMIS monthly returns to the MOH in time, HCs without essential drug stocks, accessibility of the population to health facilities, children under one year completing immunization doses, proportion of approved posts filled by trained health workers, and malaria fatality rate among children over the age of 5 years.

2.1 BACKGROUND

Uganda has been implementing reforms in the health sector since the early 1990's to reduce mortality and morbidity. These reforms are operationalized through the Health Sector Strategic Plans, focusing on reducing morbidity and mortality from major illnesses under the National Health Policy (NHP). The NHP contains the Minimum Health Care Package (MHCP) to all Ugandan households using the most cost effective interventions.

The burden of disease among maternal, newborn and children is high in Uganda and this is constraining economic development because of the severe impact on the family and society in general. Investment in child health is not only a priority for saving lives but is also critical to advancing other goals related to human welfare, equity and poverty reduction. Almost 90% of all deaths among children under 5 years are attributable to just 6 conditions (acute neonatal conditions, mainly from pre-birth, birth asphyxia and infections, lower respiratory infections mostly pneumonia, diarrhea, measles, malaria and HIV / AIDS). Most of these diseases are preventable through existing interventions that are simple, affordable and effective. These include oral rehydration therapy, antibiotics, anti-malarial drugs and insect treated nets, vitamin A and other micronutrients, promotion of breast-feeding, immunization and skilled care during pregnancy and childbirth.

There is therefore a need to take an integrated view to the reproductive, maternal, newborn and child health as one process from pregnancy through childhood. This is an approach also adopted by the GoU in the PEAP.

2.2 VISION OF THE HEALTH SECTOR

The vision of the health sector is “To make a contribution to the well-being of the people” i.e. expanded economic growth, increased social development and poverty eradication.

2.3 MISSION OF THE HEALTH SECTOR

The mission of the health sector is “The attainment of a good standard of health by all the people in Uganda, in order to promote a healthy and productive life”

2.4 MANAGEMENT OF HEALTH SERVICE DELIVERY

The delivery of health service is undertaken through a National Health System comprising of all institutions, structures and actors whose actions have a primary purpose of achieving and sustaining good health. The boundaries of Uganda's National Health System encompass the public sector comprising of MOH, Office of The Prime Minister, MOFPED, UNCS&T, URA, MOPS, MOLG, MOES, Tertiary Institutions, MOW&E, NEMA, MAAIF, Ministry of Energy, Ministry of Gender, Labour and Social Development, MOD, Ministry of Internal Affairs, Ministry of Justice, Ministry of Trade, Tourism and Industry, UIA, UNBS, UBOS, MOFA, the private health delivery system comprising of PNFP, private health practitioners, the traditional and complementary medicine practitioners, Development Partners and the communities.

The Health Sector Master Plan was developed in line with the PEAP and MDGs and in collaboration with the local authorities and the Development Partners. The plan is spelt out in the Health Policy 2000 and HSSPs and implemented by the local authorities under the decentralized system of government.

In order to deliver better health services to the public, the health sector adopted seven levels of health service delivery points each with specific health service objectives as follows:

- **HC I;** this is a community based and promotive HC at a village level serving a population of at least 1000 people. It is managed by a village health committee and it is mostly used for mobilization purposes.
- **HC II;** this is a HC found at a parish level serving an approximate population of at least 5000 people. It is responsible for providing preventive, promotive, out-patient curative health services and out reach care.
- **HC III;** this is found at sub county level serving a population of approximately 20,000 and offers preventive, promotive, out-patient curative, maternity, in-patient health services and laboratory services.
- **HC IV;** this is a HC found at county level serving a population of approximately 100,000 people and it offers promotive, out-patient curative, maternity, in-patient health services, Emergency surgery, Blood transfusion and laboratory services.
- **HC V;** this is a HC found at the district level. It is a district hospital serving an approximate population of at least 500,000 people. These HCs offer all services offered at HC IV in addition to in-service training, consultation and research in community based health care programmes.

- **HC VI;** These are HCs found at regional levels. They are regional referral hospitals serving a population of approximately 2,000,000 people covering 3 to 5 districts. In addition to services offered at a district hospital, they offer specialist services like psychiatry, Ear Nose and Throat (ENT), Ophthalmology, dentistry, intensive care, radiology, pathology, higher level surgical and medical services.
- **HC VII;** These are HCs at national level. They are national referral hospitals. In addition to services offered by the regional referral hospitals, they offer comprehensive specialist services and are involved in teaching and research.

The delivery of UMHCP is concentrated in HCs I-IV where the majority of the population lives. According to African Development Bank report (2005) on selected statistics on African countries, 79.7% (2003) of the Ugandan population lives in rural areas.

The health service delivery is implemented through a decentralized system and SWAP. Under this system, different stakeholders have been assigned different responsibilities by the Constitution of the Republic of Uganda, the Local Governments Act, the National Health Policy and the Health Sector Strategic Plan.

The central government has the following responsibilities:

- Policy formulation, standard setting and quality assurance
- Resource mobilization
- Capacity development and technical support
- Provision of nationally coordinated services like Epidemic control
- Coordination of health services
- Training and
- Monitoring and Evaluation of over all sector performance.

On the other hand, the Local Governments (Districts and delegated HSDs) have the following responsibilities:

- Implementation of national health policies
- Planning and management of district health services
- Provision of disease prevention, health promotion, curative and rehabilitative services
- Vector control
- Health education
- Ensuring provision of safe water and environmental sanitation
- Health data collection, management, interpretation, dissemination and utilization.

2.5 FINANCING

The provision of health services is funded by GoU and Development Partners. The majority of the population in Uganda lives below the poverty line with 31.1% (2006), 38.8% (2003) and 44% (2000) of the population living in absolute poverty.

With a population of 27.7 million which is expected to double to 55 million by 2025 and a life expectancy of 46 years (2003), the country faces a challenge of providing quality health services given its low level of economic development.

This, therefore, means that the majority of the people depend on free medical services provided by Government.

GoU has spent US \$ 896.26 million (Ug shs 1640 billion) over the period 2000-2005 implementing the health sector programmes. This translates into health expenditure per capita of US \$ 7.28 which is far less than the HSSP I target of US \$ 28 and WHO's Commission for microeconomics and health of US \$ 30-40.

GoU contribution to this resource envelope was US \$ 501.1million (Ug shs 917 billion), (55.9%) and the donor contribution was US \$ 395.1 million (Ug shs 723 billion), (44.1%).

GoU contribution towards the health sector expenditure has kept on increasing ,but at a reducing rate over the years from 37% in FY 2000/01 to 5% in FY 2004/05. The shortfall is absorbed by the donor counter funding though at a reducing rate.

GOU spent US \$ 193.52 million (Ug Shs 354.14 billion) over the 5 year period to finance PHC activities, accounting for 21.6% of the total health sector expenditure of US \$ 896.26 million (Ug Shs 1,640.15 billion).

Public Expenditure on Health over the HSSP I

YEARS	2000/01	2001/02	2002/03	2003/04	2004/05	TOTAL
GoU Funding (billion Ug Shs)	124.23	169.79	195.96	207.8	219.56	917.34
Donors (billion Ug Shs)	114.77	144.07	141.96	175.27	146.74	722.81
Total Public Health Expenditure (billion Ug sh)	239	313.86	337.92	383.07	366.3	1,640.15
PHC funding (billion Ug sh)	60.89	60.89	66.75	75.88	89.73	354.14
Per Capita expenditure in Ug. Shs	10,348.71	13, 128.09	13,653.90	14,969.26	13,843.27	
Per Capita expenditure in US\$	5.9	7.5	7.3	7.7	8.0	
GoU expenditure health as % of total government expenditure	7.5	8.9	9.4	9.6	9.7	
Budget performance for GoU(%)	82.8	96.2	96	95.4	92.8	
Increase on the previous year in GoU allocation		37%	15%	6%	5%	
Increase on the previous year in Donor Funding		25.5%	(1.5%)	23.5%	(16.3%)	

Source: MOFPED budget framework

2.6 REASONS FOR THE AUDIT

The audit was motivated by the realization that despite increasing Government expenditure in the health sector as shown in the previous table, there has been no significant improvement particularly community health, “maternal and infant mortality rates” have instead remained high as shown in the table below:

YEARS	2001	2002	2003	2004	2005
IMR(ADB Report)	88/1000	86/1000	84/1000	83/1000	
MMR					

3 AUDIT DESIGN

3.1 SCOPE

The study was conducted in 81 HCs in 14 out of 56 districts (refer to appendix A). The districts were drawn from all the five major regions. Stratification of the country into regions and judgmental sampling were the methods used in selecting the districts as shown in the table below.

REGION	DISTRICTS	REASONS FOR SELECTION
CENTRAL	Kampala	This is the district in which the city is located. It is very urbanized.
	Mubende	This also is not very far away from the audit office.
EASTERN	Katakwi/Amuria	This has been affected by insurgency and has IDP camps
	Busia	This is a boarder district with cross-boarder population.
	Soroti,	This is a model district selected by MOH for promotion of maternal and child health.
WESTERN	Bushenyi	This is highly populated district and shares same health conditions with neighboring districts out side the study.
	Kamwenge	This is one of the new districts and has poor health indicators and lacks medical infrastructure.
	Kabarole	This is highly populated district and shares same health conditions with neighboring districts out side the study.
	Kisoro	This is very highly populated and with a unique landscape (mountainous).
NORTHERN	Gulu	This is highly populated with IDPs
	Lira	This is one of the safe districts in the war zone.
SOUTHERN	Kalangala	This is an Island district with unique health conditions and temporary settlements.
	Rakai	This is a district that was highly affected by AIDS scourge.
	Masaka	This is one of the highly populated districts.

The audit covered five (5) financial years from 1st July 2000 to 30th June 2005. The data collection methods used in carrying out this audit review included interviews with the various stakeholders, review of financial and non-financial reports, observations and physical inspection of the health facilities.

4 DESCRIPTION OF THE AUDIT OBJECT

The health sector comprises government agencies, NGO's, private and community health providers and various Development Partners. The central authority is MOH, which formulates policies for the sector and oversees the implementation of health programmes. MOH comprises five technical departments namely; National Disease Control, Community Health, Clinical Services, Planning and Quality Assurance.

The Department of Community Health is responsible for provision of health services to keep the population healthy so that it effectively contributes to economic development. It comprises five divisions namely:-

- Child Health
- Sexual and Reproductive health
- Environmental Health
- Veterinary Public Health
- Vector born diseases

This study focuses on maternal and Child Health.

5 FINDINGS

5.1 PROGRESS

During the period under review, there was remarkable progress in some areas of the health sector against set targets as follows:-

- Polio has been eradicated and Uganda was declared polio free in November 2006.
- DPT3 Immunization coverage increased from 48% (2001) to 89% (2005) against 85% target.
- OPD utilization increased from 0.43 (2001) to 0.9 (2005) against 0.7 target.
- Dramatic decline in cases of guinea worm from 126,639 cases in 1992 to less than one case in 2006.

5.2 FUNDING

5.2.1 UNDER FUNDING

It was noted that the overall health sector budget performance over the period of 5 years has been at an average of 92.6% with the exception of Busia district which experienced a poor budget performance of 60% in FY2004/05 because MOFPED did not remit funds on time in the FY. This created a funds gap in the district budget thus affecting its ability

to implement health activities such as immunization, family planning and to purchase drugs.

It was also noted that PHC activities in the districts mainly depend on funding by the central Government with less or no contribution from the local governments as a result of the abolition of graduated tax which was among the major sources of local government revenue. Disbursements from only the central government are overwhelmed by the demand for the delivery of health services.

5.2.2 DELAYED DISBURSEMENT

MOFPED is required to release funds to districts on a quarterly basis without delay to match the districts' quarterly plans. It was generally noted that MOFPED delays to release funds at the beginning of every FY. The delay is because MOFPED operates on Vote on Account before the Appropriation Act is passed by Parliament in the first quarter. Therefore, the releases to districts in the 1st and 2nd Quarters of each FY by MOFPED do not match expenditure projections in the Quarters.

The poor budget performances in the 1st and 2nd Quarters are later compensated in the 3rd and 4th quarters.

For example during FY2003/04 only 59% and 82% of Quarter 1 and 2 funds were released compared to 103% and 111% of Quarter 3 and 4 national wide.

It was observed in Busia and Kampala districts that there was a delay in disbursement of development grants.

It was observed in Kamwenge district, that capital development funds released were insufficient leading to non-completion of structures.

In the districts of Soroti and Katakwi, it was established that funds take between 3 and 7 weeks before they are received by the HSDs due to delayed processing of payments by districts accounts staff.

Delays are also caused by health units. For example, in Kabarole district some cheques were found lying in the DDHS office uncollected due to delayed accountabilities from recipient health units.

Delayed disbursement of funds leads to funding deficits during the periods which result into lower performance of the health sector interventions like immunization of children, PMTCT, family planning, Emergency obstetric care, Child nutrition and procurement of logistics such as drugs and medical sundries.

5.2.3 BUDGETING

MOH has designed guidelines governing the budgeting process at each level of health facilities. These guidelines require full participation of all HC levels from I to IV during budgeting. Area teams have also been deployed to help districts in budgeting techniques. Health sector programmes are activity driven and districts are expected to adhere to strict budget discipline. However, under the Fiscal Decentralization System (FDS), districts are allowed to make re allocations within programmes up to a 10% limit for under or unfunded programmes.

Basing on the budget ceiling for the district, the DDHS in collaboration with the HSDs draw up budget estimates for their respective districts.

However, the lower HCs (HC III and HC II) do not participate in the drawing up of these budgets and as a result some of the lower HC activities like security, compound cleaning, building and equipment maintenance are not adequately budgeted for, yet they are essential to delivery of quality health service.

5.2.4 ALLOCATION OF FUNDS

There is a systematic and logical formula drawn by MOH for use in allocating funds equitably to both GoU and NGO health units.

This formula uses the weighing index that takes into consideration the burden of disease, epidemiological indicators, and intensity factor for averting a loss of life, project funding and hospital coverage. MOFPED disburses funds to districts basing on the advice of MOH.

Districts, however, use different methods of allocating funds to HCs. Each district has its own method of funds allocation basing on the level of the HC, population served, terrain or any other method. In Mubende district, the basis of allocations is only known to the DDHS. In Gulu and Lira districts, funds are not released to the HCs but are centrally managed by the DDHS.

It was also noted that MOFPED disburses funds to districts and regional hospitals on advice of MOH on the basis of bed capacity as one of the variables. However the actual bed capacities of these hospitals far exceed the official number with some patients sleeping on floors. It was further noted that the district and regional hospital budgets are capped to allow the growth of budgets at lower HCs.

Failure by the Districts to use a systematic and logical formula when allocating funds to

lower HCs has led to insufficient funds allocated to these HCs for delivery of quality health services.

5.2.5 FUNDING TO NGO HCs

GoU approved a policy of partnership with the private sector where by Government and Development Partners agreed to provide funds to FB-PNFP health facilities. This is intended to subsidize the user fees charged by NGO hospitals to enable a higher number of people to access health services and thus improving on the preventive and promotive aspects of health service delivery.

Under this arrangement, GoU disburses funds to NGO hospitals on a quarterly basis through the districts. Disbursements are made after previous ones have been accounted for.

It was noted during the study that although central government significantly funds NGO hospitals/ health facilities, most of them do not offer free health services but instead levy user charges.

During FYs 2000/01 to 2004/05, central government spent US \$ 40.47 million (Ug Shs74.06 billion) on NGO hospitals and health units which represented 18.5% of the total funds disbursed to districts with the exception of referral hospital as shown below:

YEAR	2000/01	2001/2002	2002/03	2003/04	2004/05	TOTAL
NGO Funding in (billion shs)	11.59	11.59	16.12	17.04	17.72	74.06
District hospitals +PHC (billion shs)	69.76	69.76	75.39	86.32	99.97	401.2
% of NGO funds	16.6%	16.6%	21.4%	19.7%	17.7%	18.5%

Source: MOH- Annual Health Sector performance Reports

Some of these NGO health units are near government HCs and from interviews with some hospital administrators and DDHS, it was noted that majority of the people prefer government HCs since these provide free health services.

It was also noted that accountabilities from these NGO hospitals are not made in time and as a result their subsequent funding is withheld. For example, in Kabarole district, cheques for some of the NGO hospitals had not been dispatched because previous accountability had not been forwarded. In some districts like Mubende district, funds are released to NGO health units without checking the correctness of accountabilities for the previous releases.

NGO hospitals have continued to charge high user fees despite the government subsidy forcing communities to go to government facilities. As a result, the number of patients accessing health services from NGO hospital has remained low due to incapacity of the poor to pay user fees.

5.2.6 DIVERSION OF FUNDS

GoU Treasury Accounting Instructions and the PFAA require the utilization of public funds in a manner that is authorized by Parliament.

It was noted that Kasilo HSDs in Soroti district was allocated US \$ 41,967 (Ug shs 76.8 million) for the purchase of drugs in two FYs (2004/05 and 2005/06) but only US \$ 22,623 (Ug shs 41.4 million) was paid for drugs leaving an un-utilized balance of US \$ 19,344 (Ug shs 35.4 million).

Further investigations revealed that only US \$ 5,738 (Ug shs 10.5 million) of the un-utilized balance was still on the account of the HSD. The balance of US \$ 13,607 (Ug shs 24.9 million) could not be explained by management.

In a related development Tirir HSD also in Soroti district diverted US \$ 2,186 (Ug shs 4 million) meant for drug procurement to financing administrative expenses contrary to drug expenditure guidelines issued by MOH.

Non adherence to the Treasury Accounting Instructions and PFAA led to the diversion of funds earmarked for the procurement of drugs and medical sundries for health sector interventions like immunization of children, PMTCT, family planning, EMOC and Child nutrition.

5.2.7 ACCUMULATION OF FUNDS AT THE HSD ACCOUNTS

It is a good budgetary practice to ensure that programme activities are carried out in the

stipulated period. This calls for the utilization of funds released according to the budget allocations.

It was noted, however, that districts and HSDs do not undertake programme activities in accordance with the budgets and leave large unutilized balances on their bank accounts.

Delayed transfer of funds from the districts towards the end of the FY to HCs, under staffing in accounts and other delays while processing payments led to accumulation of account balances.

This problem was very acute in FY2000/01 where US \$ 1.75 million (Ug shs 3.2 billion) remained unspent on district accounts only to be spent in the following year (*Annual Health sector performance report, 2001/02*).

Failure by the districts to utilize funds in implementation of health programmes may lead to inadequate drugs being procured hence affecting the delivery of health services.

5.3 ACCOUNTABILITY AND BOOK KEEPING METHODS

It is a good accounting Practice for entities in the same sector to have a uniform accounting and book keeping system to enable comparison and reporting on activities for decision making purposes. It is also a requirement under PFAA for every officer to account for public funds entrusted to him and the accountability shall be subjected to independent verification.

It was noted, however, that two different methods of book keeping are used by different districts which impacts negatively on the accountability process. These are centralized and decentralized bookkeeping.

In a centralized bookkeeping system, funds are received and spent at the district and accountability made by the district. In the decentralized system on the other hand, funds are received by the district and disbursed to the HSDs which either transmit the funds to the lower HCs or spend at the HSD on their behalf.

Where HSDs spend on behalf of the lower HCs, accountability will be found at the HSD and where the funds are transmitted to the lower HCs, accountability will be made by the respective HC and submitted to the HSD.

Districts which were centrally maintaining HCs books of accounts had their accountabilities verified by the district internal audit departments regularly whereas accountabilities for those using a decentralized system of book keeping were not subjected to independent verification on a regular basis.

As a result, accounting records in the decentralized system were not up to date because the health workers charged with this responsibility lacked accounting skills.

Due to lack of a standard system of accountability and book keeping in all districts, different districts have employed different methods and this may lead to poor accountability and misappropriation of funds which could in turn have a negative effect on health service delivery.

5.4 EQUIPMENT, DRUGS AND INFORMATION, EDUCATION AND COUNSELLING MATERIALS FOR HCs

Effective health care delivery requires a network of functional health facilities that are adequately equipped. Health facilities work as an interface between the health system and the community.

5.4.1 EQUIPMENT

The MOH national medical equipment policy provides guidelines on standard equipment expected for each HC II to IV, district and regional referral hospitals.

MOH directly specifies the type of equipment to be distributed to specific HCs.

Most of the equipment used in the HCs is procured directly from the suppliers by MOH while others are donated by projects and NGOs depending on their work plans. The equipment is delivered to the districts for further distribution to earmarked HCs.

There are circumstances when general equipment is procured by MOH for districts. On receipt of equipment, the DDHS allocates them to HCs according to the HC assessed needs.

In addition, MOH has set up regional workshops to service and repair HC equipment to which districts and referral hospitals contribute funds to meet operational costs. Specialized and/or sophisticated equipment are maintained through supplier maintenance contracts.

5.4.1.1 Recording/tracking of HC equipment

An asset register is designed to provide information about the assets in respect of location, condition, quantity, cost and date of purchase.

It was observed that in some HCs asset registers/inventory records are either non-existent

or are poorly maintained. Out of 81HCs visited, only 52 (64.2%) had asset registers/inventory records. It was also noted that HCs that maintained asset registers are mostly the higher level centers like the district and regional hospitals. Given the average population of 27,632 HCs, 9,892 HCs on a national level may be lacking assets/inventory records. (*APPENDIX B*)

Lack of assets/inventory registers was due to limited management skills exhibited mainly by lower level administrators who in most cases were pre-occupied with actual delivery of health services.

The absence of asset/inventory registers can easily lead to difficulty in identification of equipment gaps thus leading to inadequate planning for the procurement of equipment required in the delivery of quality health services.

5.4.1.2 Maintenance of HC equipment

MOH set up regional maintenance workshops to ensure that health facilities are equipped with well maintained equipment.

It was observed that the condition of equipment at HCs was not satisfactory and maintenance is not regularly done. Equipment like refrigerators, solar systems, microscopes, CD4 count machine and vehicles were found to have broken down.

In some districts, the equipment take over a year without servicing and maintenance.

In Gulu hospital, it was observed that equipment like sterilizers/boilers, theatre equipment, power generator, beds, trolleys and stretchers are very old and constantly break down.

The reasons for the above are failure by management at HCs to identify and report mechanical problems in time and limited technical skills of personnel at the mechanical workshops. For example, a CD4 count machine at Fort portal regional referral hospital was not working and the staff at the mechanical workshop had failed to repair it due to the limited technical skills.

It was also discovered that the budget provisions of HSDs in Mubende district do not provide for vehicle maintenance and as a result management is unable to obtain resources to meet these unbudgeted expenses.

Failure by management to maintain equipment leads to constant break down which disrupts health service delivery. For example, treatment of HIV-AIDS patients has become difficult in hospitals where CD4 count machines have broken down. HCs with broken down solar systems are unable to preserve immunization vaccines and this affects their out reach activities. Broken down ambulance vehicles affect the delivery of EMOC

services in HCs.

5.4.1.3 Utilization of HC equipment

In order to deliver sufficient health services, MOH constructed theaters at each HC IV and district hospital.

Out of 33 theaters visited, only 28 were found operational. 5 theaters were fully equipped but due to the absence of medical personnel were not operating.

Some laboratories were also equipped but not operating due to lack of medical personnel. Each HSD is given an ambulance vehicle – a double cabin pick-up to handle emergency cases in the HSDs.

It was observed that these vehicles are ordinary pick-ups which are not designed as ambulances. As a result management is using them for other duties such as staff transport and administrative work like collecting drugs from suppliers.

It was noted in Bukuku HC IV in Kabarole district that the solar battery charging system in the theatre was used to charge private mobile phones.

Theatre battery charging system used to charge private phones, Bukuku HC IV, Kabarole district.



Insufficient utilization of equipment has led to inadequate service delivery. Non functional laboratories lead to treatment of diseases without first examining samples from patients. Some theaters are not offering EMOC services to mothers with difficulties in delivery, exposing them and their babies to high risk of maternal and infant mortality.

THEATER EQUIPMENT AT KIGANDA HC IV NOT INSTALLED, MUBENDE DISTRICT



Inadequate and/or missing HC equipment

As already mentioned above, MOH is responsible for equipping HC II to IV, district and regional referral hospitals with necessary equipment to enable delivery of health services.

It was generally noted that all the 81 (100%) health facilities visited, lacked equipment of one type or another. The magnitude of shortage of equipment is more acute in lower HCs compared to district and regional hospitals. On the basis of this finding, it is reasonable to conclude that all the 27,632 health facilities in the country lack equipment of one type or another.

Most of the HCs lack laboratory equipment, delivery kits, testing kits, Oxygen cylinders BP machines, drip stands, scanners, examination screens, weighing scales, communication equipments, beds and mattresses. (*APPENDIX D*)

It was also noted that due to poor or lack of communication equipment like radio calls, HC IIIs are not able to communicate with HC IVs and HC IVs can not communicate with district and regional hospitals.

It was further noted that due to lack of scan and ultra sound equipment in HC IVs around Kampala district, Mulago national referral hospital was overwhelmed with patients lining up for these services.

Lack of equipment is, apart from limited funding, attributed to the following:

- Weaknesses in identifying equipment gaps at HCs to enable proper planning and budgeting by MOH
- Weaknesses in maintenance of equipment that leads to constant equipment break down
- Overwhelming number of patients that has exerted enormous pressure on a few equipment leading to break down

Laboratory equipment

It was noted that most of the health units lack laboratories and laboratory equipment leading to treatment to be done symptomatically. For example, between the years 2002 and 2005, out of a yearly average of 9 million malaria cases treated, 7.5million (83%) were not tested in laboratories as per table below:

MALARIA TREATMENT (2002-2005)

YEAR	Malaria tests done	Malaria positive slides	Malaria cases Diagnosed	Malaria cases treated, but not tested	% of treated malaria not tested
2002	1,097,562	555,990	8,008,481	6,910,919	86%
2003	1,566,474	801,784	9,276,944	7,710,470	83%
2004	1,859,780	879,032	10,681,645	8,821,865	83%
2005	1,583,795	842,594	8,188,525	6,604,730	81%
AVERAGE	1,526,903	769,850	9,038,899	7,511,996	83%

Source: MOH- Health Management Information System (HMIS)

Delivery and EMOC equipment

There has been a remarkable improvement in the number of babies delivered from health facilities as shown by percentage deliveries of 25% (2002) and 50% (2005).

It was, however, noted that fewer deliveries take place in health facilities which may be due to lack of equipment, among other reasons, despite the good ANC attendance. Table below refers.

ANNUAL DELIVERIES

YEAR	2002	2003	2004	2005	Average
NO.of deliveries in HCs	214,083	262,633	303,799	354,856	283,843
Total deliveries*	854,853	835,672	1,012,038	755,533	864,524
% deliveries in HCs	25%	31.4%	40.2%	50%	33%
ANC attendance	1,021,530	1,136,652	1,190,148	857,630	1,051,490

Source MOH- Health Management Information System (HMIS)

**Total deliveries approximated to 1st year measles immunization*

Lack of equipment among other factors has hampered the provision of EMOC services that play an important role in the mitigation of the Maternal Mortality rate which is currently standing at 506/100,000 live births, this is below the targeted 354/100,000 (2005). For example, a study carried out by MOH during FY2002/03 revealed that 4% of HC III was offering BEMOC services, 6% of HC IV while 65% of district and regional hospitals were offering CEMOC services.

There was a slight improvement in FY2003/04 as 9.5% of HC IVs offered BEMOC and 70% of district and regional hospitals offered CEMOC service.

5.4.2 DRUGS

Drugs are an important component of a health system. Availability of drugs is one of the major indicators of quality health delivery.

MOH in collaboration with the National Drug Authority, National Medical Stores and Professional Councils provide overall co-ordination and guidance on procurement of pharmaceuticals, other medical supplies, logistics and instructions on their rational use.

We noted that under the decentralization system, actual procurement of drugs in the districts is done using either the credit line method or direct purchases by the districts and HSDs.

Under the credit line, a Memorandum of Understanding is signed between GoU and NMS. Funds are allocated to each HC's account with the NMS by the MOH and drugs delivered to the district by NMS on the basis of drug requisition orders from HCs. There is a standard delivery schedule issued by NMS every year showing the order and delivery date deadlines.

Under the direct purchases method, at least 50% of PHC funds released by central government must be used to purchase drugs. These drugs must be purchased from NMS as a first priority and it is only upon issuance of a certificate of non availability by NMS that the district may purchase from any other supplier.

The method of distribution of the drugs purchased is determined by the method of book keeping used by the districts as explained above.

In a centralized system of book keeping, drugs are distributed by the districts to HSDs which later distribute them to HCs under their jurisdiction.

In a decentralized system of book keeping, drugs are distributed by the HSDs.

The method of drug distribution will also depend on the method of drug procurement. Credit line drugs are distributed by NMS to the districts and then collected by the HSDs for later distribution to HCs.

Drugs directly purchased under the 50% PHC funds are distributed by the authority responsible for the purchase. If drugs are purchased by HSD, then they will be distributed by HSD and those purchased by the district, are distributed by the district.

Under the new 'Pull system' of drug procurement, NMS has a logical accounting system that links all credit lines of health facilities. Orders are supposed to be made within specified ordering schedules and deliveries expected within a period of 2 months from the ordering date.

5.4.2.1 Procurement Procedure

The PFAA requires officers to comply with established procedures/regulations when utilizing public funds.

It was noted that under the credit line method, HCs do not have knowledge of how much

has been credited on their accounts with NMS.

Although MOH informs the districts of how much funds have been budgeted under the credit line in a given FY, districts are not notified of how much credit each HC has been allocated and actual debit by NMS in a given period.

It was again noted that although NMS operates a computerized invoicing and accounts system, drug accounts statements of individual HCs were not regularly given to them, but HCs only receive them on request.

Furthermore, it was noted that NMS does not deliver drugs to HSDs, but to the districts and HSDs take long to collect the drugs from the district stores causing delays.

In order to reduce delays on the delivery time by NMS, it was noted that Kampala and Bushenyi districts have resorted to purchasing drugs from other suppliers without waiting to attain certificates of non availability from NMS.

Lack of transparency in the procurement process may lead to misappropriation of funds and drugs. Furthermore failure by NMS to deliver drugs to HCs causes drug shortages at these centers. For example, a number of HCs were found lacking children syrups and family planning supplies.

5.4.2.2 Record Keeping

The PPDA Act requires proper recording of stores procured.

It was noted that 19 HCs (23.5%) out of 81 HCs visited did not have proper drug records. It was also noted that stock cards and dispensing records are either not kept or are not updated, reconciliations between stock records and physical stock verifications are not carried out. On a national level, the above finding deduces that 6,482 HCs do not have proper drug records.

The reasons for not keeping proper stores records include lack of skills and time by health workers to regularly post stores transactions. (*APPENDIX E*)

When store records are not maintained, it is possible for drug leakages to go un-noticed, it could also lead to delay in the identification of drug stock outs and expired drugs. The resultant effect would be drug shortages that would disrupt health service delivery.

5.4.2.3 Drug Stock Levels

Stock-Outs

Out of 81 HCs visited, 31 (38.3%) lacked essential drugs and sundries required by the

medical personnel of the HCs in carrying out their duties; extrapolated to the HC population, this indicates that 10,583 HCs national wide lack essential drugs.

For example at Olwal HC II, Pabbo HC II, Awer HC II in Gulu district, the drug store was virtually empty; and as at the time of the visit in July 2006, Olwal HC II had last received drugs in Jan/Feb 06; Mutukula HC III in Rakai district had not been supplied drugs in the last three months and Kalongo HC III in Mubende district had last received drugs six months ago. The causes of drug shortages is attributed to limited funds, delayed deliveries, overwhelming number of patients, delivery of drugs by NMS which are not ordered for by HCs, bureaucratic procurement procedures and poor stock management skills.

In Kamwenge HC III, Kamwenge district, the officer in charge was forced to discharge patients who were admitted while still in poor condition due to lack of drugs.

(APPENDIX F)

Further analysis of data from the HMIS also indicated drug stock outs in a number of HCs. On average out of 27,632 reporting HCs, 1,189 lack the first line drugs for family planning and treatment of malaria.

YEAR	Chloroquine tabs	Cotrimoxazole tabs	ORS sachets	Measles vaccine	Fansidar	Depo-Provera	Average No. of HCs lacking drugs	No. of HCs in Districts
2002	436	569	483	302	447	492	455	24,934
2003	1,085	1,986	1,933	486	1,271	1,848	1,435	29,455
2004	1,410	2,501	1,965	576	1,110	2,004	1,594	32,398
2005	1,649	2,469	1,401	348	564	1,199	1,272	23,740
AVERAGE	1,145	1,881	1,446	428	848	1,386	1,189	27,632

Source MOH- Health Management Information System (HMIS)

It was also noted that the persistent shortage of reproductive health supplies may lead to the poor performance of RH interventions. The cause of the poor performance is limited

budget allocations given to these interventions by districts, HSDs and HCs.

This is further confirmed by the low levels of family planning users and the contraceptive prevalence rate that has stagnated at 23%.

Family planning Users (calendar years)

YEAR	New users	%increase/decrease in New users	Revisits	%increase/decrease in Revisits
2002	534,113		528,283	
2003	522,969	-2%	496,392	-6%
2004	639,809	22%	617,362	24%
2005	358,424	-44%	349,403	-43%
AVERAGE	513,829	-8%	497,860	-8%

Source MOH- Health Management Information System (HMIS)

Drug stock outs have led to poor delivery of health services as patients are asked to purchase their own drugs from private clinics at exorbitant prices and those who can not afford to buy drugs go home untreated. This has also increased the number of referrals to HSDs, district hospitals and regional hospitals.

Expired Drugs

MOH has a system of identifying, collecting and disposing expired drugs in line with the NDA guidelines.

Expired drugs were noted in 17 health units as shown in the table below and **appendix G** attached.

DISTRICT	HC II	HC III	HC IV	DIST.HOSP	REG. HOSP
Gulu	Olwal, Pabbo	-	-	-	Gulu
Lira	-	Apala	-	Lira	
Soroti	-	Diana Memorial, Gweri	Tirir, Apapai	-	-
Katakwi	Akoboi, Bisiina	Toroma, Ngariam	-	-	-
Bushenyi	-	Bushenyi	-	-	-
Kabarole	-	-	-	-	Fortportal
Mubende	-	Kalongo	-	Mubende	-
Total	4	7	2	2	2

Poor stock management was also noted at the National Medical Stores, who are the major medical suppliers of health units where 42,555 packs of ARVs valued at an approximate of Ug. Shs 936 million (US \$468,000) expired.

It was noted that one of the causes of drugs expiring was poor stock management resulting in procurement of large quantities of slow moving drugs like vaccines.

NDA guidelines have not been followed and some expired drugs were still in stores at HCs at the time of the study.

It was further noted that MOH replaced HOMAPAK as a drug for treatment of malaria with COARTEM and as a result some HCs were found with large stocks of HOMAPAK which will expire if not put to use.

Expired drugs do not add value to the delivery of health services and can be misused by unscrupulous persons causing undesirable health conditions to the public.

HOMAPAK: MALARIA DRUG, NOT DISTRIBUTED AT KCC STORES



5.4.2.4 Drug Stock Storage Facilities

MOH and NDA guidelines require proper storage of drugs in health facilities in order to protect them from harmful climatic and physical conditions.

It was observed during inspection of HC stores, that 7 HCs out of 81 visited lacked or had improper drug and sundries stores implying that about 2,388 HCs on a national level lack proper drug storage facilities. Some of these stores are not well arranged, dusty, not well

ventilated, are very small and lacked shelves. Some HCs do not have stores and instead improvised a section in the dispensing or examination room as a store.

It was also noted that the drugs are kept in boxes or piled on top of each other instead of shelves which make dispensing cumbersome. In some cases, expired drugs were not separated from unexpired drugs.

HCs have no proper storage facilities thus making drugs vulnerable to destruction and theft (*APPENDIX H*)

5.4.3 IEC MATERIALS

IEC materials are designed and developed to increase awareness in the prevention and control of diseases, increase public participation and involvement in the delivery of health care and increase demand and utilization of health services. IEC materials are used for dissemination of preventive and curative information. Methods used to disseminate information include posters, leaflets, mass media including press, radio, TV, video and drama shows.

It was noted that MOH develops and designs IEC materials while districts translate the developed IEC materials into local languages of the communities in the district.

IEC materials are procured by MOH and distributed to districts or collected by participants during national workshops. The district health educators are then charged with physical distribution of these materials to HCs.

We noted that the practice of translating IEC materials is to change to involve districts in the development of the IEC materials. In Soroti district, it was noted that some of the posters translated into Ateso in Apapai HSD had spelling mistakes.

It was observed that Busia districts has a multi-lingual society, but the IEC materials displayed were not translated in all the local languages in the district. In the districts of Rakai, Kalangala ,Bushenyi, Fortportal, Kamwenge, most of the IEC materials were in English and not in the local languages.

Posters are commonly used IEC materials; however, leaflets were noted in Masaka and Bushenyi districts. It was also observed that video tapes and TV monitors are used in Soroti and Katakwi districts.

Most of the IEC materials are displayed at the HCs premises; in some cases, posters and

leaflets were still lying in stores. On enquiry, we were told that they are not displayed in other public places for fear of destruction and/or removal by some community members.

IEC MATERIALS JUST BEING KEPT IN OFFICE AT NTARA HC IV, KAMWENGE DISTRICT



Designing and development of IEC materials at the MOH headquarters does not bring out the intended message properly for the target groups since words and symbols may have different meaning in different local languages. This creates low coverage IEC materials leading to less awareness and participation of the communities in preventing and controlling diseases. For example immunization and family planning campaigns may fail due the failure by IEC materials to disseminate information to the right people in the right places.

5.4.4 HC BUILDINGS

HC buildings are expected to be constructed following standard specifications developed by the health infrastructure development and management department of MOH. These specifications determine how laboratories, theaters, maternity wards and other medical and non medical buildings should be constructed.

Most of the construction of HC facilities is funded by the central government using PHC development and LGDP funds. In some districts, constructions are also done by Development Partners through projects and NGOs. Previously, local governments used to help in the construction of some health facilities but have since stopped citing financial constraint following the abolition of graduated tax which was their major source of local funds.

According to the last inventory count taken in FY 2003/04 out of 2,734 health facilities in

the country, GoU owned 1,855 (68%) facilities, an increase of 7.8% over the previous year. (*APENDIX I*)

MATERNITY WARD AT KYABUGIMBI HCIV CONSTRUCTED USING LGDP FUNDS, BUSHENYI DISTRICT.



5.4.4.1 Non-operational completed structures

The objective of constructing medical and non medical buildings at HCs is to facilitate the delivery of health services to the community.

It was noted, however, that 9 HCs had well completed structures that were not being utilized. The reason given for non utilization of structures was lack of medical personnel and equipment.

This has affected the implementation of national health programmes. For example operations can not be carried out on mothers with birth complications at Kibito, Bukuku, Atiak, Busia and Ogur HC IVs. New born babies and mothers share the general wards with other patients thus putting them at risk since they can be infected with diseases.

(*APENDIX I*)

5.4.4.2 Incomplete Structures

Construction is expected to be carried out as per annual plans of entities and completed within specified time frame.

It was observed during the study that 16 HCs out of 81 visited had incomplete structures. These structures included maternity wards, doctors' houses, staff houses, theaters, OPDs. This translates to 5,458 HCs in the country that may be having incomplete structures.

We were informed that this is due to limited funding, shoddy work by contractors and also the fact that districts continue to requisition for funds to construct new facilities without first completing existing ones.

Scrutiny of MOH Annual Sector performance reports attributed the problem of incomplete structures to:

- Inadequate funding because unspent budgeted funds are returned at the end of the FY to MOFPED and are not recouped
- Slow and bureaucratic process of tendering construction works at districts and
- Inadequate monitoring and supervision of construction works.

Incomplete structures are not useful to government in its effort to improve on the provision of health services. New born babies and their mothers lack maternity wards, districts have failed to attract qualified medical personnel due to lack of accommodation among other reasons and many minor medical cases have continued to be referred to district and regional referral hospitals.

(APENDIX I)

5.4.4.3 Unsatisfactory Constructions

As stated above, construction of medical and non medical buildings is expected to be done in accordance with the standard specifications set by MOH under its department of health infrastructure development and management. These specifications are communicated to all districts which supervise these constructions.

It was observed that some of the constructions at the HCs though complete have been poorly constructed and the following defects were noted:

- Sagging ceiling
- Big cracks in the walls
- Incomplete ceilings in the theatre allowing free entry of vermin like bats.

Unsatisfactory works can be attributed to inadequate supervision by both the districts and the MOH supervisory units, poor selection of contractors by the districts and laxity of managers at the HCs to report poor works to higher authorities.

Buildings that have been poorly constructed have not been put to use pending additional works thus leading to wasteful expenditure.

Some of these buildings that have been put to use are a security risk to patients and medical staff. (*APENDIX I*)

5.4.4.4 Maintenance and security of HC buildings

Buildings should be maintained regularly if they are to be effectively used through out their expected useful life. It is also important to keep these facilities secure from any damage, theft or misuse.

A number of building structures in some of the HCs need to be renovated. Most of the walls require painting; floors are cracked, sewerage systems broken and rooms infested with vermin including bats and rats.

The security of especially lower HCs is compromised as most health centers have no fences around them and security guards. Some of the stores and laboratory rooms are not burglar proofed compromising the security of equipment and drugs.

Buildings have not been maintained due to insufficient budget allocations to carry out renovations, fencing and recruitment of guards at the HCs.

A PLACENTA PIT CRACKING AND WATER LOGGED AT BUKUKU HC IV, KABAROLE DISTRICT



The placenta pit was built at a site with a low water table causing it to be water logged

A review of the results of the last survey on the medical buildings carried in FY 2003/04 and summarized in the table below indicated that 32.3% and 31.6% of HC III and HC IV respectively require renovation.

NATIONAL BUILDING STATUS AS AT FY 2003/04

HC III	BUILDINGS	A	B	C	D	N	TOTAL
	OPD	266	75	66	1	12	420
	MATERNITY	210	43	37	0	130	420
	GEN. WARD	101	30	23	0	266	420
	TOTAL	577	148	126	1	408	1260
HC IV	BUILDINGS	A	B	C	D	N	TOTAL
	OPD	65	18	19	1	0	103
	MATERNITY	59	19	17	0	8	103
	GEN. WARD	49	18	14	0	21	102
	OP THEATRE	87	6	3	0	7	103
	MORTUARY	17	7	6	0	73	103
	TOTAL	277	68	59	1	109	514

KEY:

A	<i>Good condition only needed routine maintenance</i>	C	<i>Major renovations</i>
B	<i>Minor renovations</i>	D	<i>Recommended for demolition</i>
		N	<i>Buildings not available</i>

Source: MOH- Annual Health Sector Performance Report 2003/04

5.5 STAFFING

5.5.1 STAFF TRAINING

In-service training plays an essential part in the development of Human Resource for Health (HRH). A trained and skilled health sector work force contributes to achieving the National Health Policy through the implementation of HSSP. It is important that training is systematically planned and implemented with less disruption of health service delivery.

It was noted that most training programmes organized by MOH are adhoc i.e when there are disease outbreaks or national campaigns.

In some districts staff identify their own training needs and solicit for funding privately while in other districts like Rakai, the staff have had training on an annual basis in

different fields of specialization. In Kalangala and Gulu districts, there was no evidence of training in the last 5 years.

Staff training has mainly been on job training, workshops and seminars and a few staff going for long courses in the field of medicine.

Health workers commonly train in PMTCT, VCT and immunization courses because these interventions are adequately funded by donors.

It was noted that districts do not properly provide for staff training in their annual budgets by making regular reviews of the manpower requirements to identify training gaps. Training by the MOH is also not properly organized; It is in most cases adhoc and skewed to particular programmes.

Lack of systematic training programmes has resulted in most staff remaining untrained in required medical disciplines and duplication of training efforts which results in wastage of resources. Some health interventions like administration of ARVs, Family planning programmes, child nutrition campaigns have not been implemented in some HCs due to lack of required skills by medical workers.

5.5.2 JOB ROTATION AND TRANSFERS

It is a good human resource management practice to transfer and rotate staff regularly in order to improve their performance levels. This is a key requirement in the human resource management policy.

It was noted that districts do not have a policy on transfer and rotation of staff. The current practice is that staff are transferred or rotated when a need is identified in a particular HC and not on a routine basis. Thus, health workers in hard to reach areas are not rotated as was noted in Kabarole district.

According to the national medical staff survey carried out in FY2003/04 the staffing levels in the districts countrywide varied from 40% to 265%. This means that some districts attract more health workers than others.

Unclear resource management policies in districts have affected the development of guidelines on staff rotation and transfer. This has in turn led to concentration of staff in urbanized areas of districts causing staffing gaps in rural HCs. The delivery of health services in the rural areas is affected more by insufficient staff numbers among other reasons.

5.5.3 STAFF APPRAISAL AND SUPERVISION

Public service guidelines require confirmed public servants to be individually appraised once a year while those on probation are to be appraised half yearly.

A sample of appraisal forms seen in personnel files for medical staff in the districts of Soroti, Katakwi and Masaka were up to date but those of Gulu, Lira, Busia, Bushenyi, Kamwenge, Kabarole, Kalangala and Mubende districts were not. In some districts, medical staff were last appraised in 2002.

Some supervisors complained that a lot of information is requested in the appraisal forms yet it is not linked to staff performance and that recommendations on some staff are not implemented.

The delay in the regular appraisal of staff was attributed to the fact that staff do not submit their forms in time and that they only do so for promotional interviews.

When staff are not regularly appraised their performance levels can not be ascertained and this may cause staff to relax and fail to meet their targets. The level of staff commitment will determine the level of health service delivery. For example, the efficient and effective extension of out reach services on immunization, family planning, counseling and public health education requires a motivated staff force.

PATIENTS WAITING FOR MEDICAL WORKERS AT RUKUNYU HC IV, KAMWENGE DISTRICT



The audit team reached Rukunyu HC IV at 10.00 am and there were no medical workers present

5.5.4 STAFFING GAPS

The availability of qualified health workers and other service providers is very crucial for the attainment of better service delivery to the people.

The number of staff to be recruited at each level of HC is determined by the staffing requirements in the HSSP and district ceilings as shown in the table below:

STAFF CATEGORY	HC II	HC III	HC IV
Enrolled nurse	02	03	03
Nursing assistant	02	03	05
Nursing office (Psychiatry)			01
Nursing officer (Midwifery)			01
Nursing officer (Nursing)		01	01
Senior nursing officer			01
Enrolled midwives		02	03
Enrolled psychiatry nurse			01
Senior clinical officer		01	
Clinical officer		01	02
Medical officer			01
Senior medical officer			01
Health assistant		01	01
Laboratory technician		01	01
Laboratory assistant		01	01
Health information officer		01	01
Public health dental officer			01
Assistant health educator			01
Dispenser			01
Public health nurse			01
Health inspector			01
Medical entomology officer			01
Anesthetic officer			01
Cold chain assistant			01
Office typist			01
Stores assistant			01
Driver			01
Security guards & support staff			03@

Because of the decentralization policy, recruitment, appraisal and deployment of health workers for HCs and district hospitals are carried out by the respective DSC, with the staff ceiling given by MOH. The DSC therefore advertises, shortlists, interviews and selects the suitable medical staff. Recruitment of health workers in Regional and National referral hospitals is done by the HSC.

All 81(100%) HCs and hospitals visited had manpower shortages. The number of staff deployed at the HCs and hospitals is not per recommended staffing guidelines and HSSP norms issued by the MOH stated above. This would also indicate that there is a staffing problem in all the 27,632 health facilities in the country.

It was noted that in some HCs, mothers deliver without the help of midwives, laboratories do not function due to lack of lab technicians, nursing assistants dispense drugs, records assistants receive patients on arrival and health workers engage in accounting and administration work among others. (*APPENDIX J*)

The HMIS data on ANC and deliveries for the years 2002 to 2005 revealed that out of an average of 1,051,490 mothers who re-attended ANC, only 356,729 (34%) gave birth under skilled care as shown in the table below:

MATERNITY FIGURES 2002-2005

YEAR	ANC re-att	Maternity Admissions	Deliveries in Units	Deliveries with TBA	Deliveries under skilled care	Deliveries outside skilled care*
2002	1,021,530	301,283	243,551	86,728	330,279	720,247
2003	1,136,652	348,585	261,086	96,321	357,407	788,067
2004	1,190,148	378,419	287,824	109,735	397,559	811,729
2005	857,630	324,559	271,858	69,812	341,670	533,071
AVERAGE	1,051,490	338,212	266,080	90,649	356,729	713,279

Source MOH- Health Management Information System (HMIS)

* *Mothers who attended ANC but did not give birth at health units or using TBAs.*

One of the reasons given by some expectant mothers interviewed for not returning to give birth under skilled care cited lack of midwives and lack of confidence in non functional health facilities.

The problem of limited staff numbers is not only due to lack of funds to recruit staff, but also poor manpower planning, deployment, training, transfer and retention. For example 4 health workers at Kibiito HC IV, Kabarole district were allowed to go on study leave of more than 2 years while Kamwenge district which has only two doctors allowed both of them to go on 2 years study leave.

A review of MOH- Annual health sector reports also revealed that the sector has been experiencing staffing gaps that has hindered service delivery as shown in the table below:

Minimum staffing norms MOH

YEARS	2001/2002	2002/03	2003/04	2004/05*
NORM	3,712	9,919	13,232	3,860
ACTUAL	2,867	8,371	11,389	2,453
GAP	845	1,548	1,843	1,407
% of filled posts	77.2%	84.4%	86%	63.5%

Source: MOH- Annual Health Sector performance Reports.

** Figures only include MOH headquarters and Regional referral Hospitals*

5.6 MONITORING & EVALUATION

MOH is expected to carry out monitoring visits in all districts on a quarterly basis in accordance with the national supervision guidelines.

It sets up monitoring area teams to visit all the districts. An area of focus is set for these teams and because it is understaffed, it at times seeks assistance from the medical staff at regional hospitals and co-opts medical interns to be part of the teams.

The districts also deploy health teams to carry out monitoring of the HSDs and lower HCs every month.

Under the referral system, hospitals are expected to carry out support supervision and mentoring visits. National referral hospitals visit Regional referral hospitals which in turn visit General hospitals (District hospitals). District hospitals also visit HC IVs. This arrangement helps to fill the medical skills gaps at the lower levels and allows sharing of experience among the medical staff.

It was noted that monitoring and supervisory visits that are undertaken are much less compared to those required by the guidelines. The few visits that are carried out lacked a wide coverage in terms of HCs visited.

It was also noted that the monitoring reports are not always forwarded to the districts but instead the findings and recommendations are discussed generally at Joint Review Mission workshops. Implementation of the recommendations is normally done if it is within the budget and if funds are available.

The findings and recommendations of the district monitoring teams on HCs are also discussed at district forum in general terms.

It was also established that districts which receive funding from UPHOLD project have a support supervision mechanism under the theme “Yellow Star” i.e quality assurance in which Pre-designed forms with standard variables are used to conduct the supervision. Findings are immediately communicated to the HC.

For example in Kalangala district, Kyamuswa and Bujjamba HSDs were visited twice in the last 5 years by MOH.

Monitoring and supervision system does not only depend on sufficient funding, but also on effective planning at different political and administrative levels. Also, insufficient staff numbers has overwhelmed the few staff with other health interventions.

Inadequate monitoring and supervision affects the quality health of service delivery. Staff tend to relax if they know that their performance is not constantly monitored and it might be difficult for health sector management to identify areas of weakness for improvement.

5.6.1 PERFORMANCE EVALUATION SYSTEM

MOH has developed a good computerized monitoring and evaluation system- HMIS. This system captures all the variables needed in assessing the performance of the health sector at all levels of implementation and they include:- OPD attendance, maternity attendance, family planning usage, child health care, financial data, support supervision data, drug stock outs. These variables are used in setting performance indicators for measuring the extent to which the set health goals and objectives are met.

It is a requirement under the HMIS for all levels of HCs, HSDs and districts to complete HMIS forms every month and submit them to the MOH headquarters. The HMIS is designed to produce monthly and annual reports at every HC level and private hospitals. These reports are consolidated at the district level and forwarded to MOH which consolidates district reports to form national reports. It is from the national report that the

national annual performance report is made.

It was noted that the system is not being fully implemented by all the HCs visited. For example the average number of HCs using the system for the last five years was 24,095 out of a total of 27,632. This represented an average of 89% compliance as per table below:

Number of HCs reporting

YEAR	HCs in Districts	Units reporting	% Units reporting
2002	24,934	20,622	86%
2003	29,455	25,898	89%
2004	32,398	28,589	90%
2005	23,740	21,271	91%
AVERAGE	27,632	24,095	89%

Source MOH- Health Management Information System (HMIS)

It was further noted that some of the HCs using the system leave out some important information and some of the reports are not submitted in time. Information on number of visits by support supervision teams, planned and actual out reaches, funds budgeted, released and spent and drug shortages was found missing from a sample of the HMIS forms seen.

Most of the HMIS assistants interviewed stated that they lacked sufficient skills to use the system while others complained of inadequate stationery.

It was also noted that enforcement of compliance at lower HCs is weak.

Some districts manually run the system, making it difficult to enter and summarize data while others with computers lacked competent personnel.

Incomplete and delayed reports do not help management address health challenges in time and this negatively impacts on the quality of health service delivered.

For example, health campaigns on immunization, family planning, child nutrition, VCT and PMTCT could be emphasized in areas that show poor performance indicators. This would help in efficient utilization of the much limited resources.

STATUS OF HMIS REPORTS SUBMITTED BY DISTRICTS

Characteristic	2001/2002	2002/2003	2003/2004	2004/05	Average
Completeness	95%	86%	85%	85%	87.75%
Timeliness	77%	70%	90%	90%	81.75%

Source: MOH- Annual Health Sector performance Reports.

5.7 ACCESSIBILITY

5.7.1 BASIS OF LOCATION AND COVERAGE OF HCS

This is carried out by districts on the basis of guidelines provided by MOH as follows:- HC II per parish, HC III per subcounty, HC IV per constituency, general hospital for every 500,000 people and a regional referral hospital for every 2,000,000 people. MOH also provide that ideally, a HC should be within a radius of 5km of the community it is serving.

After decentralization, the responsibility of allocation of HCs was passed to districts. It was noted that some HCs were not distributed in accordance with the guidelines set by MOH. As a result some HC are located near each other, near established hospitals including NGO hospitals or far away from the large communities as shown in the table below:

DISTRICT	HEALTH FACILITY	REMARKS
Busia	2 HC IV	2 HC IV in one constituency contrary to MOH guidelines.
Kabarole	Bukuku HC IV, Karambi HC III And Nyabuswa HC II	All the 3 facilities located near Fortportal Regional hospital.
Mubende	Buwekula HC IV	Located in the district hospital.
	Kalongo HC III	Located near Kiganda HC IV
Soroti	Diana Memorial HC III	Located near Soroti District hospital and Tirir HC IV

It was also noted that the health workers in some of these HCs have taken advantage of the short distance and keep referring even minor cases to the main hospitals. This may render them less relevant as patients always prefer well established hospitals to lower HCs.

There is still a low coverage of HCs compared to the national guidelines as shown below:-

- Bushenyi district has 89 parishes out of 170 accessing health services within a radius of 5 km. This represents coverage of 52.35%.
- Kabarole district has 45 parishes out of 58 accessing health services giving coverage of 77.5%.
- Kamwenge districts has 25 parishes out of 51 accessing health services giving a coverage of 49%
- Mubende district has 35 parishes out of 91 accessing health services giving coverage of 35.5%

The poor accessibility to health facilities has caused among other factors the low levels of immunization of babies and mothers. Mothers find it difficult to travel long distances with babies and also the medical workers encounter difficulties when extending out reach services.

The level of completion of immunization by mothers and children is on average 19% and 77% respectively. Children are expected to finish their immunization before the age of 1 year, but many still receive it late. For example, between 2002 and 2005, on a yearly average, 101,560 and 209,472 Children received BCG and Measles dosages respectively very late as shown in the table below:

YEAR	TT Dose 1	TT Dose 5	% of completion of TT Dose	BCG under 1yr	BCG 1 - 4yrs	Measles under 1yr	Measles 1 - 4yrs	%of children complete dosage in time
2002	448,599	83,649	19%	1,098,266	135,985	854,853	250,783	78%
2003	456,136	85,403	19%	1,129,474	115,751	835,672	216,177	74%
2004	510,053	99,580	20%	1,284,942	96,950	1,012,038	214,651	79%
2005	416,028	80,947	19%	953,907	57,553	755,533	156,275	79%
AVERAGE	457,704	87,395	19%	1,116,647	101,560	864,524	209,472	77%

Source: MOH- Annual Health Sector performance Reports.

6. CONCLUSIONS

6.1 FUNDING

- Delivery of health services is largely funded by central Government and Development Partners with minimal/nil contribution by local governments.
- There are delays in the release of funds at MOFPED and district levels due to delays in notification, under staffing in the accounts departments, delays in processing of payment and late accountabilities.
- Disbursement of funds is irregular and inadequate installments disrupt the districts and HSD plans designed to achieve HSSP objectives like timely completion of constructions.
- Lower HCs do not participate in the budgeting process and this has resulted in some requirements at HCs lacking adequate funding, for example, maintenance of buildings and cleaning of compounds.
- Whereas the MOH uses a standard formula when allocating funds to districts, there is no formula used by districts and HSDs to allocate funds to lower health units leading to inequitable allocation and utilization of resources.
- The formula used by MOH in allocating funds to district and referral hospitals is unrealistic because hospitals have since surpassed their official bed capacities.
- The objective of funding NGO health units to decongest government HCs has not been achieved because of the user fees charged.
- Accountabilities of funds released to NGO hospitals are not checked and submitted in time.
- Diversion of funds in some HC affects service delivery and increases the acute drug stock outs experienced.
- Accumulation of funds on bank accounts pending utilization in some HCs may lead to delay or suffocation of service delivery especially when health activities are not financed and it can also lead to misappropriation of funds.

6.2 EQUIPMENT

- The absence of asset/inventory registers can easily lead to asset misappropriation and difficulties in verifying and identifying equipment gaps.
- Low level of equipment maintenance leads to constant breakdowns which hamper health service delivery.
- The level of equipment utilization was found not satisfactory thus affecting health service delivery.

- The vehicles given to HSDs as ambulances are not well designed and can therefore, not satisfactorily be used as ambulances.
- Delivery of emergency and referral services is affected by poor or lack of communication equipment and ambulances.
- Lack of equipment at lower HCs has led to minor cases being referred leading to congestion of patients in district and regional hospitals.

6.3 DRUGS

- Lack of information sharing amongst the MOH, districts and HCs concerning drug allocation under the credit line method has led to poor stock management.
- Non-compliance with the drug delivery procedure and schedule issued by NMS has led to late delivery of drugs.
- Delayed collection of drugs from the districts by HSDs leads to drug shortages.
- Reconciliation of drugs procured under the credit line between NMS and districts, HSD and HCs are not prepared to monitor drug utilization and account balances.
- Drug stores records in some HCs are not kept and this coupled with limited segregation of duties can lead to drug leakages going unnoticed.
- Poor stores management skills lead to inappropriate store records which in turn causes delayed identification of drug stock outs and expired drugs.
- HCs lack proper drug storage facilities which results in exposure of drugs to bad weather conditions and theft.

6.4 IEC MATERIALS

- The development and design of IEC materials is centralized at the MOH headquarters and may lead to the intended message not getting to the target groups since words and symbols may mean different things when translated in different languages.
- There is low coverage of IEC materials leading to less awareness and participation of the communities in preventing and controlling disease.
- IEC materials are not developed in all local languages and symbols leading to ineffective delivery of the intended message.

6.5 HC BUILDINGS

- Districts have completed health structures that have not been put to use thus denying the communities access to health services.

- Districts have incomplete structures which do not add value to health service delivery and continued construction of both new and old structures puts pressure on the already limited funds.
- Districts have some poorly constructed structures which will require more funds to put them to effective use.

6.6 STAFFING

- Decentralized recruitment of staff leads to staffing gaps and poor deployment of staff and this compromises the delivery of health services.
- Districts do not have a clear policy on training and mainly depend on adhoc workshops, conferences and training organized by MOH.
- Lack of a clear policy on staff transfer and rotation has led to congestion of health workers in urban areas and acute staffing gaps in rural and remote areas.
- Irregular appraisal and supervision of staff has led to less commitment by staff in delivery of health services.

6.7 MONITORING AND EVALUATION

- There is a break down in supervision visits under the referral hospital system.
- Monitoring and evaluation is not regularly carried out in accordance with guidelines leading to laxity by districts and HCs in providing quality health service.
- The HMIS is not used properly causing delays and lack of sufficient information for decision making.

6.8 ACCESSIBILITY

The distribution of some HCs was not in accordance with national guidelines and this affected the delivery of health services.

7. RECOMMENDATIONS

7.1 FUNDING

- The activity based budgeting system used by MOH should be operationalized at HSD and lower level HCs.
- There is need to enforce MOH Standard guidelines on the disbursement and accountability of funds at districts, HSDs and HCs.
- Funding to NGO HCs should be limited to those offering free health services.
- There is need to enforce adherence to the terms and conditions set in the MOU between GoU and NGO hospitals.
- MOFPED should be encouraged to disburse funds as and when needed by districts with minimal variations between quarters to enable districts, HSD and HCs implement their health programmes without delay.
- There should be a clear and standard method of book keeping in all districts, HSDs and HCs and which should be regularly reviewed.

7.2 EQUIPMENT

- A system of keeping the inventory and detailed status of equipment should be maintained in all HCs so as to provide information needed for planning, budgeting, procurement and maintenance of equipment.
- MOH engineering department in collaboration with the regional workshops should carry out routine checks on the equipment to avoid eventual break-downs.
- Procurement contracts of specialized equipment should include a clause for after-sales service.
- The vehicles should be re-designed as ambulances to reduce on their misuse.

7.3 DRUGS

- The credit line method of drug procurement should be made more transparent to allow districts, HCs, politicians and health management committees access information on how much has been allocated and for reconciliation purposes.
- If NMS can not meet increasing demands of the HCs, the districts should be allowed to buy drugs from the other approved suppliers without hindrance (certificate of non availability) and MOH should have more pre-qualified companies added on its list.
- The system of recording drugs at the HCs should be improved to ensure proper management of stock levels and utilization of drugs.

- The drug ordering system should be automated and centrally controlled at the HSDs to reduce ordering time.
- MOH should devise a mechanism such that drugs with short shelf life or those about to expire are exchanged for other drugs from other HCs to avoid incidences of some HCs having expired drugs yet others experience stock-outs for the same drugs.
- Delivery time of drugs to health facilities should be improved.

7.4 IEC MATERIALS

- The districts should be involved in the design and development of IEC materials to increase local acceptability.
- The provision and continuous distribution of IEC materials for the various maternal and child health programmes in local languages should be encouraged.
- IEC materials should also be put in other public places apart from premises at HCs.
- There is need to develop IEC materials for all health interventions and not concentrate on a few health programmes.

7.5 HC BUILDINGS

- The practice of districts budgeting for new constructions before first completing the older ones should be discouraged.
- The districts should require contractors who provide unsatisfactory constructions to compensate them.
- District engineers who certify unsatisfactory works should be disciplined.
- HCs should be encouraged to include routine maintenance and security of facilities in their budgets.
- Regular and effective supervision of construction of health facilities should be encouraged by MOH through its Health Infrastructure Division and the district engineering departments.
- There is need to improve on the selection process of contractors at the districts and early development of tender documents for civil works.

7.6 STAFFING

- There is need for more comprehensive and coordinated human resource planning involving districts, HSDs, HCs and MOH.

- The recruitment system of health workers should be centralized i.e recruitment adverts should be for the country and not specific districts. Also, clear policies on transfer and rotation of staff in order to retain staff in hard to reach areas should be developed.
- District staff ceilings should be arrived at by the MOH after a thorough staff needs assessment of each district.
- Districts should develop clear policies on training of the medical staff and also carry out training needs assessment for its staff.
- Staff appraisal forms should be regularly updated to include relevant information and recommendations of supervisors should be taken into consideration to aid decision making.
- Organizational structures of HSDs should be enriched to accommodate the post of an administrator to relieve doctors from administrative work which hinders them from concentrating on health duties.

7.7 MONITORING AND EVALUATION

- In addition to the discussion of the monitoring reports in general terms at workshops and seminars, each district, HSD and HCs should receive feedback on their respective reports to enable them implement the recommendations specifically applicable to them.
- MOH should develop a mechanism to ensure accurate and timely completion of HMIS forms by districts, HSDs and HCs to improve on the quality of reports and decisions made on the basis of HMIS.
- Districts, HSDs and HCs should be encouraged to generate reports from the HMIS and use them to improve on their performance.
- All information assistants in the districts, HSDs and HCs should be adequately trained to input data and should be provided with the necessary tools to enable them generate accurate and reliable reports.
- District administrators and politicians should be encouraged to conduct multi-sectoral monitoring of all government programs.
- The referral hospital support supervision system and consultants out reach programme should be re-activated to improve health service delivery at HCs.

7.8 ACCESSIBILITY

- MOH guidelines on distribution of HCs should be followed and districts which do not find it practical, should inform MOH so that where justifiable, the guideline is changed to avoid deviations which could lead to over concentration of HCs in particular areas at the expense of others.
- Districts and HSDs should plan to increase the number of out-reach activities in maternal and child health programmes like child immunization and family planning to overcome the low coverage in remote and difficult to reach areas.

APPENDIX A HEALTH FACILITIES VISITED

REGION /DISTRICTS	HCII	HC III	HC IV	DISTRICT HOSP	REGIONAL HOSP	NATIONAL HOSP
CENTRAL:			Naguru			
Kampala			Kiswa			Mulago
Mubende		Kalongo	Kiganda	Mubende		
			Buwekula			
SOUTHERN:						
kalangala	Jana	Bwendero	Bujjumba			
	Mulabana	Mazinga	Bukasa			
	Bubere	Lulamba				
		Bufumira				
		Mugoye				
		Bubene				
Rakai	Mayanja	Lwaada	Kakuuto	Rakai		
	Butembe	Mutukula	Lyantonde	Kalisizo		
Masaka	Kiti	Lukaya	Bukulula		Masaka	
WESTERN:						
Bushenyi	Rutooma	Bushenyi	Kyabugimbi	Kitagata		
	Swazi	Kyamuhunga	Comboni			
Kabarole	Kicucu	Kisomoro	Kibiito		Fort portal	
	Nyabuswa	Karambi	Bukuku			
Kamwenge	Kyakarafa	Kamwenge	Rukunyu			
	Rwenjasa	Nyabbani	Ntara			

Kisoro	Bunagana	Muramba	Rubuguri	Kisoro		
NORTHERN:						
Gulu	Olwal		Attiak		Gulu	
	Pabbo					
	Awer					
Lira	Obim Rock	Apala	Ogur	Lira		
	Ongica					
EASTERN:						
Soroti	Kamod	Gweri	Tirir			
	Aukot	Diana Memorial	Apapai			
Katakwi	Akoboi	Toroma	Usuk			
	Bisiina	Ngariam				
Busia	Bumungi	Buhehe	Masafu			
		Sibona	Busia			
		Bulumbi				
Total	23	25	23	6	3	1
G/Total	81					

APPENDIX B

HEALTH FACILITIES WITHOUT ASSETS REGISTERS

DISTRICT	HC II	HC III	HC IV
Bushenyi			
	Swazi	Kyamuhunga	Igara East Kyabugimbi HC IV (HSD)
Kamwenge			
		Nyabbani	Ntara
		Kamwenge	Rukunyu
Kabarole		Karambi	Bukuku
	Kicucu		Kibiito
Mbende		Kalongo	
Gulu	Olwal		Attiak
	Pabbo		
	Awer		
Lira			
	Obim Rock	Apala	Ogur
	Ongica		
Masaka			
	Kiti	Lukaya	Bukulula
Kalangala			
	Mulabana	Mugoye	Kalangala
	Jana	Bufumira	Bukasa
Total No.	10	9	10
G/Total	29		

APPENDIX C

UNDER UTILIZATION OF EQUIPMENTS

DISTRICT	HEALTH CENTRE	LEVEL	EQUIPMENT NOT UTILIZED	REMARKS
Kamwenge	Rukunyu	HC IV	Theatre equipment	Doctor on study leave
	Ntara	HC IV	Theatre equipment	Doctor on study leave
Kabarole	Kisomoro	HC III	Lab equipment	No reagents to use
	Fort portal	REG HOSP	CD4 count machine	Needs repairing
			Theatre equipment	Doctor is always not around
	Bukuku	HC IV	Battery charging system	Used to charge public mobile phones
	Karambi	HC III	Lab equipment	No reagents to use
Mubende	Kalongo	HC III	Lab equipment	Lab poorly constructed
Lira	Kiganda	HC IV	Theatre equipment	Doctor on study leave
	Ogur	HC IV	Lab equipment	No reagents to use
Masaka	Bukulula	HC IV	Theatre equipment	Equipment lying idle

APPENDIX D
INADEQUATE/MISSING EQUIPMENT

DISTRICT	HEALTH CENTRE	LEVEL	EQUIPMENTS MISSING
Bushenyi	Kyabungimbi	HC IV	Theatre equipment
			Delivery kit is not complete it lacks forceps and scissors
			Incinerator
			Fridge for immunization
			Weighing scale
			Lab microscope
			Ultra sound
	Bushenyi	HC III	Aids testing kits
			Binocular microscope
			Delivery kits
			beds
			forceps
			BP machines
			weighing scales
			drip stands
			screens
			examination beds
	Rutooma	HC II	weighing scales
			Dust bins and dispensing trays
	Kitagata	DIST HOSP	Surgical Equipment for various operations

			Beds
			Communication Equipment
			Vehicle
			X-ray machine unit
			Ultra sound scanner
			vacuum extractor
			surgical Kits
			standby oxygen cylinder
			Pressure lamps
			Standby generator
			Nutrition center equipment
	Kyamuhunga	HC III	lab equipment
Kabarole	Kibiito	HC IV	Fridges for blood
			Theater equipment
			Lab Equipment
			Beds
			Mattresses
			Ultra sound
	Kisomoro	HC III	Microscope
			Testing Kits (HIV)
	Kicucu	HC II	Weighing scales
			Immunization kits
	Fort portal	REG HOSP	Dressing equipment
			Trays & trolleys
			Beds
			Delivery kits
			IV stands

			Trolleys
			Cyflow and Konlab machines
			Hema-screen 18
			Immunological analyzer
			Testing kits
	Karambi	HC III	Microscope
			Testing Kits (HIV)
			Delivering kits
Kamwenge	Rukunyu	HC IV	Weighing scale
			Delivery kits
			Beds
			HIV testing Kits
			Ultra sound
	Kamwenge	HC III	Delivery kits
			Resuscitation table
			Evacuation sets
			Weighing scale
			Trolley
			Drug cupboard
			BP machine
			Thermometer
			Weighing scale
			Fridge for vaccines
			EPI (immunizations unit)
			Stationery bags
	Ntara	HC IV	Theater equipment
			Generator
			Ultra sound

	Nyabbani	HC III	Delivery kits
			Weighing scales
			Slides for testing malaria & TB
			Immunization fridge
			HIV kits
Mubende	Mubende	DIST HOSP	Incubator
			Chemistry machine
			Metrological analyzer
			Microscope
			Fire extinguisher
			Centrifridge
			CD4 count machine
	Kalongo	HC III	Delivery set
			Lab. Table and chairs
			HIV testing kits
			Weighing scale
			Cupboard
Gulu	Olwal	HC II	Weighing scales
			Eye chart Vision testing
			Screens
			Diagonistic equipment set
			Sterilizer drums
			Emergency delivery bed
			Emergency Vacuum Extractor
			Emergency Suction pump
	Pabbo	HC II	Examination bed
			Furniture

			Instrument set dressing
			Eye chart Vision testing
	Awer	HC II	Instrument set dressing
			Drip stand double hook
			Eye chart Vision testing
	Attiack	HC IV	Theatre equipment
			Screens
			Instrument set dressing
			Ultra sound
	Gulu	REG HOSP	X-ray equipment
			Ultra sound Equipment
			Surgical equipments (minor)
			Instrument set dressing
			Mattresses
Busia	Busia	HC IV	Theatre equipment
			Ultra sound
	Masafu	HC IV	Surgical Equipments
			All OPD equipment
			Ultra sound
	Bumungi	HC II	Weighing scales
	Buhehe	HC III	Stethoscope
			BP machine
Lira	Ogur	HC IV	Theatre equipment
			BP machines
			Paediatric beds & mattresses

			Weighing scales
			Ultra sound
	Apala	HC III	Lab equipments
			Patients screen
			Stethoscope
			Drip stand
			Resuscitator manual for infants
			Instrument set dressing
			Immunization kit
	Obim Rock	HC II	Examination wood couch
			Instrument set dressing
			Instrument set stitch removing
			BP machine
			Doctor's thermometer
	Ongica	HC II	Examination wood couch
			Instrument set dressing
			Instrument set stitch removing
			BP machine
			Furniture
			Water container with tap, 20 litre incl. basin
Masaka	Masaka	REG HOSP	Diagnostic equipment set
			Resuscitation equipment
Soroti	Tirir	HC IV	BP machines
			Weighing scales
			Delivery instrument set
			Ultra sound

	Apapai	HC IV	BP machines
			Weighing scales
			Delivery instrument set
			Ultra sound
	Gweri	HC III	Lab equipment
			Patients screen
			Stethoscope
			Drip stand
			Resuscitator manual for infants
			Instrument set dressing
			Immunization kit
Rakai	Kalisizo	DIST HOSP	Ambulance
			X-ray equipment
			Ultra sound

APPENDIX E

HCs WITHOUT STORES RECORDS

DISTRICT	HC II	HCIII	HC IV	DISTRICT HOSPITAL
Bushenyi				
		Bushenyi		
	Rutooma	Kyamuhunga		
Kabarole				
	Kicucu		Kibiito	
	Karambi			
Kamwenge			Rukunyu	
		Yabbani		
Gulu	Pabbo			
	Olwal			
Busia	Bumungi			
Lira				Lira
	Obim Rock	Apala		
Katakwi		Ngariam		
Kalangala			Kalangala	
	Mulabana	Mugoye	Kyamuswa	
TOTAL	8	6	4	1
G/TOTAL	19			

APPENDIX F

HCs WITH DRUG SHORTAGES

DISTRICT	HEALTH CENTRE	LEVEL	DRUGS
Bushenyi	Kyabungimbi	HC IV	<ul style="list-style-type: none"> • Dextrose • Coartem
	Bushenyi	HC III	<ul style="list-style-type: none"> • Neverapine • Paracetamol • aspirin, • coartem for adults • amoxicillin • septrin • gloves
	Rutooma	HC II	<ul style="list-style-type: none"> • Paracetamol • aspirin, • coartem for adults • amoxicillin • septrin
	Kitagata	DIST HOSP	<ul style="list-style-type: none"> • Syrups for children • oxygen for new born babies
	Kisomoro	HCIII	<ul style="list-style-type: none"> • Antibiotics like PPF, amoxicillin & Pen-V • IV Dextrose

			Lab reagents
	Kicucu	HC II	Antibiotics like PPF, amoxicillin & Pen-V
	Forportal	REG HOSP	Ampicilin inj 15/6/
			Vitamin B 23/3
			Condoms 22/2
			Capron 3/2
			Insulin 30/3
			IV flagyl
			straczone
			injection
			IV fluids
			oxygen for the ward
			Nystatin pessary
			Retinol capsules
	Karambi	HC III	Antibiotics like PPF, amoxicillin, Pen-V, etc
			IV Dextrose
			Lab reagents
Kamwenge	Rukunyu	HC IV	ARVs are not supplied
			Metronidazole
			septrin
			doxycycline
			ferrous sulphate
			nitrofladan
			paracetamol tabs
			Gynecological gloves
	Kamwenge	HC III	Fansidar
			Chloroquine

	Ntara	HC IV	<ul style="list-style-type: none"> • ARVs
			<ul style="list-style-type: none"> • HIV testing kits
			<ul style="list-style-type: none"> • Coartem
			<ul style="list-style-type: none"> • TB drugs
			<ul style="list-style-type: none"> • Enthromycine
	Nyabbani	HC III	<ul style="list-style-type: none"> • chloroquine
			<ul style="list-style-type: none"> • fansidar
			<ul style="list-style-type: none"> • Surgical gloves
Mubende	Buwekula	HC IV	<ul style="list-style-type: none"> ▪ Artermether
			<ul style="list-style-type: none"> ▪ Lumefanitrine
			<ul style="list-style-type: none"> ▪ benzatrine
	Kalongo	HC III	<ul style="list-style-type: none"> • Septrin
			<ul style="list-style-type: none"> • Amoxicillin
			<ul style="list-style-type: none"> • Erythromycin
			<ul style="list-style-type: none"> • Chloroquine injection
			<ul style="list-style-type: none"> • Quinine injection
			<ul style="list-style-type: none"> • Fragyl
			<ul style="list-style-type: none"> • Lab. Reagents
Gulu	Olwal	HC II	All drugs
	Pabbo	HC II	Vaccines
			Homapak
			Coartem
			Sundries
	Awer	HC II	Homapak
			Coartem

	Attiack	HC IV	Lab reagents
Busia	Masafu	HC IV	Coartem
	Busia	HC IV	Metrobandazole
	Buhehe	HC III	Panadol
Soroti	Tirir	HC IV	Septtrin
			Quinine
			Chloroquine
	Appai	HC IV	Septtrin
			Quinine
			Chloroquine
			Erythromycin
	Diana Memorial	HC III	Metrobandazole
			Erythromycin
			Folic acid
	Kamod	HC II	Septtrin
			Quinine
			Chloroquine
			Erythromycin
	Aukot	HC II	Quinine
			Chloroquine Inj.
			Panadol
Katakwi	USUK	HC IV	Chloroquine
			Erythromycin
	Ngariam	HC III	Septtrin
			Quinine
			Chloroquine

	Akoboi	HC II	Seprin
			Quinine
			Chloroquine
			Erythromycin
	Bisiina	HC II	Seprin
			Quinine
			Chloroquine
			Erythromycin

TOTAL

31

APPENDIX G

LIST OF EXPIRED DRUGS

MUBENDE DISTRICT STORES			
NO	NAME OF DRUG	UNIT MEASURE	QUANTITY
1	nitrofurantoin tabs	1000	10
2	chlompromazine tabs	1000	418
3	tetracycline caps	1000	10
4	chlompromazine inj.		9 amps
5	asprin tabs	1000	20
6	streptomycin inj.		25 vials
7	folic acid tabs	1000	3
8	calcigard -10 caps	100	13
9	phenytoin tabs	1000	24
10	adrenaline inj.		70 amps
11	chloramphenicol inj.		100 vials
12	lidocaine hydrochloride 2%		125 vials
13	frusemide tabs	1000	13
14	methyldopa tabs	1000	1
15	diazepam inj.	10mg/2ml	20 amps
16	promethazine hydrochloride	1000	12
17	salbutamol tabs	1000	6
18	vitamin B complex	1000	15
19	erthromycin stearate	1000	3
20	quinine suilhate	1000	1
21	tetracycline eye ointment		300
22	nycostat pessaries	strips	14000
BUSHENYI HC III			
	Homapak		
FORTPORTAL REGIONAL HOSPITAL			
	Nystatin pessary		

		Retinol capsules	
KALONGO HC III			
	Nystatin pessary		
GULU REGIONAL HOSPITAL			
	Chlorpromazine	28 tins	
	Benzazine	16 tins	
LIRA DISTRICT HOSPITAL			
	Folic Acid	11 tins	
APAPAI HC IV			
	Homapak	620 doses	
	Lagactile	120 ampoules	
	Praziquantel	500 tabs	
GWERI HC III			
	Homapak	518 doses	
TOROMA HC III			
	Homapak	700 doses	
	Nystatin pessary		
NGARIAM HC III			
	Iron tablets		
	Vitamin A tablets		
BISIINA HC II			
	Homapak	670 doses	
	Lagactile	80 ampoules	
	Praziquantel	450 tabs	

MUBENDE HOSPITAL			
	Chlorophenical E/drop	1unit	
	Codeine tabs	1unit	
	Nystatin pessary	1unit	
	Adrenaline	1unit	
	Surgical blades	25pcs	
	Benndrofluazide	1000 units	
	Methyldopa	1000 units	
	Promethazine	1000 units	
	Atropine inj.	1 unit	

APPENDIX H

HCs WITH POOR STORAGE FACILITIES

DISTRICT	HC	LEVEL	CONDITION
Gulu	Pabbo	HC II	Store is small with inadequate light
Soroti	Apapai	HC IV	Stores small, expired drugs are mixed with good ones
	Gweri	HC III	Stores lack shelves, expired drugs are mixed with good ones
Katakwi	Ngariam	HC III	Stores small, expired drugs are mixed with good ones
	Bisiina	HC II	Stores lack shelves, expired drugs are mixed with good ones
Kisoro	Kisoro	DIST HOSP	Lack shelves
Rakai	Kalisizo	DIST HOSP	lack space
TOTAL		7	

APPENDIX I

STATUS OF BUILDINGS

DISTRICT	HC	LEVEL	FACILITY	STATUS	REMARKS
Kabarole	Kibiito	HC IV	Theatre	Not functional	poor workmanship and no equipment
			Doctors house	not used	Doctor does not sleep at the HC
	Kisomoro	HC III	Lab	Not functional	lacks Lab technician and reagents
	Bukuku	HC IV	Theatre	Not functional	Absentee Doctor
			Doctors house	not used	Doctor does not sleep at the HC
Kamwenge	Ntara	HC IV	Maternity	Not functional	Delayed completion and lack equipment
	Rukunyu	HC IV	Theatre	Not functional	Poor workmanship & lack a doctor
	Rwenjasa	HC II	OPD	Not functional	Lack personnel
Gulu	Attiaak	HC IV	Theatre	Not functional	Lack equipment
	Gulu	REG HOSP	Drug store	Curving ceiling	Needs repairing
Busia	Busia	HC IV	Theatre	Not functional	poor workmanship and no equipment
Lira	Ogur	HC IV	Theatre	Not functional	Lack equipment

DISTRICT	HC	LEVEL	FACILITY	PROGRESS	YEAR OF IMPLEMENTATION
Kamwenge	Biguli	HC II	Maternity	Wall Plate	2005/06
	Bunoga	HC II	Ward	Wall Plate	2004/05
	Kyakarafa	HC II	OPD	Slab	2004/05
	Kabuga	HC III	Ward	Plastering	2004/05
	Mahyoro	HC III	Maternity	Plumbing	2005/06
Mubende	Kassanda	HC IV	Theatre	Incomplete	2003/04
	Butoloogo	HC III	Maternity	Incomplete	2004/05
Katakwi	Ongutoi	HC II	whole unit	Under construction	
	Golokwara	HC II	whole unit	Under construction	
	Amusus	HC II	whole unit	Under construction	
	Olwal	HC II	whole unit	Under construction	
	Aijelik	HC II	whole unit	Under construction	
	Nyanda	HC II	whole unit	Under construction	
	Opot	HC II	whole unit	Under construction	
	Katakwi	HC IV	maternity	Finishing level	
			Staff houses	Finishing level	
	Usuk	HC IV	Pit latrine	Finishing level	

FY2002/03

LEVEL OF FACILITY	OWNERSHIP				
	GOVT	NGO	PRIVATE	TOTAL	% OF GOU
HOSPITALS	56	44	4	104	54%
HC IV	143	8	3	154	93%
HC III	650	147	12	809	80%
HC II	845	362	262	1469	58%
TOTAL	1694	561	281	2536	67%

FY2003/04

LEVEL OF FACILITY	OWNERSHIP				
	GOVT	NGO	PRIVATE	TOTAL	% OF GOU
HOSPITALS	56	45	7	108	52%
HC IV	148	9	3	160	93%
HC III	706	157	10	873	81%
HC II	945	391	257	1593	59%
TOTAL	1855	602	277	2734	68%

APPENDIX J STAFFING GAPS

DISTRICT	HEALTH CENTRE	LEVEL	IDENTIFIED GAPS	OVER STAFFED
Bushenyi	Kyabungimbi	HC IV	01 Senior medical officer	
			01 Medical officer	
			01 Public health dental officer	
			01 Dispenser	
			01 Senior nursing officer	
			01 Public health nurse	
			01 Enrolled psychiatric nurse	
			02 Enrolled nurse	
			04 Nursing Assistants	
			01 Ophthalmic clinical officer	
			01 Health inspector	
			01 Health Assistant	
			01 Medical entomology officer	
			01 Health Educator	
			01 Anaesthetic officer	
			01 Lab technician	
	Bushenyi	HC III	01 Nursing officer	05 Nursing Asst
			01 Senior clinical officer	01 Clinical officer
			01 Health Assistant	
			01 Lab technician	
			01 Records Asst	
	Rutooma	HC II	02 Enrolled nurse	

	Kitagata	DIST HOSP	01 Principal medical officer	01 Nursing Asst
			01 Medical officer	02 Health Asst
			01 Dental surgeon	
			01 Pharmacist	
			01 Principal nursing officer	
			02 Senior nursing officer	
			09 Nursing officers	
			03 Nursing officer (Midwifery)	
			01 Nursing officer (psychiatric)	
			01 Public health nurse	
			01 Enrolled/nurse (psychiatric)	
			34 Enrolled nurse	
			21 Enrolled Midwives	
			01 Senior clinical officer	
			01 Clinical officer	
			01 Psychiatric clinical officer	
			01 Health inspector	
			01 Medical entomology officer	
			02 Radiographers	
			01 Senior lab technologist	
	Kyamuhunga	HCIII	01 Senior clinical officer	
			01 Nursing officer (nursing)	
			02 Enrolled Nurse	
			02 Enrolled Midwives	
			01 Nursing Assistant	
			01 Health Assistant	
			01 Lab Assistant	
			01 Lab Technician	

	Swazi	HCII	01 Enrolled Nurse	
			02 Nursing Asst	
Kabarole	Kibiito	HCIV	01 Senior medical officer	01 Medical officer
			01 Public health dental officer	01 clinical officer
			01 Dispenser	
			01 Senior nursing officer	
			01 Nursing officer (midwifery)	
			01 Nursing officer (psychiatric)	
			01 Enrolled psychiatric nurse	
			02 Enrolled midwives	
			01 Nursing Assistant	
			01 Ophthalmic clinical officer	
			01 health Inspector	
			01 Medical entomology officer	
			01 Lab Assistant	
			01 Lab Technician	
	Kisomoro	HCIII	01 Senior clinical officer	01 clinical officer
			01 Nursing officer (nursing)	
			02 Enrolled Nurse	
			02 Nursing Assistant	
			01 Health Assistant	
			01 Lab Assistant	
	Kicucu	HCII	02 nursing Assistant	
			01 Enrolled nurse	

