

## Assessing Public Expenditure Governance in Uganda's Health Sector: The case of Gulu, Kamuli, and Luweero Districts.

Application of an Innovative Framework



Kajungu Dan • Lukwago Daniel • Tumushabe Godber



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**Published by ACODE**

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**Citation:**

Kajungu, D., Lukwago, D., and Tumushabe, G., *Assessing Public Expenditure Governance in Uganda's Health Sector: The case of Gulu, Kamuli, and Luweero Districts: Application of an Innovative Framework*. ACODE Policy Research Series, No. 69, 2015.

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**ISBN 978 9970 34 04 15**

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## List of Acronyms

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ACODE	Advocates Coalition for Development and Environment
BFP	Budget Framework Paper
CAO	Chief Administrative Officers
CFO	Chief Finance Officer
CHI	Community Health Insurance
CSO	Civil Society Organisation
DAC	District Collection Account
DHOs	District Health Officer
DHS	District Health Service
DP	District Planner
ED	Executive Director
EMHS	Essential Medicines and Health Supplies
ENT	Ear Nose and Throat
EPHF	Essential Public Health Functions
ESCAP	Economic and Social Commission for Asia and the Pacific
EU	European Union
FBOs	Faith Based Organizations
FGD	Focus Group Discussions
FY	Financial Year
GoU	Government of Uganda
HAS	Health Systems Assessment
HC	Health Centres
HDP	Health Development Partners
HR	Human Resource
HSC	Health Service Commission
HSDU	Health Service Delivery Unit
HSSIP	Health Sector Strategic Investment Plan
HUMC	Health Unit Management Committees

ICPD	International Conference on Population and Development
IPFs	Indicative Planning Figures
KII's	Key Informative Interviews
LG	Local Government
LQAS	Lot Quality Assurance Sampling
LSDP	Local Government Development Programme
MDG	Millennium Development Goals
MoFPED	Ministry of Finance, Planning and Economic Development
MoH	Ministry of Health
MoLG	Ministry of Local Government
MSH	Management Sciences for Health
MTEF	Medium Term Expenditure Framework
MUSPH	Makerere University School of Public Health
NDA	National Drug Authority
NDP	National Development Plan
NGO	Non- Governmental Organization
NHP	National Health Policy
NMS	National Medical Stores
OBT	Out put Budgeting Tool
ODA	Overseas Development Assistance
OOPs	Out-of-Pocket
PAHO	Pan African Health Organisation
PEG	Public Expenditure Governance
PETs	Public Expenditure Tracking Study
PFP	Private for Profit
PHC	Primary Health Care
PNFP	Private Not for Profit
PS	Permanent Secretary
PWDs	People with Disabilities
SDI	Service Delivery Indicators

SWAPs	Sector-Wide Approach
TASO	The Aids Support Organisation
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau of Statistics
UBTS	Uganda Blood Transfusion Services
UDHS	Uganda Demographic and Health Survey
UDN	Uganda Debt Network
UNCCD	United Nations Convention to Combat Desertification
UNDP	United Nations Development Programme
UNHCO	National Health Consumers Organisation
UNMHCP	Uganda National Minimum Health Care Package
USAID	United States Agency for International Development
VHTs	Village Health Teams
WHO	World Health Organisation
WTO	World Trade Organisation



## Acknowledgements

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The research and publication of this research report would not have been possible without the support and efforts of several stakeholders. To this end, ACODE Management and Board of Trustees are grateful to the Hewlett Foundation for funding this study. We hope that this study will contribute towards improving 'Public Expenditure Governance' and the quality of service delivery in Uganda's health sector.

The research team is also grateful to technical staff and the political leadership of Gulu, Luweero and Kamuli districts and respondents at the health facilities. The information they provided gave the research team important insights into the processes and interlocutors in the governance of public expenditure in the health sector. Many thanks go to community members who shared their time and perspectives during field interviews.

During the course of the study, the research team greatly relied on the guidance of a reference group comprising of Engineer Henry Francis Okinyal- (Retired) Ministry of Education and Sports; Dr. Polycarp Musinguzi –African Central Bank; Mr. Nelson Nowahabwe- Office of the Prime Minister; Mr. Mark Amanyana- MFPED; Dr. John Mbadhwe - Ministry of Works and Transport (MoWT); Mr. Opio Owalu Charles- MoWT; Honorable John G. Ssewungu - Parliament of Uganda; and Ms. Shakira Rahim-URF. The reference group provided the research team valuable information and technical guidance on their respective Ministries and Agencies. We are also grateful to Professor Russell Rhoads, Professor Kiran Cunningham, Professor Wilson W. Muhwezi, Mr. George Bogere and Dr. Arthur Bainomugisha for the invaluable support to the team.

While the persons mentioned above greatly contributed to this study in various ways, the views expressed here are strictly those of the authors. The authors also take sole responsibility for any errors and omissions in this report.

## Executive Summary

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This research report is one of the policy analyses prepared by ACODE to assess the governance of public expenditure (hereafter, public expenditure governance or PEG) in Uganda's health, road, education and agriculture sectors. The report is premised against the dimensions of governance elaborated in the framework suggested by Baez-Camargo and Jacobs (2011). The report provides the first attempt to model indicators for assessing PEG in Uganda's health sector, which can also be replicated in other sectors of the economy and other countries.

This report specifically presents the assessment of Public Expenditure Governance (PEG) within the health sector and how this affects the performance of the sector. Unlike tools for assessing public financial management which tend to focus specifically on management of funds, the PEG assessment focuses on inputs, processes and outcomes. Inputs are the laws, policies, rules, regulations, goals and priorities that govern actions and decision making. The assessment principles associated with the input side of PEG are participation and strategic vision. The assessment principles focusing on process are accountability and transparency, both of which are essential if processes are to lead to desired outcomes. The desired outcomes of PEG associated with health care are equity, efficiency and effectiveness. Using this PEG conceptual framework, the overall objective of this research was to examine the links between public spending, governance, and outcomes in the health sector.

The research was undertaken between January and September 2014. The scope of this study was limited to health facilities (hospital and health centres) in the districts of Luweero, Gulu and Kamuli. The major finding was that despite some improvements, the sector is grappling with numerous challenges in health service delivery. Apart from strategic vision, the sector is not doing well on all the other governance aspects of accountability, transparency, participation, responsiveness, fairness and equity. Poor performance in these aspects was found to be a major stumbling block along the path of achieving effective and efficient outcomes in governance of public expenditure in health.

The study also elicited other emerging issues. For instance, Health Unit Management Committees (HUMCs) and Hospital Management Committees (HMCs) were found to exist in all health facilities visited. However, the functionality of these HUMCs and HMCs left a lot to be desired. Reasons for dysfunctionality of these committees ranged from ignorance about roles and lack of facilitation of members to do their work. In addition, the roles and responsibilities of these committees were not well understood by communities that participated in this study.

Funding of Health Service Delivery Units (HSDUs) was found to be alarmingly low with untimely availability and most health facilities were unable to effectively provide expected services to communities. This was found to be due to delays by

District Health Officers (DHOs) to disburse funds to their accounts. Besides being meager, funding for health facilities were found to be conditional in nature and to limit the flexibility of managers in the utilization of these funds.

Citizen involvement in decision-making process at the HSDU was found to be very minimal. In theory, the budgeting process is supposed to be a bottom-up approach starting from the health facility. However, this study found that citizens were not involved in budgeting for health facilities. Although the HUMC / HMCs generally represent the community at the health facility level, these committees were found not to be accountable to the community. In most cases, most community members did not know these committees.

Accountability of funds was one of the teething challenges in health service delivery. Since HSDUs depend largely on central government transfers, they mainly account to the central government. However, most of HSDUs were not publically displaying their accountabilities on notice boards, for whoever is interested to cross-check.

Access to information is key in fostering transparency and critical in enhancing accountability in health service delivery. However, the study found that there is very minimal information provided to citizens and when it's done, it's mainly put on notice boards at health facility centres. The problem with that is that most people don't utilize such information partly because of high illiteracy levels.

The Ministry of Health (MoH) developed and put in place the 'Patient's Charter'. Unfortunately, it was found that the charter had not been fully disseminated to health facilities, as evidenced in those visited during fieldwork for this study. None of the health facilities visited had a copy of the Patient's Charter implying that citizens, who are supposed to be beneficiaries of this charter were not aware of it. In addition, all the HSDUs visited were unable to respond to the needs or legitimate expectations of citizens in a timely manner. This was mainly due to inadequate funding, low staffing, and low staff morale. In most HSDUs, the quality of health facilities was poor. The most cited factor discouraging people from using Health Centres was the rudeness and lack of courtesy by health workers.

To ensure equity to access to health care, HSDUs were supposed to have special programmes for the excluded groups of citizens. However, all the health facilities visited did not have such programmes. None of the health facilities had any funding for programmes to facilitate access by marginalized groups like people with physical disability. The amount of funds transferred by the central government to the HSDU did not consider equity issues.

The health facilities visited indicated that they had not had all the vacant human resource positions filled in the last three years. They lacked critical staff such as specialist healthcare professionals. Staffing of health facilities was found to be based on the level of the health facility rather than output (population covered and disease burden). In most cases, the healthcare staffs were found to be over-burdened and unable to effectively deliver services. In addition, there were

challenges with the wage bill ceiling (the ceiling was found to be based on total wages not the number of staff).

In all health facilities visited, there was low staff motivation. Absenteeism and late coming was high partly due to poor supervision (especially by the DHO's office), and lack of staff accommodation. Since staff performance is not linked to remuneration (salary); salaries of health workers are directly sent to their accounts; disregarding whether a staff worked or not. This was found to make it hard for the administrators to punish poor performers by withholding their salaries. Village Health Teams (VHTs) are critical in increasing awareness and promoting community participation in health care delivery and utilization of health services, but their visibility was found to be low because they are essentially volunteers.

Given the vertical integration required for sound public expenditure governance, many of the recommendations given in this report need to be implemented at multiple levels. Some target the central government, local government, and health facilities:

1. Government needs to urgently come up with a comprehensive strategy to recruit more health workers, offer them appropriate remuneration, accommodation and refresher training.
2. Government should increase budget allocations to health facilities to enable them meet the increasing burden of health care.
3. Government needs to ensure that lower level health facilities (HC II and IIIs) function effectively in order to reduce the burden on HC IVs and hospitals
4. Government should ensure that staffing of health facilities is based on performance (output) delivered by the health facility.
5. MoH should ensure that all HUMCs are oriented and their guidelines are fully disseminated to all HUMCs
6. MoH needs to ensure that the Patient's Charter is translated in local languages and massively disseminated to all health facilities in Uganda.
7. Government needs to expedite the health insurance scheme or promote Community Health Insurance (CHI).

# CHAPTER 1

## INTRODUCTION

---

### 1.1 Introduction and Background

Over the last two decades, the Government of Uganda has taken deliberate actions to improve the delivery of health services to the citizens. Key among these actions include: reform of existing policies, laws and institutions; improving the health physical infrastructure by constructing a network of health facilities across the country; and increasing the allocations of public funds to the health sector (Ministry of Health July, 2010). There have also been considerable inflows of funds from the international development community through loans and grants. In general terms, there have been noticeable gains in the quality of health services delivery. For example, infant mortality rate reduced from 88 deaths per 1,000 live births in 2000-01 to 54 death per 1,000 live births in 2011 and child mortality rate reduced from 152 to 90 deaths per 1,000 live births in the same period (Uganda Bureau of Statistics and MEASURE DHS March, 2012).

However, the increased inflow of public funds and aid has not eliminated the current deficiencies in the health services delivery system and major gaps remain. Policy makers and the beneficiaries of public funded health services remain concerned about the quality of public health services. In spite of the sustained and increased public spending in the sector, Uganda reported slow progress on three out of four MDG goals and targets as of 2010. There is slow progress in reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria and other diseases (Ministry of Finance Planning and Economic Development September, 2010).

A number of research tools for assessing the effectiveness of public expenditure in the health and other public services delivery sectors have evolved over time. The most prominent of these tools include: the Public Expenditure Tracking Studies (PETS), Service Delivery Indicators (SDIs) and Health Systems Assessment (HSA). The Public Expenditure Tracking Surveys (PETS) are quantitative exercises that trace the flow of resources from origin to destination and determine the location and scale of anomaly (Dehn et al. 2003). The PETS highlight not only the use and abuse of public money, but also give insights into the concepts of capture, cost efficiency, decentralization, and accountability. The PETS focus mainly on how funds flow along the public expenditure chain. They do not tell us what factors or decision processes influence the flow of public funds along this chain from budget allocations to the frontline health services delivery units.

The Service Delivery Indicators (SDI), also known as "the Indicators," provide a set of metrics for benchmarking service delivery performance in education and health in Africa to track progress across and within countries over time. The Indicators seek to enhance active monitoring of service delivery by policymakers

and citizens, as well as to increase accountability and good governance (Bold et al. February, 2011).

Health System Assessment (HAS) helps countries understand and strengthen their health systems. The approach covers key health system functions and is organized around World Health Organization (WTO's) six health system building blocks: leadership and governance; health financing; service delivery; human resources for health; medical products, vaccines, and technologies; and health information systems ( United States Agency for International Development, 2008).

It is our contention that the current failures of the public health delivery system are rooted in the way public expenditure in the sector is governed, in other words, in "public expenditure governance." For the purpose of this study, Public Expenditure Governance (PEG) is defined as the processes by which individuals, groups of people, or their designated leaders exercise their authority through the making and implementing of decisions. Good governance is characterized by responsiveness, accountability, transparent policy processes, engagement of citizens, and the operational capacity of government to plan, manage, and regulate policy and service delivery (Bogere and Makaaru 2014).

We did not come across any empirical studies that have been undertaken to understand the governance of public health expenditure in Uganda; therefore, we did not come across any indicators that have been developed to assess the governance of expenditure along the public health delivery chain. Consequently, policy makers in Uganda have no empirical data or evidence to make informed policy choices in reforming the public expenditure delivery system. This study provides a framework and set of indicators that can be utilized when undertaking a comprehensive public expenditure governance assessment study in Uganda's health sector. The indicators were tested by applying them at health service delivery unit (HSDU) to ensure their validity and applicability. While the indicators are specific to Uganda, they are generic enough to be used in other developing countries.

This research identified the challenges in health sector public expenditure governance that affect the level of health service delivery. They range from poor dissemination of the key policies and decisions made at the central level, the inadequate and sometimes delayed funding from the government which is the main source for the HSDUs, presence of manpower gaps as most HSDUs have unfilled positions. The structures put in place to involve citizens like the health unit management committees, the village health teams and the political leadership are not effective. This in turn affects the level of participation by the service beneficiaries – the community. Poor performance in the studied assessment areas is a major stumbling block along the path to achieving effective and efficient outcomes in governance of public expenditure in health.

The specific objectives that guided this study of public expenditure governance in Uganda's health sector were to:

- i. Identify the actors and their roles in decision making regarding budget allocations and service delivery
- ii. Develop indicators for assessing expenditure governance in the health sector
- iii. Identify and assess the effects of budget allocation decisions on health sector performance
- iv. Identify and assess the efficiency of accountability mechanisms, including community participation, sanctions and rewards

## 1.2 Methodology

This study was carried out between January and September 2014. In order to achieve the above objectives, a mixed methods and approaches were used to carry out this PEG assessment in the health sector. The methods used incorporated collection and analysis of qualitative and quantitative data. Document analysis, key informant interviews, focus group discussion and data from national and local government budgets allocations, facility financial records, and budget releases all contributed to the multifaceted understanding of structures and processes of public expenditure governance in the health sector.

### Document Analysis

Key documents that were reviewed included the National Health Policy 2010, the Health sector strategic investment plans (HSSIP), 2010, the National Development Plan 2010, the Constitution of Uganda, 1995, Health Sector Ministerial Policy Statements, and Estimate of Revenue and Expenditures. At the district and health facility levels; we reviewed the budgets, minutes of the HUMCs, financial records, and the HSDU work plans. The document review process informed the development of Focus Group Discussions and Key Informant Interviews tools.

### Study Districts

Three districts covered were Gulu in the North, Luweero in Central region and Kamuli in the East. The districts were selected to represent geographical diversity, and '*age of existence*' in terms of when they were established. They also represented a range of health service delivery performance as indicated by their rankings on annual assessments of LG capacities under the Local Government Development Programme (LGDP). In each study district, focus was on budgeting and financing roles played by policy makers, political leaders, and managers at all levels of health service delivery. The health service delivery units (HSDUs) visited included hospitals and health centre IVs and IIIs. All were public and/or government health facilities. Table 1 shows the distribution of HSDUs visited in each of the three districts.

**Table 1: Health Facilities Visited**

District	Facility Name	Level of care
<b>Gulu</b>	Gulu Regional Referral	Hospital
	Lalogi	Health Centre IV
	Awach	Health Centre IV
	Bobi	Health centre III
	Chwero	Health Centre III
<b>Luweero</b>	Luweero	Health Centre IV
	Nyimbwa	Health Centre IV
	Bowa	Health Centre III
	Kalagala	Health Centre III
	Butuntumula	Health Centre III
<b>Kamuli</b>	Kamuli General Hospital	Hospital
	Nakandulo	Health Centre IV
	Mbulamuti	Health Centre III
	Nabirumba	Health Centre III

Most HSDUs in the study were rural based except Gulu Regional Referral hospital, Kamuli General Hospital, and Luweero HC IV. The heads of hospitals (Hospital Directors) and health centres (In-Charges), the Board of Directors Governors for hospitals and Health Unit Management Committees (HUMCs) participated as key informants.

### **Key Informant Interviews (KII)**

Key informant interviews were conducted with range of stakeholders using an interview guide. The stakeholders included: a) district technical staff like; the Chief Administrative Officers (CAOs), Chief Finance Officer (CFO), the District Planners, District Health Officers (DHOs), District Personnel Officers, Sub-county Chiefs and b) district political leaders like; the LCV Chairpersons and Members of the District Committees on Health.

At the HSDU, KIIs were mainly conducted at unit premises. The participants were unit in-charges, medical superintendents, hospital administrators, Board of Directors of hospitals, and the members of the Health Unit Management Committees (HUMCs) and Hospital Management Committees (HMCs).

### **Focus Group Discussions**

Focus Group Discussions (FGDs) were conducted with HUMC members, Village Health Teams and community members. The FGDs had a mixture of both male and females to get a balanced representation of views and opinions. Each FGD consisted of between eight and ten participants and were conducted in local languages.

### **How the Health PEG Assessment was done**

The framework for assessing public expenditure governance in Uganda (see Figure 1) was used to develop the indicators for the assessment for this study.



The indicators were arranged in such a way to cover the governance principles of strategic vision, participation and consensus orientation, accountability, transparency, responsiveness, equity and fairness, effectiveness and efficiency. Under each principle, key assessment areas were formulated with specific questions to enable the assessment process. The tool was administered to the players at district, and service delivery levels within the health sector. They were asked to answer questions relevant to their roles within the governance, budgeting, and service provision processes.

A variety of tools were developed to manage the volume of generated data and to use that data to refine the PEG assessment indicators. These included funds release schedules, HSDU budget, and the personnel records sheets, which enabled systematic analyses of budget allocations, flows of funds, and use of resources along the various links in the health service delivery. All of the KIIs and FGDs responses were recorded on the questionnaires and in field notebooks which were later entered into pre-designed excel worksheets by the investigators.

### **Ethical Considerations**

Moderators and note-takers for both FGDs and KIIs ensured that each item on the question guide was fully discussed and that all study participants had sufficient opportunity to air their views. During interviews and FGDs, one researcher facilitated while the other recorded the proceedings, noting key themes and monitoring verbal and non-verbal interactions. In areas where group members did not understand English, the researcher who understood the local language moderated the discussion. Care was taken to observe human-subject protocols by ensuring confidentiality and anonymity whenever possible.

### **Data Management and Analysis**

A number of strategies were employed to manage and analyse the various types of data collected. At the onset, a methodology matrix organized around the key assessment principles was developed to identify the sources of data needed and the kinds of information that was required from each source. The information in this matrix was then used to develop guides for key informants and focus group discussions. Summaries of interviews and focus group discussions were eventually coded and analyzed for recurring themes. Documents were analyzed using content and thematic analysis.

### **1.3 Limitations of the Study**

This study faced two limitations. The researchers were not able to assess all the health facilities that were selected for the study, mainly due to inability to access heads of the units at the time the research team visited the health facilities and absence of records in some of the facilities. Second, there is limit to which findings can be generalized to other institutions not assessed by the study, since much of the assessment was qualitative in nature.

#### 1.4. Conceptual Framework for Assessing PEG in Health Sector

Governance, as a concept, covers factors associated with state authority, spending, bureaucratic structures, and decision-making processes. According to Uganda's Ministry of Local Government, governance is understood as the exercise of political administration, managerial authority and order, which is legitimate, accountable, transparent, democratic, efficient and equitable in allocating and using resources to promote human welfare and positive change in society (Green 2008; Ministry of Local Government 2007) and other organizations do not differ in describing the characteristics of good governance.

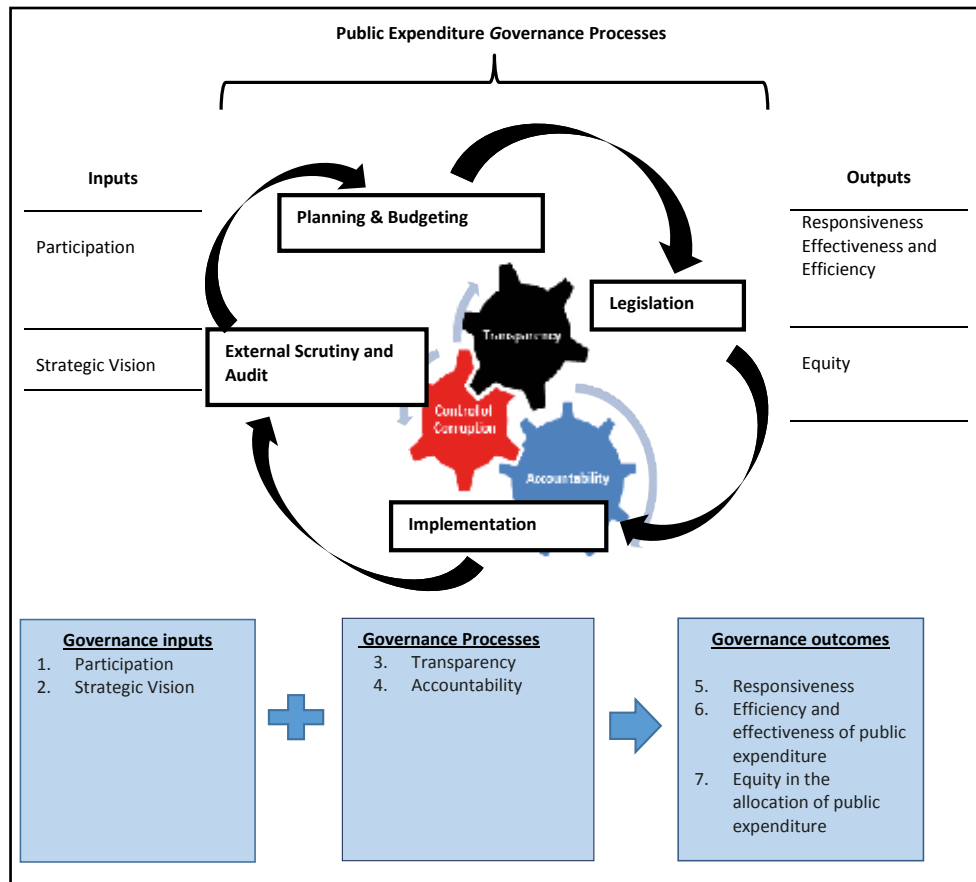
UNDP's (1997) The United Nations Development (UNDP) characterizes good governance as explained in Box 1 (United Nations Development Programme 2007). The Commonwealth Foundation governance principles address inclusiveness and participation of citizens in decisions which affect them, the rule of law, respect for human rights, transparency, accountability, efficient and effective public management systems and processes (Commonwealth Foundation 2005). The common feature in all these descriptions are tenets of political accountability, freedom of association and participation, reliable and equitable legal framework, bureaucratic transparency, the availability of valid information, and effective and efficient public sector management. These elements underlie the PEG assessment indicators developed through this research.

##### **Box 1: Core Characteristics of Good Governance**

Participation; Transparency; Responsiveness; Accountability; Legitimacy; Partnership; Rule of Law; Consensus Orientation; Equity; Effectiveness and Efficiency; Strategic Vision; Resource Prudence; Ecological Soundness; Empowering and Enabling and Spatial Grounding in Communities (United Nations Development Programme 2007).

The PEG assessment framework is grounded in a dynamic model of governance (Baez-Camargo and Jacobs 2008). This framework is understood in terms of inputs, processes and outcome as outlined in Figure 1. Inputs are the laws, policies, rules and regulations that govern actions and decision making. In this research, the assessment principles associated with the input side of PEG are participation and strategic vision. These processes cover legislation, implementation, auditing, and planning and budgeting. The assessment principles focusing on process are accountability and transparency, both of which are essential if processes are to lead to the desired outcomes. The desired outcomes of PEG are associated with quality health services that are equitably, efficiently and effectively delivered, and involve a mechanism for responsive feedback from the end-user.

**Figure 1: Public Expenditure Governance in Health Model**



After providing an overview of the structures and processes central to Uganda's health sector in Chapter 2, the remainder of the paper is dedicated to understand the strengths and short-comings of public expenditure governance in this sector using the assessment framework that stems from this PEG model.

# CHAPTER 2

## OVERVIEW OF THE HEALTH SECTOR

---

### 2.1 Context of the Study

Uganda went through both political and economic upheavals in the period between 1970s and 1980s. This led to service delivery breakdown in many sectors including health which was characterized by general system failure. There was insufficient funding leading to dilapidated infrastructure, late and meagre salaries of health workers, and lasting shortages of medicines and supplies. The country was thus dependent on foreign aid, and as a result donors and aid agencies influenced both health and development policy (Okuonzi and Macrae 1995).

When the National Resistance Movement took power in 1986, the government's initial efforts focused on the restoration of law and order and on the restoration of public systems. However, the government was constrained in terms of the funding available for social services including the health sector. This led to the intervention of number of bilateral and multilateral donors who provided post-conflict support like emergency rehabilitation of the health infrastructure. In the late 1980s, user fees were introduced against a backdrop of poor health system but did not spread widely until early 1990s. The fees were later abolished in 2001, with the exception of private wings in health facilities as a health sector reform strategy (Kipp et al. 1999).

It is in the early 1990's that the government of Ugandan embraced decentralization as part of a cross-cutting public sector reform. The central government's mandate through the Ministry of Health remained policy formulation, standard setting, quality assurance, resource mobilization, capacity development, technical support, and provision of nationally coordinated services such as epidemic control, coordination of health research and monitoring and evaluation of overall sector performance.

On the other hand the Local government were mandated to provide curative and rehabilitative services, vector/ communicable diseases control, health education, ensuring provision of safe water and sanitation and mobilize additional resources. The health care delivery system in Uganda is devolved to districts, which are subdivided into counties and then into sub-counties. According to the 1999 National Health Policy, the sub-counties are primarily responsible for health service delivery.

### 2.2 Policy Framework for Health in Uganda

In the 1990s, the government started preparing a National Health Policy and a Health Sector Strategic Plan. It was around this time that some bilateral and

multilateral agencies were trying to get an alternative to the project-based method of delivering aid and when the international community had begun to query the existing modalities of providing Overseas Development Assistance (ODA). This led to the introduction of the sector-wide approach (SWAp) for health development which meant that instead of focusing on individual projects, donors would support and fund the implementation of a coordinated and sector-wide strategy. This development was welcomed by the government of Uganda because of the challenges of managing ODA.

Uganda's first Health Sector Strategic Plan (HSSP I) covered the period 2000/01 to 2004/05. The plan helped to guide the government of Uganda in its health sector investments, which were led by the Ministry of Health, Health Development Partners (HDPs), and other stakeholders over this period. Continuous monitoring through quarterly and mid-term reviews helped to assess key achievements and challenges during the implementation of HSSP I and formed the basis for the development of HSSP II for the period 2005/06 to 2009/10. With the stewardship of the Ministry of Health (MOH), the Ugandan government developed the second National Health Policy (NHP II) to cover a ten-year period from 2010/11 to 2019/20. The third Health Sector Strategic Plan (HSSP III) was developed to operationalize the NHP II and the health sector component of the National Development Plan (NDP) 2010/11-2014/15, which is the overall development plan for Uganda. The HSSP III provides an overall framework for the health sector.

### 2.3 Uganda's International Commitments

Every nation's global health engagement necessitates it to be part of international treaties, partnerships, agreements and commitments. Nations are more reliant on each other for cohesive development of global health policies and practice. The health challenges are increasingly becoming common in all nations due to globalization and hence the importance and use of international agreements and treaties in framing policy and national commitments. At international level, the government of Uganda is a signatory to international agreements and treaties like the declaration of Alma-Ata (1978)<sup>1</sup>, the Abuja Declaration and Plan of Action (2000)<sup>2</sup>, the Millennium Development Goals (2000)<sup>3</sup>, the Maputo Plan of Action (2006)<sup>4</sup>, Paris Declaration on Aid Effectiveness (2005), and the Accra Agenda for Action (2008)<sup>5</sup> and many others (see Table2).

<sup>1</sup> Declaration of Alma-Ata, International Conference on primary health care, Alma-Ata, USSR, 6-12 September 1978

<sup>2</sup> The Abuja Declaration and the Plan of Action, By the Africa Heads of State and Governments, 25<sup>th</sup> April 2000, Abuja, Nigeria

<sup>3</sup> The Millennium Development Goals Report, <http://www.un.org/millenniumgoals/>

<sup>4</sup> Maputo Plan of Action, Maputo Plan of Action to curb maternal deaths in Africa, African Union

<sup>5</sup> The Paris Declaration on Aid Effectiveness (2005), and Accra Agenda for Action (2008) <http://www.oecd.org/development/effectiveness/34428351.pdf>

**Table 2: International Agreements and Treaties to which Uganda is a Signatory**

Year	Treaty or agreement	Narration
1978	Alma Ata	Expressed the need for urgent action by all governments, all health and development workers, and the world community to protect the health of all people. Recognising the need for good quality family planning and other reproductive health care. In 1994 at the United Nations International Conference on Population and Development (ICPD) in Cairo, representatives of 179 countries agreed to improve reproductive health care and better meet people's needs.
2000	Abuja Declaration and Plan of Action	The Abuja Declaration and Plan of Action recommended that countries allocate 15% of their total domestic budgets to health by 2015. However, Uganda is still far below the Abuja target; the share of the health sector budget in national budget has consistently remained less than 9% over the last decade
2000	Millennium Development Goals	Heads of State and Governments of 191 nations including Uganda adopted the Millennium Declaration with its eight Millennium Development Goals (MDGs), three of which aim at improving people's health; reduce child mortality (MDG 4), improve maternal health (MDG 5), and combat HIV/AIDS, malaria and other diseases (MDG 6). The need to achieve universal access to reproductive health was consolidated and augmented by the World Summit in 2005, which made universal access to reproductive health by 2015 a target under MDG5.
2006	Maputo Plan of Action	Ministers of health and delegates from 48 African countries agreed unanimously that the right to health is under serious threat in Africa, and that poor sexual and reproductive health is a leading killer. They adopted a plan of action to ensure universal access to comprehensive sexual and reproductive health (SRH) services on the continent. The plan recommends a number of measures, among them the following: <ul style="list-style-type: none"> <li>▪ integrating HIV/AIDS services into sexual and reproductive health and rights;</li> <li>▪ promoting family planning as a crucial factor in attaining the Millennium Development Goals;</li> <li>▪ supporting the sexual and reproductive health needs of adolescents and young people as a key SRH component;</li> <li>▪ addressing unsafe abortions through family planning;</li> <li>▪ delivering quality and affordable health services to promote safe motherhood, child survival, and maternal, newborn and child health;</li> <li>▪ adopting strategies that would ensure reproductive health commodity security.</li> </ul>

Year	Treaty or agreement	Narration
2005	Paris Declaration of Aid Effectiveness	The Paris declaration on Aid Effectiveness and later the Accra Agenda for Action reaffirmed commitment to supporting partner countries to accelerating achievement of the Millennium Development Goals. Attainment of the health-related MDGs would also make a contribution to the achievement of all the other goals, in particular those related to the eradication of extreme poverty and hunger, education and gender equality.
2008	Accra agenda of action	

Such agreements establish political and legal commitments, formalize international relationships, and coordinate roles and responsibilities in an increasingly complex and interconnected world. Some of these agreements are legally binding under international law, and may also be binding under national law, whereas others are non-binding but may confer political, diplomatic, governance, or other expectations on parties.

Whether a nation chooses to become party to an agreement may send an important signal to the international community regarding national priorities, help to shape the dialogue on key global health issues, and may in turn serve to influence the direction of national policies and programs.

Despite all the international commitments the Uganda government has made, there is a significant gap between commitments on paper and practice. For example the Abuja declaration of allocating 15% of the national domestic budget to health has never been adhered to in Uganda. Policy makers ought to act on the commitments that support proper public expenditure governance by identifying funds to implement them and monitoring the implementation of programmes for efficiency and effectiveness.

## 2.4 Uganda Health Services Delivery System

The Uganda health care delivery system revolves around two levels operating within the decentralization framework with a strong public private partnership for health component. The levels include the Central Government Ministries, Departments and agencies at central level and Local governments comprising of districts and municipalities. Under the decentralized system, the ownership of public health facilities (health centers and general hospitals) and the responsibility for delivering health services is by local governments (Ministry of Health July, 2010).

The key Central Government institutions include: Ministry of Health Headquarters, Uganda AIDS Commission (UAC), Uganda Blood Transfusion Services (UBTS), Health Service Commission (HSC), National and Regional Referral Hospitals; Professional Councils and the National Drug Authority (NDA) (Ministry of Health

July, 2010). The Ministry of Health has the core functions of policy formulation, setting standards, and quality assurance, resource mobilization, capacity development, training and technical support supervision and provision of nationally coordinated services including emergency preparedness and response. The other central level institutions are responsible for specialized functions; Uganda AIDS Commission coordinates the multi-sectoral response to HIV/AIDS, UBTS manages the blood transfusion service for the country, the national and regional referral hospitals provide tertiary and specialized health services respectively, the health service commission acts as the human resource agency for the sector, handling specifications (including requirements, terms & conditions of service), recruitment, and promotion among others (Ministry of Health July, 2010).

The health system comprises public, private not for profit (PNFP) and private for profit (PFP) providers as well as traditional and complementary practitioners. National and Regional Referral Hospitals report to the central government; District hospitals and Health Centers (HCs) ( II–IV) report to the local governments. The districts are further divided into Health Sub Districts, which are administered at the HC IV level. The PNFP facility based providers are predominantly faith based (78 percent) and are administratively coordinated nationally by the respective bureaus, and locally by the diocesan boards. The PFP providers predominantly comprise clinics, but also include drug shops and vendors operating informally. With the advent of HIV/AIDS, Uganda has witnessed proliferation of the PNFP non facility based nongovernmental organization (NGOs) service providers (Okwero et al. ,2010).

The Ministry of Health Health Facility Inventory 2011, reported 4,980 health facilities in Uganda (54 percent public, 17 percent PNFP, and 29 percent private. There was a 16 percent increase in the number of public health from 2,301 in 2006 to 2,679 in 2011 (see Table 3). The increase was principally driven by construction of new health centers by the government in its drive to improve access to health services. Although health infrastructure has expanded, the vast majority of health facilities are not fully functional, lack equipment and staff, and are poorly maintained.

**Table 3: Number of Health Facilities by Ownership**

Level of Facility	Public		PNFP		PFP		Total	
	2006	2011	2006	2011	2006	2011	2006	2011
Hospitals	60	66	46	61	8	16	114	143
HC IV	147	166	12	16	1	8	160	190
HC III	762	859	186	278	7	40	955	1,177
HC II	1,332	1,588	415	516	261	1366	2,008	3,470
Total	2,301	2,679	659	871	277	1,430	3,237	4,980

Source: MoH (2011), Health Facility Inventory Jan 2011



As illustrated in Table 4, health care provision in Uganda is delivered through a tiered structure of facilities based on services they provide and catchment area they are intended to serve (Ministry of Health et al. April, 2012). The facilities are designated as Health Centre level one (HC 1) to Health Centre level four (HC IV); General Hospital, Regional Referral Hospital, and National Referral Hospital.

**Table 4: Health Care Delivery Structure**

Level	Catchment area	Health centre	Approximate population served	Services provided
District	Village	I	1,000	Community based preventive and promotive health services
	Parish	II	5,000	Preventive, promotive and outpatient curative health services and outreaches
	Sub County	III	20,000	Preventive, promotive and outpatient curative services, maternity and in-patient health services and laboratory services
	County	IV	100,000	Preventive, promotive and outpatient curative services, maternity, in-patient health services, emergency surgery, blood transfusion and laboratory services
	District/s	General Hospital	500,000	In addition to services offered at health center level IV, other general services are provided including in-service training, consultation and research for community-based health care programs
Regional	Region	Regional Referral Hospital	2,000,000	In addition to all services offered at general hospital, specialist services such as psychiatry, Ear, Nose and Throat (ENT), ophthalmology, dentistry, intensive care, radiology, pathology, higher level surgical and medical services.
National		National Referral Hospital	35,000,000	Comprehensive specialist services, teaching and research

Source: SAM - MoH, 2006; HSSIP - MoH, 2010

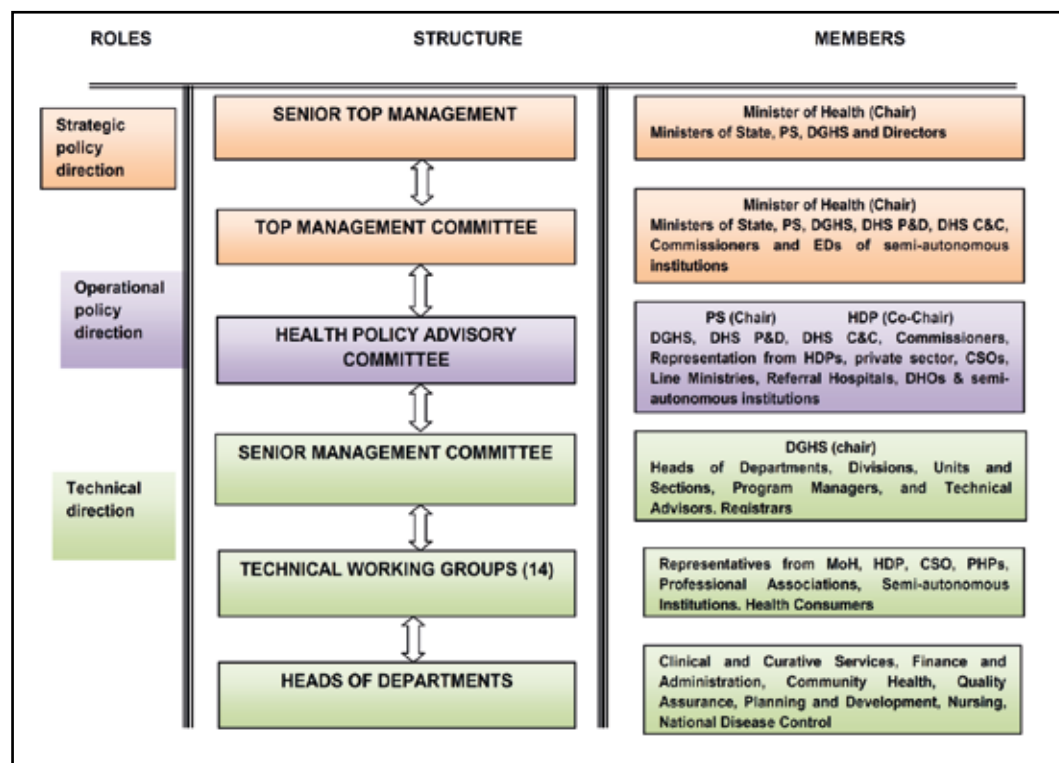
## 2.5 Health Sector Governance Framework

Each level in the health service delivery structure described above has its own institutional governance and management setup in addition to the one at the national and district local government stakeholders. Moreover, there are other power centres whose decisions usually affect the performance at these levels and hence service delivery. There are many different institutional actors involved in the governance of the health sector as shown in Figure 2. At the national level, there is the Cabinet, Parliamentary Committee on Health, and the MoH Senior Top Management committee. The autonomous public and private institutions are governed by boards.

According to the Health Sector Strategic Plan, “The Local Governments have the responsibility for the delivery of health services, recruitment, deployment, development and management of human resource (HR) for district health services, development and passing of health related by-laws and monitoring of overall health sector performance” (Ministry of Health July, 2010). This implies that local governments are responsible for the delivery of the majority of frontline health services to Ugandan households.

At the district level, the District Executive Committee, together with the district Social Services Committee, provide oversight for policy implementation, planning, resource allocation and use of services, in adherence to national laws. Governance at the sub-county level is comprised of Local Council III Executive, and the Sub-County Social Services Committee. The referral hospitals have boards of governors who provide the oversight role for the effective functioning of the hospital in order to deliver quality services. General Hospital, HC IV, III & II have the in-charges and unit management committees which draw representation from the community members and provide the oversight function for primary care facilities.

**Figure 2: Governance Structure of Uganda's Health Sector**



Source: MoH (2010)

### 2.6 Health Sector Financing

During the last ten years, the share of the health sector budget allocation to the national budget has hardly grown; stagnated at less than 10% (see Table 5). This is far below the Abuja declaration, where Uganda committed to allocate at least 15% of the national budget to the health sector.

**Table 5: Health Sector Budget allocations over years: Budget Vs Outturns, excluding donor funds**

Allocation Priorities	2008/09		2009/10		2010/11		2011/12		2012/13		2013/14	
	Budget	Outturn	Budget	Outturn	Budget	Outturn	Budget	Outturn	Budget	Outturn	Budget	Outturn
LG Health Services	157.59	166.40	190.90	197.55	207.42	221.15	229.62	2.95	248.92	303.43		
Regional Hospitals	43.61	44.65	46.52	46.45	50.16	52.16	52.50	55.21	58.34	70.35		
National Referral Hospitals	53.90	54.63	81.22	45.08	65.42	46.09	83.41	44.59	45.08	46.89		
MoH Hqts	364.11	109.58	323.70	59.95	106.55	44.20	207.72	40.70	48.95	462.64		
NMS	0.00	0.00	75.71	54.67	201.73	181.15	206.81	191.48	208.29	219.37		
Other Agencies	9.26	6.18	17.62	13.34	28.74	14.84	19.06	18.50	21.21	24.48		
<b>Total</b>	<b>628.47</b>	<b>381.42</b>	<b>735.67</b>	<b>417.03</b>	<b>660.02</b>	<b>559.58</b>	<b>799.11</b>	<b>353.42</b>	<b>630.79</b>	<b>1,127.16</b>		
Share of the Total National Budget	10.7%	8.4%	10.4%	8.1%	6.9%	7.6%	8.3%	4.3%	7.1%	8.7%		

*Outturn- excludes donor funds*

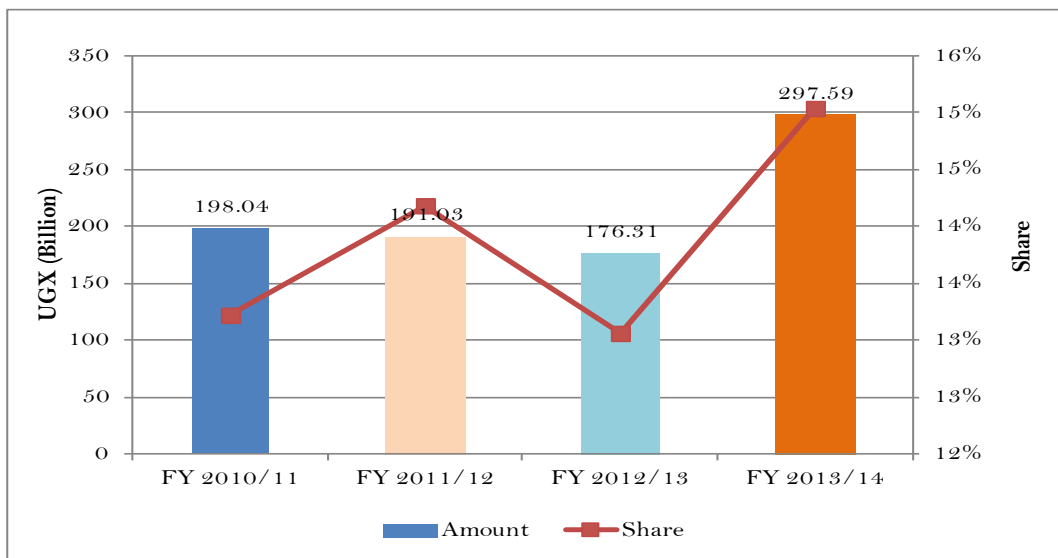
*Source: Author's calculations based on the MoFPED, Approved Estimates of Revenue and Expenditure.*

The 2002 Health Financing Strategy estimates that in order for the sector to be able to provide the Minimum Health Care Package, USD 28 per capita expenditure would be required, however for FY 2012/13, only USD 9.0 per capita (which includes donor projects and Global Health Initiatives captured in the MTEF) was available. Uganda's per capita spending on health is significantly lower than that of other SSA countries (Ministry of Health et al. April, 2012). Inadequate investment in the health sector is hampering efficient delivery of health services in Uganda.

The low funding to the sector adversely affects more the poorest people who cannot afford other alternatives to health care other than from government health units. Thus the poor rely much more on government health facilities for treatment and use private facilities less. Over 39% of the poorest households went to government health facilities compared to 18% for the less poor who rely on private facilities (Ministry of Finance Planning and Economic Development , 2007).

Under the decentralization policy framework, Local Governments (LGs) to implement required to provide most of the health care services. To enable LGs provide health services, the central government provides funding through transfers in form of conditional grants to LGs. These include: PHC Salaries, PHC Non-Wage, District Hospitals, PHC NGO Hospital Non-wage, NGO Wage Subvention, and PHC Development. On average over the last four years (2010/11-2013/14), the central government transferred about Shs 216 billion. This constituted about 14% of the total central government transfers to LGs during the same period (see *Figure 3*). The total budget for grants allocated to each district is determined centrally on an annual basis using an 'allocation formula' that takes into account district population and other demographic characteristics.

**Figure 3: Trends in central government Health sector transfers to LGs**



Source: Author's calculations based on data from MoFPED and LGFC releases to LGs

## 2.7 Budget Process and Flow of funds

The budget process has evolved over the last decade, with reforms of the public expenditure management resulting in new institutional arrangements for budgeting. Critical components of these arrangements include: Sector Wide Approaches (SWAPs), the Medium-term Expenditure Framework (MTEF), Output Budgeting Tool (OBT) and the fiscal decentralization process.

Important components of the budget process are the Budget Framework Papers (BFPs), which are prepared at the national, sectoral and local government levels. They are five-year rolling frameworks used to streamline and guide the budget process, setting out planned outputs and their associated expenditures in the medium term (United Nations Convention to Combat Desertification (UNCCD) 2007). The sector working groups (SWGs) are responsible for the sectoral budget process. The sectoral BFP is the official statement of sector expenditure priorities and outlines the sector's contribution to poverty reduction.

In theory, a high-quality, well-formulated sectoral Budget Framework Paper accompanied by high sector performance leads to balanced and adequate allocations of sector ceilings in the MTEF. However, in practice this does not happen, since sector ceiling are set within the MTEF, which in most cases is not based on the quality of the sector BFP. Although the National Development Plan (NDP) ranks its priorities, this is not followed when setting sector ceiling in the MTEF. For instance, the health sector expenditure framework under the NDP was projected on average at 11.3%, however, the actual budget allocation during the same period averaged 7%.

The Sector Working Group (SWG) is an important level for influencing what gets funded within a sector. Some of the sector specific institutions can lobby for increased budget allocations at this level. Since, both Government and donors are also represented at this level, it is possible to raise some of the additional financing issues that are sector specific, which can later be addressed at the national level. However, the SWG outcomes are hindered by the deviation between the MTEF and the actual annual budget allocation and later on the release of funds.

Health service delivery happens at the front line service delivery unit, which is the hospital or health center. Therefore, non-wage funds have to be transferred from the central government to the service delivery unit. The mechanism of transfer of funds involves release of funds by the MoFPED to LGs (District Account), then to the DHO account and then to the service delivery unit account.

# CHAPTER 3:

## ASSESSMENT OF PUBLIC EXPENDITURE GOVERNANCE IN HEALTH

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### 3.1 Introduction

There have been attempts to study the role played by governance in health systems specifically the effectiveness of governance in community health partnership. In Uganda this study is the first attempt of developing a framework for assessing governance of the health sector. This framework looks at the principles of governance in terms of assessment areas, and specific questions for various levels including district, health service delivery units and finally the community members. This framework is capable of working a good analytical tool that helps to understand the public expenditure governance bottlenecks at policy formulation and implementation levels. In this way it provides a good basis for informing the development of interventions by providing empirical evidence about the complex governance issues to health managers and policymakers.

When assessing public expenditure governance in Uganda's health sector, the following principles which have been proposed to be appropriate for developing countries were considered: strategic vision, participation and consensus orientation, accountability, transparency, responsiveness, equity and fairness, effectiveness and efficiency (Siddi et al. 2009). This assessment provides a basis for diagnosing the bottlenecks in public expenditure governance in the health sector; at policy and operational levels as well as service delivery points for improvement. This process of assessing the public expenditure governance of health systems builds upon the widely accepted: (i) World Health Organization's (WHO) domains of stewardship; (ii) Pan American Health Organization's (PAHO) essential public health functions (EPHF); (iii) World Bank's six basic aspects of governance; (iv) UNDP's principles of good governance. (Travis et al. 2002).

### 3.2 PEG Principles and Indicators in the health sector

#### 3.2.1 Strategic Vision

Leadership in the health sector is required to have a broad and long-term perspective on health and human development, along with a sense of strategic directions for such development as well as an understanding of the historical, cultural and social complexities in which that perspective is grounded. Ideally, public health leadership and management should involve leadership connected to four sub-functions of governance responsibilities: (i) national health policy (NHP), (ii) national health strategic plan (NHSP), (ii) dissemination of NHP and NHSP, and (iii) implementation of NHSP (Kirigia and Kirigia 2011). Drawing on these ideas of

leadership, our assessment of the strategic vision principle for PEG in Uganda's health sector focused on (i) the existence of a sector long term vision, (ii) the existence of Health Management Committees and Boards, (iii) transparency of Health Management Committees and Boards, and (iv) general funding systems at HSDUs.

### ***The Existence of the sector Long-term Vision***

The long term vision for Uganda's health sector is clearly stated in the National Health Policy (2010), the Health Sector Strategic Investment plan 2010/11 – 2014/15, the National Development Plan 2010/11 – 2014/15, and the Constitution of Uganda 1995 (Ministry of Health July, 2010). In each of these documents, the long term vision of the health sector is stated as *“a healthy and productive population that contributes to socio-economic growth and national development.”*

The current National Health Policy (NHP II) has been informed by the NDP, which contains the overall planning and development agenda for Uganda. The NDP places emphasis on investing in the promotion of people's health, a fundamental human right for all people. Constitutionally, the GoU has an obligation to provide basic medical services to its people and promote proper nutrition. The Constitution further provides for all people in Uganda to enjoy rights and opportunities and have access to education, health services and clean and safe water.<sup>6</sup> Investing in the promotion of people's health shall ensure they remain productive and contribute to national development.

It is important that different stakeholders (including communities and individuals) are aware of the policy and their role in the implementation process. In order to ensure that this policy is widely known, accepted and adhered to by all stakeholders, government should print and disseminate the policy at all levels. The MoH and other stakeholders at all levels should engage in communicating and disseminating the policy among all stakeholders (Ministry of Health 2009). However, findings from the Health facilities visited show that availability and knowledge of the existence of such policy documents varies with most stakeholders expressing ignorance of their existence. For instance, the In-Charge at a HCIII in Kamuli District stated that plans and policy documents are *“things we look at but we don't take note of them.”* Of those that knew about existence of such documents, many did not understand fully them. The In-Charge at a HC IV in Luweero District said, that *“majority of staff don't understand the vision and yet they are serving these institutions..., [which is] partly contributing to low staff motivation.”* The DHO in one of the study districts added that there is fair understanding of the strategic vision at district level but not at lower levels.

<sup>6</sup> Principle XIV of the National Objectives and Directive Principles of State policy as contained in the Constitution of Uganda 1995



### **Health Unit Management Committees (HUMCs) and Hospital Management Committees (HMCs)**

The HUMCs for lower level health centres and hospitals are vehicles for public participation as they are comprised of nominated representatives from the community. HUMCs and HMCs are supposed to oversee the running of the health units and district hospitals, supervise management of finances, and encourage community participation in health activities among others. HUMCs and HMCs were in existence in all the HSDUs visited and their selection or appointment generally followed the guidelines developed by the MoH. The Ministry of Health tried to strengthen HUMCs, and guidelines for HUMCs were developed; however, most of the HUMCs did not even have copy of the guidelines. The In-Charge at an HC IV in Kamuli District admitted that he was “not aware of their (HUMC) guidelines, neither their appointment instrument.” Thus, most of them were operating solely on the advice provided by the in-charge of the health facility.

The performance of staff at most HUMCs and HMCs has been negatively affected by a lack of orientation to their roles and responsibilities and poor financial facilitation. An In-Charge at a HC IV in Luweero District explained, that “. . . *when we used to have cost-sharing, the staff were very vigilant; they had money to facilitate their (HUMCs) activities . . . however, nowadays, they are not effective.*” Consequently, supervisors are reluctant to make demands of staff. As an In-Charge at a Luweero HC III stated, “. . . *sometimes i fear to invite them for meetings because of lack of funds.*”

Although the HUMCs and HMCs were appointed by the Sub-county and/or District Executive, most of them reported that they did not submit reports of their work to the appointing authority. Thus, it was hard for the appointing authority to appraise their work. A Sub-county Chief in Luweero District like in other districts visited illustrated this finding when he confirmed this by stating that “. . . *we don't receive their (HUMC) reports.*”

### **Transparency of Health Management Committees and Boards**

The HUMCs and HMCs guidelines require the committees to be transparent when conducting their businesses (Ministry of Health 2003). They are supposed to hold regular meetings as prescribed by their governing instrument or other directives. Data from the study districts revealed that the HUMCs and HMCs hold meetings on a quarterly basis to discuss issues related to running of HSDU, especially human resource issues. However, in lower health units, the committees were found not to be meeting regularly due to limited funding. Participation in these meetings was considered a voluntary community service. At that level, the information gathered suggested that it was mainly the Chairman who worked closely with the in-charge of the health unit.

The committees are supposed to supervise the management of the finances. They should be involved in budgeting and supervising the expenditures of the HSDU. For transparency purposes, their decisions on budgets and expenditures should

be made public to the users of the health services. However, most members of the committees interviewed, especially at the lower health unit, were not aware of this role and had not performed this function.

The role of the committees in the budgeting was limited partly due to the nature of funding of health units. All health units depended on grants from the central government, which were very small and conditional, making it nearly impossible to even run the health unit.

### **General funding systems at HSDUs**

The HSDU is supposed to develop an annual budget and a corresponding work plan for the implementation of the planned activities. Funding for the HSDU is supposed to come from the central government, district (locally generated revenues), own revenues (e.g. private wings for hospitals) and donors. However, in all the HSDUs visited, funding was primarily from the Central Government. As discussed above, the Central Government funding is through conditional grants targeted at wage and non-wage and development. The wages and salaries are sent directly to personal accounts of health workers. The non-wage is communicated through the indicative planning figures (IPFs) and sent to the account of the HSDU, and the development budget is handled by the district. Thus, the level of budgetary discretion left to the HSDU is very minimal.

Funding for the HSDU was found to be grossly inadequate. For instance, the study found that average per quarter non-wage funding for district hospitals was Shs 32 million, HCIVs Shs 3.0 million, and HCIIIs Shs 0.8 million. With this level of funding, the health units were clearly unable to provide the required levels of health care to the population.

The districts receive conditional grants whose amounts are predetermined by the MoFPED. The indicative planning figures (IPFs) do not give chance for flexibility in terms of budgeting for specific and unique needs at the health service delivery unit (HSDU). To make matters worse, funding for the HSDUs had not substantially increased over the last five years, despite the increase in population and disease burden. As an In-Charge of HC III in Luweero observed, “... *we were told to budget as we did last year, the amount cannot change.*” Further complicating matters is that, as an In-Charge of HC IV in Kamuli noted, “...*predictability of the funding especially from central government is a challenge.*”

In most cases funds are allocated based on the level of care of the health facility. However, the facilities may be at the same level of care (e.g HC IV) but differing in patient load and individual health facility burden of disease mainly due to the location of the facility and the population densities. For example, facilities located along highways and in urban settings receive more patients than others, yet in budgeting they are allocated almost similar amount of money since they are all at the same level of care.

### 3.2.2 Participation and Consensus Orientation

All men and women should have a voice in decision-making for health, either directly or through legitimate intermediate institutions that represent their interests. Such broad participation is built on freedom of association and speech, as well as capacities to participate constructively. Good governance of the health system mediates differing interests to reach a broad consensus on what is in the best interests of the group and, where possible, on health policies and procedures (Siddi et al. 2009).

The citizen should be at the core of the service delivery system by receiving the services and participating in designing of the agenda for public service delivery. This is critical in health sector because service delivery directly affects their lives and livelihood. It is important to consider the citizen's views on health care systems as they reflect the priorities and perspectives of the public (Bruni et al. 2008). It is not enough to depend on only the professionals and managers in health care in decision making processes but also to be informed by the opinions of the general public (Wiseman et al. 2003). The roles of citizens in public service delivery should not be limited to demand generation for a *quid pro quo* for their taxes. The PEG assessment of the participation aspect of good governance focused on participation in decision-making processes, and participation in the budgeting process.

#### ***Participation in decision-making processes***

Citizen involvement in decision-making is central to some of the most popular movements in public health. The main challenge, however, is ensuring that people are actually involved in decision-making processes. Decentralization is one of the strategies that can foster participation. Decentralization ensures that decision making is made at local levels by leaders who are elected by the people. The most common form of participation is through democratically elected representatives from the community.

The district and sub-county councils, comprised of elected councillors, appoint members of the HMC and HUMCs. The committees are the major vehicles for public participation. Ideally, these should represent the interests of the community and should be in constant communication with their communities. However, this study found that, the interactions between communities and management committees were weak. Most community members interviewed were not aware of the existence of the health unit management committees. Those who were aware of them had not interacted with most of them and were dissatisfied with the performance. Health centre III reported high levels of participation compared to health centre IVs and hospitals, which may be attributable to the presence of active village health teams and HUMC members who are closer to the communities.

#### ***Participation in the budgeting process***

In theory, the budgeting process is supposed to be a bottom-up approach starting from the health facilities, through the districts, to the MoH. However, in

reality budgeting is top-down since budget ceilings by MoFPED, meaning the needs and concerns of the citizens are not taken into account. In interviews and focus groups in the three districts we heard time and again about how citizens are essentially excluded from the budget process. In Luwero, one district official said, *“citizens views are not considered in the budget process...partly due to the IPFs.”* In Kamuli, another stated that *“central government just pushes down money... people are not consulted.”* One official hit the nail on the head by saying, *“... participatory budgeting is dead...budgets are determined by the centre through IFPs, we only place the budget in a template; Output Budget Tool (OBT).”*

Researchers in this study found no community participation in budgeting for the health unit. As the In-Charge at a HC IV in Luweero said, *“even if i conducted a village meeting, and came-up with issues, they would not make a difference... the government has its own priorities.”* There was also a lack of awareness about the facility budget and how funds are spent. In all facilities visited, there were no display of budgets and expenditure of the health facility.

In Kamuli, one donor, CORDAID, has been promoting performance-based financing in some health facilities. Under this funding, facilities are provided with flexible funding and are allowed to plan and budget for these funds, using 30% for staff motivation and 70% for capital development. This motivates health staff since they know they will be rewarded when they perform well. Financing is based on performance on indicators as shown in Table 6.

**Table 6: Performance Based Financing by CORDAID**

Indicator	Amount (per case) -Shs
OPD 1 <sup>st</sup> Visit	1,000
ANC 1 <sup>st</sup> visit	500
IPT 2	500
Deliveries	15,000
Referrals	2,000
PNC	2,500
Family Planning	1,000
Child full immunized	2,500
TB fully treated	5,000
Caesarian section	50,000

*Source: Nakandulo HC IV, Kamuli district*

### 3.2.3 Accountability

Accountability entails procedures and processes by which one party provides a justification and is held responsible for its actions by another party that has an interest in the actions. Accountability can be dissected into into three essential components of accountability: (i) the loci of accountability, (ii) the domains of

accountability, and (iii) the procedures of accountability (Emanuel and Emanuel 1996). In the health sector, the loci of accountability consists of distinct parties that can be held accountable or hold others accountable. These include: (i) citizens (patients); (ii) health care providers such as nurses; (iii) managers of health units (administrators and management committees); and (iv) elected leaders. The domain of accountability consists of the practice, or issue for which a party can legitimately be held responsible and called on to justify or change its action. These include; financial performance, and access to spending information. The procedures (formal and informal) of accountability consists of clients charters. In this study we examine the accountability of the health unit management committees/hospital boards to citizens; accountability of elected political leaders to citizens; accountability of funds; and citizen's awareness of the client charters.

### **Accountability of the HUMC/HMCs to citizens**

The HUMC/HMCs are supposed to link the HSDU with the community. Therefore they are supposed to organize community meetings or other forums to account for their decisions. However, this study found that this is not happening. This is partly due to the fact members of the HUMCs/HMCs are appointed by the sub-county/district council and thus are accountable to the council. The committees don't see themselves as accountable to the citizens. Citizens are at times complacent with the lack of accountability. As one district official in Kamuli pointed out, *"...the challenge is that citizens get free health services....they think we are doing them a favour...so, they don't hold us accountable."*

In some cases, the management structure of the HSDU is prominently displayed in appropriate places accessible to the public such as notice boards. This is supposed to help communities know whom they can contact when there is case of service delivery failure. However, most community members we talked with were ignorant of the HSDU management structure and their contacts. This is partly due to high illiteracy levels and poor reading culture of most citizens.

The study found also that the HUMCs don't engage with other community structures such as the Village Health Teams (VHTs). For instance, the VHTs interviewed in Bowa HC III did not even know the members of the HUMC. In Nakandulo HC IV, the VHTs we talked to noted that HUMC did not engage them.

In some cases, the management of the HSDUs provided channels for citizens to communicate their grievances about service delivery failures to the management of the Unit. This was done through suggestion boxes, VHTs, and SMS (in Kamuli funded by CORDAID). However, most in-charges of the HSDUs noted that they rarely receive any complaints through the suggestion boxes. However, they did admit that they get some feedback through the VHTs. On the other hand, community members reported being blackmailed by the fear of being victimised and harassed if they report any service delivery failures to for example, politicians or anyone with authority. This was mainly due to lack of a designated platforms or agency where citizens could lodge their complaints. In cases where complaints

were received, there was no evidence that the citizens' complaints/grievances collected through these channels were being utilised to improve service delivery.

### ***Accountability of elected political leaders to citizens***

As a good practice, elected local leaders are supposed to convene citizen's accountability meetings to receive feedback or complaints regarding the quality of service delivery at the unit. However, the political leaders that participated in this study had not performed this role. While some expressed ignorance on these roles, others noted they did not have funds to organise such meetings, since in most cases; citizens demand facilitation to attend such meetings. In some cases, elected leaders used social functions like funeral vents, marriage gatherings, religious events and many others to solicit feedback from communities on health and other service delivery concerns.

A recent innovation by the Government of Uganda through the Office of the Prime Minister (OPM) was use of 'Barazas' as one of the avenues to solicit citizens views and providing feedback. However, the barazas were found to be a on small scale and to handle all issues. The implication could be that health issues may not be adequately handled in such forums. In addition, some elected political leaders organised feedback meetings. A case in point was the LCV of Kamuli district who reported that she often organised feedback meetings every Friday. Her lamentation was that "*...barazas could not be effective because they involve very few people....when people don't see solutions, they don't participate.*"

### ***Accountability of funds***

The HSDUs depend largely on central government transfers which are channelled through the District and DHO. Most the HSDUs visited complained of late release of funds, especially the non-wage component which is meant to run the activities of the facilities. Accountability of funds is among the biggest challenges in health service delivery. Though health facilities receive meagre funds, they are supposed to publish how they utilise the little funds. In some health facilities such as Butuntumula HCIII, the expenditure information for the HSDU was prominently displayed at places accessible to the public on the notice boards. In these cases, the expenditure information displayed was clear enough to show how the funds received were spent. However, financial information was not prominently displayed at places accessible to the public in most health units visited. Table 7 provides the results of our observations at the health units in the three districts.

**Table 7: Display of financial information at health units**

District	HSDU	Displayed information
Luweero	Luweero HC IV	No
	Butuntumula HC III	Yes
	Nyimbwa HC IV	No
	Bowa HC III	No
Kamuli	Kamuli Hospital	No
	Nakandulo HC IV	No
	Mbulamuti HC III	No
	Nabilumba HC III	No
Gulu	Bobi HC III	No
	Gulu Regional Referral Hospital	No
	Awach HC IV	Yes
	Chwero HC III	No
	Lalogi HC IV	Yes

An In-Charge at a HC IV in Luweero explained why they didn't display the financial information by saying, *"...we don't display financial information, since it doesn't make a difference, because when I cry the communities would not help. But if they ask for it (which they don't), I would show them."*

All the HSDUs visited noted that they submit their accountability report of funds to their supervising authority running through HC III to HC IVs and HC IVs to DHO. This was noted to be largely a formality since the supervising authority was a signatory to the bank account of the health facility. As a Sub-county chief in Luweero District stated, *"...the sub-county is not involved in their budgeting; however, I get to know how much the facility receives, because am a signatory to the bank account."* It was not clear if there were any sanctions for failure to account for funds in time.

While in some HSDUs, the financial accountability reports were made accessible to the HUMCs, such reports were not made public at the time when they are submitted to the relevant authority. Citizens were not aware of how funds are utilised by the HSDU management. There was a tendency by most HSDUs to ensure vertical accountability by reporting to the offices above, but not downwards accountability to the citizens.

### ***Citizen awareness of the Patients Charter***

In 2009, the MoH with support and collaboration from development partners and government developed a patient's charter with the intention of raising the standard of health care by empowering clients and patients to responsibly demand good quality health care from government facilities. In addition, the patients' charter was supposed to motivate the community to participate in the management of their health by promoting disease prevention and timely referral of patients to health facilities for immediate attention of their health problems and concerns (Ministry of Health October, 2009)

In most of the HSDU especially at lower levels, the management and HUMCs member did not know about the patient's Charter. Most of those who reported some knowledge of the charter did not have copies of the charter, though one Luweero district health official mentioned that "*the charter had just come in... we use the ethics code of conduct.*" Consequently, the rights and obligations of patients as stipulated in the charter were not prominently displayed at the HSDU in places accessible to the public. In some facilities researchers observed a set of patient's rights displayed that were developed by Uganda National Health Consumer Organisation (UNHCO), a civil society organization. However, the document displayed was in English and not translated into local languages for communities.

### 3.2.4 Transparency

According to Transparency International, transparency ensures that public officials, civil servants, managers, board members and businessmen act visibly and understandably, and report on their activities. And it means that the general public can hold their leaders to account. Transparency helps increase trust in the people and institutions.<sup>7</sup> Similarly, the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) explain transparency as 'decisions taken and their enforcement done in a manner that follows rules and regulations'. It also means that information is freely available, directly accessible to those who will be affected by such decisions and their enforcement, and provided in a form that is easily understandable to the public and the media. This definition includes openness of the decision-making and enforcement processes as well as access to and distribution of information (Weiss and Steiner 2006).

Access to information is key in fostering transparency. In Uganda, the right of access to information is guaranteed in the Uganda Constitution; Chapter 4 article 41(1) "*Every citizen has a right of access to information in the possession of the State or any other organ or agency of the State except where the release of the information is likely to prejudice the security or sovereignty of the State or interfere with the right to the privacy of any other person*". This is operationalized in the Access to Information Act 2005; PART II section 5 (1) "*Every citizen has right to access information and records in possession of the state or any public body, except where the release of the information is likely to prejudice the security or sovereignty of the state or interfere with the right of privacy of other person.*"

<sup>7</sup> Transparency International. [https://www.transparency.org/whoweare/organisation/faqs\\_on\\_corruption/2/#transparency](https://www.transparency.org/whoweare/organisation/faqs_on_corruption/2/#transparency)



Most citizens did not know that they have a right to information with regard to public expenditure at the HSDU. They did not seek information about public expenditure at the HSDU through verbal or written requests or in some other forms. Consequently, most communities talked to during FGDs were not aware of the financing of the health facilities. Indeed, the In-Charge of an HC IV in Kamuli District noted that, *"citizens have never requested budget information."* A sub-county official in Luweero district thought that *"people who go for health care are sick and stressed; they don't care about finances of the facility; they only need treatment."* However, it is also the case that the management of the HSDUs did not proactively provide or publish its information on public expenditure. Some of the political leaders we talked to noted that there is a lot of resistance from the technical staff to provide information.

### 3.2.5 Responsiveness

Responsiveness is the outcome that can be achieved when institutions and institutional relationships are designed in such a way that they are cognisant and respond appropriately to the universally legitimate expectations of individuals (De Silva and Valentine 2000). Thus, responsiveness encompasses the non-health enhancing, and non-financial aspects of the health system.

This study found that none of the HSDU visited were able to respond to the needs or legitimate expectations of citizens in a timely manner, mainly due to inadequate funding, low staffing, and low staff morale. All the HSDUs visited, especially at lower levels, complained of lack of funds and staff to effectively meet the increasing demand for health services due to rapid increase in the population. In Luweero, the In-Charge of an HC IV stated, that *"every month we have 150 mothers delivering at this facility, but we have only 4 mid-wives and 14 beds."* Similarly, at an HC III in Kamuli, the In-Charge said that *"...we only have one delivery bed, yet the facility is expected to deliver more than 2 mothers per day."* Moreover, most of the health facilities visited lacked effective emergence services such as ambulances. Most of them did not have an ambulance and those who had said that they had broken down and they lacked funds to repair them.



*Broken down ambulance at Kamuli hospital*

The quality of facilities (such as beds, wards, delivery beds) was poor and most of them were not fully functioning. A case in point was Nakandulo HC IV in Kamuli district where a Theatre that was constructed in 2002 was not functional. This was reported to be due to poor design by the contractors; the theatre was not conducive for operations. The situation was further worsened by the fact that government policy stipulates that funding and staffing should be based on level of health facility rather than the population served and demand. For instance, Luweero HC IV being on highway and in an urban centre, was receiving funding for HC IV yet, the services provided were that of a hospital.

The meagre funds available also negatively affect the incentive mechanism for the healthcare staff. For instance, the staff appraisals done annually seem not to necessarily influence promotion or salary increment. Thus, staff appraisal seemed not to be treated seriously. As explained by the In-Charge at an HC IV in Luweero, *“staff appraisals are done every year, but there is no good feedback on staff performance, so consequently, staffs don’t respond; even those who respond are not rewarded.”*

Most health facilities noted an improvement in the delivery of drugs by National Medical Stores (NMS). The In-Charges of HSDUs reported, however, that while

there was a reduction in drug stock-outs, the drugs supplied by NMS were not necessarily the ones needed. As one In-Charge stated, *"sometimes, our stores are full of drugs, but they are not relevant to the diseases most patients have."* An additional issue with drug stocks is that NMS is supposed to deliver the drugs during day time, but sometimes they would be delivered at night. This limited the ability of the In-charges to ensure that the right quantities would be delivered, and inhibited the ability of members of the HUMC to witness the delivery. As one Luweero In-Charge explained, *"...sometimes, the NMS people deliver drugs and medicines at night...and when you refuse to receive them they take them away and you miss on the supply that month."*

In the three districts, there were independent groups such as Social Services Performance Monitoring using Lot Quality Assurance Sampling (LQAS) (Management Sciences for Health (MSH) STAR-E LQAS 2013) and Uganda National Health Consumers' Organisation (UNHCO) that were conducting periodic health service delivery satisfaction surveys. The findings from these surveys were usually published. However, their recommendations were rarely acted upon by the district and HSDU in a timely manner.

### **3.2.6 Fairness and Equity**

Health systems promote equity when their design and management specifically consider the circumstances and needs of socially disadvantaged and marginalized populations, including women, the poor and groups who experience stigma and discrimination, enabling social action by these groups and the civil society organisations supporting them (Gilson et al. 2007). The National Health Policy promised to mobilise sufficient financial resources to fund the health sector programmes whilst ensuring equity, efficiency, transparency and accountability in resource allocation and utilisation.

#### ***Equity in access to care***

To ensure equity to access to health care, the HSDUs are supposed to have special programmes for the excluded groups of citizens and proactively provide information about the availability of these special programmes. They are also supposed to have appropriate mechanisms for excluded persons to raise concerns or register their grievances regarding lack of access to appropriate health services. However, findings from this study show that none of the HSDUs have special programmes for marginalised populations like people with disabilities (PWDs). Such people are treated like any other person. The health facilities did not have interpreters for people with hearing impairment nor did they have ramps for those with physical disabilities. As a result, most such people were not able to access health services easily. When speaking with health officials about this issue, researchers encountered both resistance and resignation. An official in Lowero, for example, implied that everything was fine, stating *"...at the health facility, everyone is served including the needy...there is no special programme for the*

socially disadvantaged and marginalized populations.” An In-Charge in Kamuli, however, acknowledged the problem but said that “...we only counsel them and explain to them the inadequacies...and refer them to higher health facilities.” Most of the special programmes for the excluded groups of citizens that did exist were being supported or implemented by NGOs and Donors, such as Sight Savers and Star East in Kamuli, but on a small scale and in an unsustainable manner.

**Fairness in financing of health care**

To ensure equity, HSDUs need to dedicate funding for special programmes for access to health services by excluded groups. However, none of the health facilities has any funding for programmes for access to health services by excluded groups. The amount of funds sent by the central government to the HSDU did not consider equity issues.

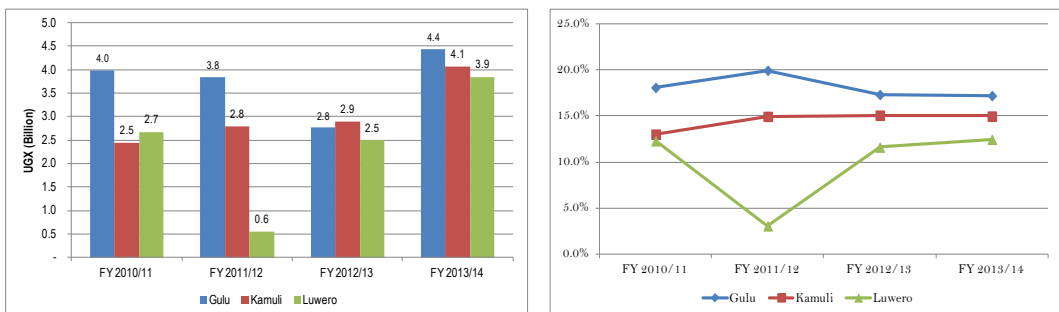
**3.2.7 Effectiveness and Efficiency**

The HSSIP III promises to improve the efficiency and effectiveness of resource management for service delivery in the sector. Therefore, the processes and institutions should produce results that meet population needs and influence health outcomes while making the best use of resources. However, the decentralisation of health services has been affected by capacity challenges which limit the effectiveness and efficiency of health service delivery. The capacity challenges specifically relate to human and financial inadequacies. Efficiency is currently not well addressed in the way resources are mobilized, allocated and used.

**Levels of Funding**

On average over the last four years (2010/11-2013/14), Gulu, Kamuli and Luweero district received about Shs 3.8 billion, Shs 3.1 billion, and Shs 2.4 billion respectively for the central government. This constituted about 18%, 15%, and 10% of the total central government transfers to Gulu, Kamuli and Luweero district respectively (see Figure 4).

**Figure 4: Trends in central government Health sector transfers to Gulu, Kamuli and Luweero district**



Since LGs largely depend on central government transfers, their budget allocation towards the health sectors mirrors the central government transfers. Based on the available information, on average over the last three FYs (2011/12-2013/14) Gulu, Kamuli and Luweero district allocate Shs 3.7 billion, Shs 4.1 billion, and Shs 2.7 billion respectively of their total budget towards health. This constituted about 17%, 16%, and 13% of the total district budget for Gulu, Kamuli and Luweero district respectively (see Table 8).

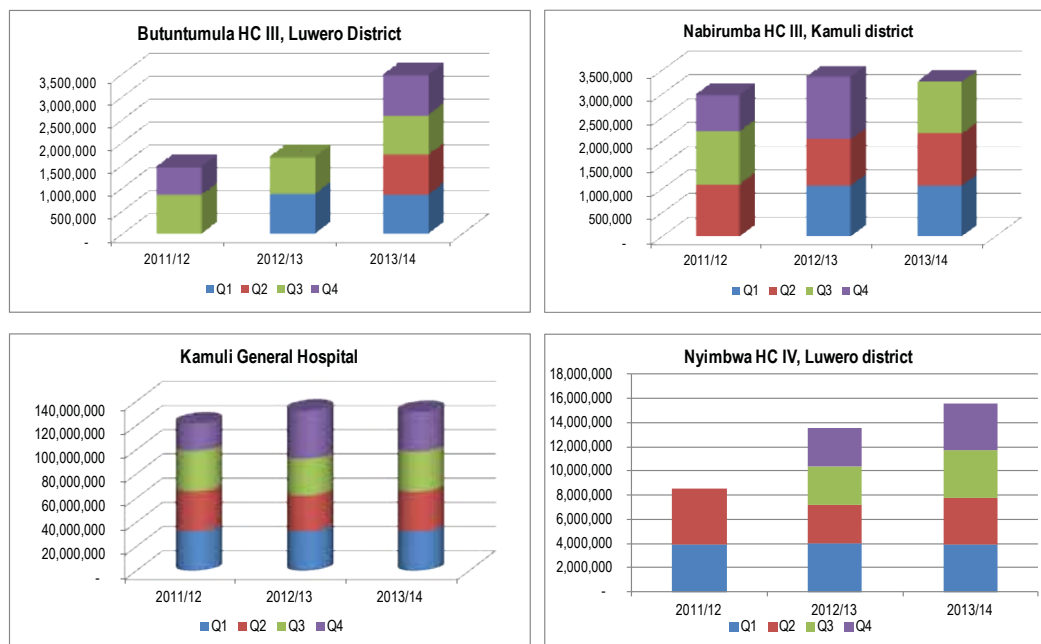
**Table 8: Trends in District Health sector budget allocations**

District		FY 2011/12	FY 2012/13	FY 2013/14
Gulu	Amount (Billion)	5.35	2.09	-
	Share	18.0%	13.5%	
Kamuli	Amount (Billion)	-	4.11	-
	Share		13.5%	
Luweero	Amount (Billion)	3.34	3.80	1.08
	Share	12.7%	12.8%	13.4%

Source: District Annual Budgets

It should be noted that the majority of the health sector budget is spent on Healthcare Management Services which includes salaries and wages and arrears instead of procurement of drugs, equipment, and other infrastructural costs; a situation observed to be a critical impediment to effective service delivery. Though the amount allocated to the health sector at district level is relatively high, the amount funds (non-wage- which meant to run the facility) allocated at health service delivery units (hospitals and health units) is alarmingly low. For instance, the study found that on average per quarter (three months) Kamuli hospital received Shs 32 million, HCIVs received Shs 3.0 million, and HCIIIs received Shs 0.8 million (see *Figure 5*). These funds are supposed to cater for general running of the facility, outreaches and immunization, fuel for ambulance, pay for utilities, support supervision of lower facilities, HUMC allowances, among others.

The impact of low funding is exemplified by this scenario. Mbulambuti HC III, in Kamuli district budgets for Shs 150,000 per month for electricity, but the monthly bill is Shs 200,000. By the time of the study, the electricity arrears had reached Shs 2.2 million, meaning that very soon electricity would have been disconnected.

**Figure 5: Trends in Health Units funding (non-wage)**

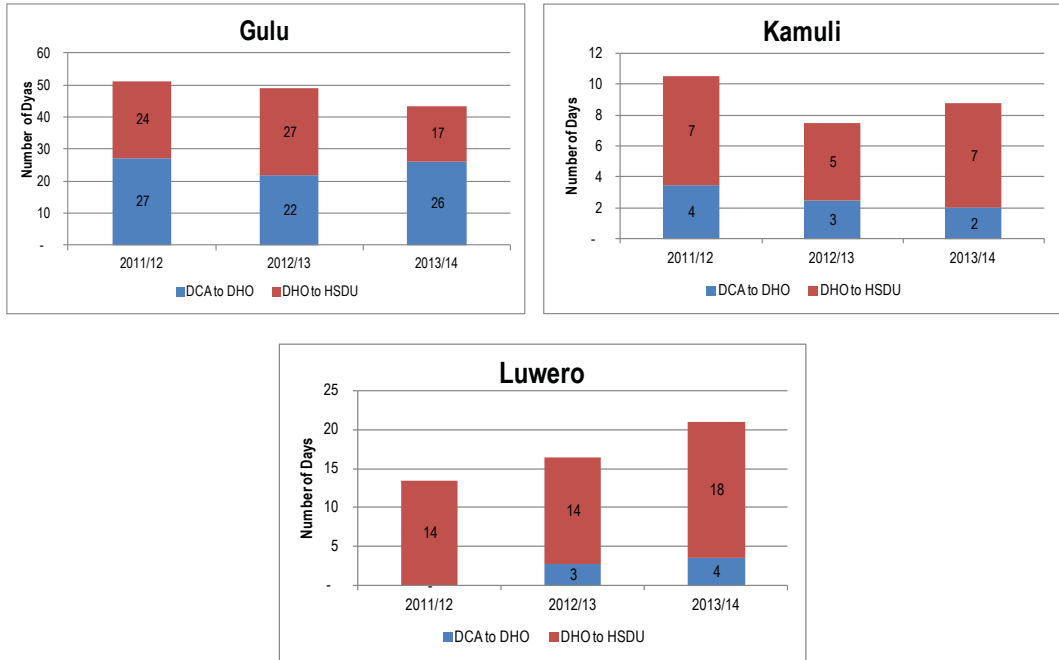
This level of funding is grossly inadequate to meet the increasing health care demands at frontline service delivery units. Due to low funding, health facilities are unable to provide effective health care services for citizens. The situation is worsened by inadequate staffing and high levels of staff absentees.

### ***Timeliness of Funds***

The district officials interviewed noted that there was a significant time lag between when the MoFPED announced the releases and when they get the funds. There are delays between the national treasury and commercial banks in terms of reconciliation of release schedules and amounts transferred to the bank account of the districts. For instance, the CFO has to pick the hard copies of release schedules from MoFPED in Kampala and s/he has to reconcile the release schedules and amounts transferred on the bank account, and this usually takes time. In some instance, the amounts received are not consistent with the releases schedule, which causes more delays, since the district has to then get clarification from MoFPED.

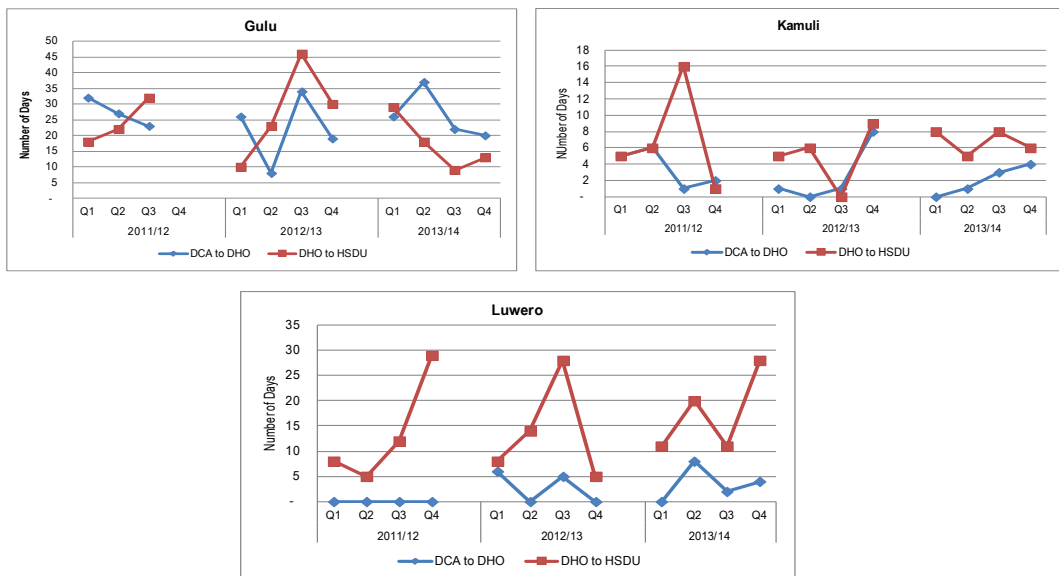
This study found that during the last three financial years (2011/12-2013/14) the average time it took for the funds to move from District Collection Account (DCA) to the health service delivery unit (HSDU) account, was 48 days in Gulu, 9 days in Kamuli, and 17 days in Luweero. The longest delay was between the DHO account and HSDU Account (see Figure 6). Such delays are caused by the DHOs office, who for one reason or other takes long to sanction transfer of funds to health units.

**Figure 6: Flow of funds (average number of days)**



The delays in release of funds to the front line service delivery units was mentioned by most respondents as one of the main challenges of effective service delivery. Many described funds not arriving until the end of the quarter. However, due to the recent reforms in public finance management such as publication in the media releases by MoFPED, there has been some reduction in the number of days it takes funds to reach the front line service delivery units, as illustrated in Figure 7.

**Figure 7: Flow of funds timing (number of days)**



### **Adequacy of human resources**

The health sector decentralized many responsibilities to the district level, particularly to the office of the District Health Officer (DHO). This has had implications for human resource planning and recruitment. The Ministry of Health has established staffing norms and services that should be in place at the district and lower levels so as to reach out to the communities and provide quality services. The three districts, still experience human resource gaps for implementation of priority health interventions, and are not allowed to recruit staff to fill those gaps due to the freeze on recruitment of staff by the central government.

As illustrated in Table 9, staff at most of the visited facilities indicated that they have not had all the positions filled in the last three years. Compounding the problem is that staff recruitment is not tagged to a particular health facility. Sometimes, staffs are hired at one facility but do not report to that facility, remaining instead at a different district or the health sub district. For instance, in Nakandulo HC IV in Kamuli district, a Senior Clinical Officer who was supposed to be posted there was actually working at the district. In Luweero, it was reported that sometimes staff transfers are done by the DHO without informing the In-charges of the affected health facilities. In some cases, staffs are transferred to health facilities without providing them facilities like housing. Since most health facilities don't have staff houses, some staff don't turn-up while others work on very few days. For instance, in Nakandulo HC IV in Kamuli district, the research team found that four staff that were posted to the facility had not reported for work.

**Table 9: Staffing levels**

District	HSDU	No of staff	Staffing levels	Comments
Luweero	Luweero HC IV		170%	
	Butuntumula HC III	11		
	Nyimbwa HC IV	53		
	Bowa HC III	16		
Kamuli	Kamuli Hospital		90%	TASO and CLAIM (SDS) support over 40 staff
	Nakandulo HC IV		65%	Staffing was worse (at 48%) before July 2013. Majority are one year old
	Mbulamuti HC III	18		High levels of staff absenteeism; over 28% of staff were absent on the day of the interview
	Nabilumba HC III	13		The in-charge did not know the recommended staffing level



District	HSDU	No of staff	Staffing levels	Comments
Gulu	Bobi HC III		60%	
	Gulu Regional ref Hospital		90%	
	Awach HC IV		80%	
	Chwero HC III		79%	
	Lalogi HC IV		95%	

Source: Interview with HSDUs

The challenge is that the power to recruit staff for the HSDU is vested in the District Service Commission, which exercise no control over the people it hires.. The HSDUs have no powers to recruit and fill the vacant staff positions. As the In-Charge of an HC III in Kamuli stated, *“they (staff) are pushed to me ...some are political.”* In Kamuli, with support from TASO and USAID, the district was able to recruit and retain medical doctors in Kamuli hospital. However, they face a challenge of sustainability when the donors pull out, since the district does not have funding.

### **Staff motivation and retention**

Low staff motivation and retention are among the critical challenges facing the health sector. None of the HSDU surveyed had structured incentives regimes or other staff motivation programmes to ensure retention of key technical staff at the unit. Some of the incentives reported were arrived at locally such as creating opportunities for professional development so that well performing healthcare workers get an opportunity to get an allowance once they go for those opportunities. Some facilities reported reserving opportunities for further studies to members of staff considered to be performing well as a way of motivating them. Others reported using innovative incentives such as end of year recognition and parties, and delegation of duties.

The HSDUs have limited powers to ensure discipline and attendance of its staff; consequently, most health facilities registered high staff absenteeism. Though the In-charges of HSDUs have power to ensure discipline, most reported this is not effective, since they did not recruit the staff and staff salary is paid directly to respective bank accounts of staff. Thus, ineffective implementation of sanctions for non-performance of staff is negatively affecting health service delivery. As one district health official in Kamuli stated, *“...we have a disciplinary committee; but systems are not working properly.”* Similarly, a sub-county official in Luweero lamented that *“Sanctions are not effective because they are not linked to remuneration and are poorly implemented.”* The systemic nature of the problem is reflected in the statement by an In-Charge at a HC III in Kamuli who said, *“...even when staff misbehaves, I fear to write a warning letter...some are too powerful; I only use verbal warning.”*

### 3.3 Summary of Findings

#### ***Strategic Vision***

- The health sector has a well-articulated long-term vision. However, this vision is not well understood at frontline service delivery levels.
- Health Unit Management Committees (HUMCs) and Hospital Management Committees (HMCs) exist in all health facilities visited, but most of them are not functioning effectively as expected due to ignorance about their roles and lack of facilitation of their work. In addition, the roles and responsibilities of these committees are not well understood by the community.
- Funding of HSDUs is alarmingly low and most facilities are unable to effectively provide expected services to the community. Financing is not adequate to cover the costs of health service delivery. Financing of the health services is not in tandem with the population growth. Most facilities don't even get the little funds in time. This is due to delays by the DHO to disburse funds to their accounts.

#### ***Participation and consensus orientation***

- Participation in decision-making processes. Citizen involvement in decision-making process at the HSDU was found to be very minimal.
- Participation in the budgeting process. In theory, the budgeting process is supposed to be a bottom-up approach starting from the health facility; however, the study found that citizens are not involved in budgeting for the health facility.

#### ***Accountability***

- Accountability of the HUMC / HMCs to citizens. Although these committees generally represent the community at the health facility level, the study most found that they are not accountable to the community. In most cases, most community members don't even know them.
- Accountability of elected political leaders to citizens. Elected political leaders are supposed to account to the community especially on health service delivery. To a great extent they try to inform and take on issues raised by citizens to higher authorities. However, there is minimal response from the concerned higher authorities.
- Accountability of funds. Accountability of funds is among the teething challenges in health service delivery. Since HSDUs depend largely on central government transfers, they only account to government; however, most of them don't publically display their accountabilities on notice boards.

- Citizens' awareness of the patients' charter. In all health facilities visited, the patients' charter was not available, thus citizens were not aware of the patients' charter.

### ***Transparency***

- Access to information by communities is critical in enhancing accountability in the health service delivery. The study found that very minimal information is provided to the citizens and when it's done, it's mainly put on notice boards at the facilities. However, most people don't utilise the information partly to due high illiteracy levels.

### ***Responsiveness***

- All the HSDU visited were not able to respond to the needs or legitimate expectations of citizens in a timely manner. This is mainly due to inadequate funding, low staffing, and low staff morale. In most HSDUs, the quality of facilities is poor and most health facilities are not fully functioning.

### ***Fairness and Equity***

- Equity in access to care. To ensure equity to access to health care, the HSDUs are supposed to have special programmes for the excluded groups of citizens, however, all the health facilities visited did not have such programmes.
- Fairness in financing of health care. None of the health facility visited had any funding for programmes for access to health services by excluded groups. The amount of funds sent by the central government to the HSDUs did not consider equity issues.

### ***Effectiveness and Efficiency***

- Quality of human resource. Most of the visited facility indicated that they had not had all the positions filled in the last three years. They lacked critical staff such as specialist and doctors. Staffing is hampered by favouritism in recruitment and posting. There are challenges in staff recruitment and transfers due to wage bill ceiling. In addition, staffing is based on level of health facility rather than output (population covered and disease burden).
- Staff motivation and retention. In all health facilities visited, there was low staff motivation. Absenteeism and late coming was high partly due to poor supervision (especially by the DHO's office), and lack of staff accommodation.

In conclusion, apart from strategic vision, the health sector is not doing well on all the other governance aspects of Accountability, Transparency, Participation, Responsiveness, Fairness and Equity. There are challenges in funding and accountability which also impact of on meaningful participation. This is affecting the effectiveness and efficiency in the delivery of health services.

# CHAPTER 4:

## CONCLUSIONS AND RECOMMENDATIONS

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### 4.1 Conclusions

This study assessed public expenditure governance within the health sector and how it affects performance of the health sector in Uganda. Specifically, it examined the governance principles that would influence service delivery in the sector. Using a conceptual and analytical framework for assessing Public Expenditure Governance, the study compiled the governance indicators and assessed the performance of the health sector at local government and health service delivery unit levels.

The PEG assessment framework, defined in terms of inputs, processes and outcomes, was used to examine the legal and policy frameworks in the health sector. Participation and strategic vision are the key assessment principles associated with the input side of PEG. The study focused on the assessment areas of accountability and transparency, both of which are essential if processes are to lead to the desired outcomes. Finally, on the outcomes, the PEG assessment focused on three issues: equity, efficiency and effectiveness.

Among the key findings on governance inputs were the existence of robust legal and institutional framework that is supposed to govern relationships among different actors within the health sector. Among these include the 1996 Constitution of the Republic of Uganda and the National Health Policy. The health sector vision is well articulated at national levels; however, very little understanding of the vision was visible at local levels. The HUMCs and HMCs exist in all health facilities visited, but most of them are not functioning effectively as expected due to ignorance of their roles and lack of facilitation of their work. In addition, the roles and responsibilities of these committees are not well understood by the community.

Financial and other resources form important inputs into the system. However, it is important to note that the level of funding and the staffing in the sector low. Besides funding being low, timely disbursement of these funds is still a challenge. In addition, the involvement of the HUMCs in the management of funds is very weak and in some cases not happening.

Another important finding that has a direct bearing on outcomes and future interventions relate to significant human resource constraints at the health service delivery units. Most of the visited facility indicated that they had not had all the positions filled in the last three years. They lacked critical staff such as specialist and doctors. There are challenges in staff recruitment and transfers due to wage bill ceiling. Staffing is hampered by favouritism in recruitment and posting.

The research found that the health sector cannot respond to the needs or legitimate expectations of citizens in a timely manner. This mainly because, the sector is

constrained in terms of funding, staffing, working conditions, logistical support which makes the service providers ineffective in fulfilling their mandates.

These findings point to a range of recommendations and policy options for future interventions to improve health outcomes.

## 4.2 Recommendations

The following recommendations flow from the findings and conclusions of this study of public expenditure governance in the health sector. The recommendations are geared at policy makers at central government, local government and health service delivery units.

- a. Government needs to urgently come up with a comprehensive strategy to recruit more health workers, offer them appropriate remuneration and accommodation and refresher training. Increasing the number of health workers and outreach programmes especially at local levels will extend health services closer to the poor people who need them most, thus improving their conditions.
- b. Besides being meager, funding for health facilities are conditional in nature and limits the flexibility of managers in the utilisation of these funds. Therefore, Government should provide adequate and flexible funding to health facilities to enable them meet the increasing burden of health care.
- c. Efficiency of the health institutions could be improved by strengthening the local government capacity through particularly increasing the professional staffing levels at the district level
- d. Ensuring the lower health facilities (HC II and IIIs) functioning effectively in order to reduce the burden on HC IVs and hospitals. They need to be adequately staffed and equipped with the required equipment and infrastructure.
- e. The research found that most of the in-charges of the lower health units did not have management skills and thus, were unable to effectively manage the health units. This calls for building their capacity to effectively manage health facilities.
- f. Recruitment of the health staff is vested in the District Service Commission; however, some in-charges of health facilities complained that some staff are not recruited on merit and when they are posted to health centres they don't turn-up. Therefore, District Service Commission should ensure that all staff are recruited on merit.
- g. Staffing of health facilities is based on level of health facility rather than output (population covered and disease burden). In most cases, the health staff are over-burdened and are unable to effectively deliver services. Government should ensure that staffing of health facilities is based on output delivered by the health facility.

- h. Most of the community members talked to during the research complained that most health staff are crude and lack customer care. This sometimes discourages people from utilizing government health facilities. Therefore, the Ministry of Health should ensure that all health workers are trained in customer (patient's) care. They also need to be oriented on the patients' charter.
- i. The research found that staff performance is not linked with remuneration (salary). Salaries of health workers are directly sent to their accounts; whether a staff works or not. This makes it hard for the administrators to punish poor performers but withholding their salaries. Since the pay roll has been decentralized, the CAO and DHO should ensure that remuneration of staff is linked to performance.
- j. Although all the health facilities visited had HUMCs, however, most of them were not oriented on their roles and did even have a copy of the guidelines on their work. Therefore, most of them were not performing their roles as expected. Thus, Government should ensure that all HUMCs are oriented and their guidelines are fully disseminated to all HUMCs.
- k. Access to information by communities is critical in enhancing accountability in the health service delivery. When people are informed on their health rights, funding and utilisation of the fund, they are able to hold the health providers accountable. The study found that very minimal information is provided to the citizens and when it's done, it's mainly put on notice boards at the facilities. However, most people don't utilize the information partly due to high literacy levels. Therefore, the health providers need to devise other mechanisms for disseminating information such as use of radios.
- l. The MoH developed a patient's charter; however, the charter has not been fully disseminated at health facilities. None of the health facilities had a copy of the patient's charter. Therefore, the MoH needs to ensure that the patient's charters is translated in local languages and massively disseminated to all health facilities in Uganda.
- m. Since government abolished cost-sharing health facilities in Uganda cannot respond to the legitimate needs of the citizens. Government needs to expedite the health insurance scheme or promote Community Health Insurance (CHI) such as Rwanda's Mutuelles<sup>8</sup>. CHI are run on a not for profit basis, targeting informal sector and applying the basic principles of risk-sharing and members' participation in management.
- n. Village Health Teams (VHTs) are critical in increasing health awareness and promoting community participation in health care delivery and utilisation of health services. However, in most health facilities visited the VHTs were not very effective partly due to lack of facilitation. Thus, government needs to strengthen the VHTs through improving on their facilitation.

<sup>8</sup> Mutuelles is a community-based health insurance program, established since 1999 by the Government of Rwanda as a key component of the national health strategy on providing universal health care.

## Bibliography

- Baez-Camargo, C. and Jacobs, E. (2008), 'A Framework to Assess Governance of Health Systems in Low Income Countries', (Working Paper No. 11: Basel Institute on Governance).
- Bogere, G., & Makaaru, A. J. (2014): 'Assessing Public Expenditure Governance in Uganda: A Conceptual and Analytical Framework. A paper presented at the Annual South African Association of Public Administration and Management Conference, March 26 – 28, 2014, Mokopane (Limpopo Province) South Africa.
- Bold, T., et al. (February, 2011), 'Service Delivery Indicators: Pilot in Education and Health Care in Africa', (African Economic Research Consortium (AERC) in Nairobi, the World Bank and the William and Flora Hewlett Foundation).
- Bruni, R. A., Laupacis, A., and Martin, D. K. (2008), 'Public engagement in setting priorities in health care', *Cmaj*, 1 (15-18).
- Commonwealth Foundation (2005), 'Citizens' Education for Good Governance: Citizen's Education Action Learning Guide', (Marlborough House, Pall Mall, London UK).
- De Silva, A. and Valentine, N. (2000), 'Measuring responsiveness: results of a key informants survey in 35 countries', (Geneva, World Health Organization, (Global Programme on Evidence for Health Policy Discussion Paper No. 21)).
- Dehn, J., Reinikka, R., and Svensson, J. (2003), 'Survey Tools for Assessing Performance in Service Delivery'. <<http://www1.worldbank.org/publicsector/pe/PEAMCourse04/RitvaBackground1.pdf> (accessed 10 September 2014)>.
- Emanuel, E. J. and Emanuel, L. L. (1996), 'What Is Accountability in Health Care?', *Annals of Internal Medicine*, 124 (2), 229-39.
- Gilson, L., et al. (2007), 'Challenging Inequity through Health Systems: . Final Report', (World Health Organization (WHO) Commission on the Social Determinants of Health).
- Green, E. (2008), 'District Creation and Decentralization in Uganda', (Working Paper No. 24: Crisis States Research Centre: Development Studies Institute, London School of Economics).
- Hutchinson, P., Habte, D., and Mulusa, M. (1999), 'Health care in Uganda: selected issues', *World Bank Publication Discussion Paper*, 404 (13).

- Kipp, W., et al. (1999), 'Cost sharing In Kabarole District, Western Uganda: communities' and health professionals perceptions about health financing', *Journal of Health and Population in Developing Countries*, (2), 30–38.
- Kirigia, J. M. and Kirigia, D. G. (2011), 'The essence of governance in health development', *International Archives of Medicine*, 4 (11), 2-13.
- Management Sciences for Health (MSH) STAR-E LQAS (2013), 'Social Service Performance Monitoring Using Lot Quality Assurance Sampling (LQAS) Methodology. Report of Indicators tracked in 66 districts of Uganda', (Management Sciences for Health (MSH), STAR-E project and USAID).
- Ministry of Finance Planning and Economic Development (2007), 'Public Service Delivery in Uganda: Abetting or Containing Inequality?', (Discussion Paper 13).
- (September, 2010), 'Millennium Development Goals Report for Uganda: Accelerating progress towards improving maternal health', (Republic of Uganda).
- Ministry of Health, Health Systems 20/20, and Makerere University School of Public Health (April, 2012), 'Uganda Health System Assessment 2011', (Kampala, Uganda and Bethesda, MD: Abt Associates Inc).
- Ministry of Local Government (2007), 'Annual Assessment of Minimum Conditions and Performance Measures for Local Governments, 2006', (Republic of Uganda).
- Ministry of Health (2003), 'Guidelines on Health Management Committees for Health Centre III', (Republic of Uganda).
- (2006). Service Availability Mapping (SAM). Collaboration between MoH, Republic of Uganda and World Health Organization
- (2009), 'Final Report of Essential Medicines and Health Supplies Tracking Study', (Republic of Uganda).
- (October, 2009), 'Patients' Charter', (Department of Quality Assurance, Ministry of Health, Republic of Uganda).
- (2009), 'Final Report of Essential Medicines and Health Supplies Tracking Study', (Republic of Uganda).
- (October, 2009), 'Patients' Charter', (Department of Quality Assurance, Ministry of Health, Republic of Uganda).
- (July, 2010), 'Health Sector Strategic & Investment Plan: Promoting People's Health to Enhance Socio-economic Development 2010/11 – 2014/15', (Republic of Uganda).



- Okuonzi, S. A. and Macrae, J. (1995), 'Whose policy anyway? International and National Policies on Health policy Development in Uganda', *Health Policy & Planning*, (10), 122–32.
- Okwero, P., et al. (2010), 'Fiscal space for health in Uganda', *Fiscal space for health in Uganda. World Bank Working Paper, 186* (Africa human development series. Washington, DC: World Bank. <http://documents.worldbank.org/curated/en/2010/03/11994326/fiscal-space-health-uganda>).
- Siddi, S., et al. (2009), 'Framework for assessing governance of the health system in developing countries: gateway to good governance', *Health Policy*, (90), 13-25.
- Travis, P., et al. (2002), 'Towards better stewardship: concepts and critical issues', (World Health Organisation: Evidence and Information for Policy, <http://www.who.int/healthinfo/paper48.pdf> (accessed October 20 2014)).
- Uganda Bureau of Statistics and MEASURE DHS (March, 2012), 'Uganda Demographic and Health Survey 2011', (Uganda Bureau of Statistics, Kampala, Uganda and ICF International, Calverton, Maryland, USA ).
- United Nations Convention to Combat Desertification (UNCCD) (2007), 'Budget processes and financing instruments in Uganda: Towards increased financing for the implementation of the United Nations Convention to Combat Desertification', (The Global Mechanism of the UNCCD).
- United Nations Development Programme (2007), 'Decentralised Governance Programme: Strengthening Capacity for People-Centred Development Management Development and Governance Division', (Bureau for Development Policy United Nations Development Programme. <http://www.pogar.org/publications/other/undp/decentralization/decenpro97e.pdf>. (accessed 10 September 2014)).
- United States Agency for International Development (200), Health Systems Assessment Approach: A How-To Manual. [http://www.healthsystemassessment.com/wp-content/uploads/2015/03/Health-Systems-Assessment-Approach-How-To-Manual\\_Brief.pdf](http://www.healthsystemassessment.com/wp-content/uploads/2015/03/Health-Systems-Assessment-Approach-How-To-Manual_Brief.pdf) (accessed on 17 June 2015)
- Weiss, F. and Steiner, S. (2006), 'Transparency as an Element of Good Governance in the Practice of the EU and the WTO: Overview and Comparison', *Fordham International Law Journal*, 30 (5), 1545-86.
- Wiseman, V., et al. (2003), 'Involving the general public in priority setting: experiences from Australia', *Soc Sci Med*, 56 (5), 1001-12.

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ISBN 978 9970 34 04 15



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