ANTI CORRUPTION COALITION UGANDA
(ACCU)

Health Sector Policy Audit:

Implementing Policy in ways that Reduce Tendencies of Corruption

April 2016

With support from DGF Democratic Governance Facility

The Anti-Corruption Coalition Uganda (ACCU) was formed in January 1999 and formally registered as an NGO under the NGO Statute in 2003. The organization brings together like-minded entities and individual actors whose preoccupation is publicizing, exposing and advocating for curbing corruption in Uganda. ACCU provides a forum through which these actors can enhance their capacities in the fight against corruption as one strong voice and force that can effectively engage government on issues of corruption. The organizations' mission is to: *"Empower people to actively and sustainably demand for transparency and accountability from public and private sector"* and her vision is attaining a, *"Transparent and corruption free society".*

Acronyms and Abbreviations

ACCU	-	Anti-Corruption Coalition of Uganda
AMC	-	Average Monthly Consumption
BFPs	-	Budget Framework Papers
CSOs	-	Civil Society Organizations
DDPs	-	District Development Plans
FY	-	Financial Year
GDP	-	Gross Domestic Product
GoU	-	Government of Uganda
HC	-	Health Center
HMIS	-	Health Management Information System
HSSP	-	Health Sector Strategic Plan
IFMIS	-	Integrated Financial Management System
IGG	-	Inspector General of Government
IPFs	-	Indicate Planning Figures
LGs	-	Local Governments
MoLG	-	Ministry of Local Government
MoU	-	Memorandum of Understanding
NCD	-	Non Communicable Diseases
NDA	-	National Drug Authority
NMS	-	National Medical Stores
OAG	-	Office of the Auditor General
PFM	-	Public Finance Management
PHC	-	Primary Health Care
UDN	-	Uganda Debt Network
UGX	-	Uganda Shillings
UNBS	-	Uganda National Bureau of Standards
URA	-	Uganda Revenue Authority

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1. Background and Rationale

1.1 Why Conduct a Health Policy Audit?

CItizens uphold their right to services, pay taxes and observe the rule of law. In return they expect their Government to respond with a level of service provision that elevates their lives in ways that unleashes their productive potential and engagement in their own development and that of their society. Public policies are therefore designed to ensure that this expectation is met. Policies provide a regulatory framework and guidance of the overall direction that will bring about the desired delivery of services. Such is the case with Uganda's Health Policy (2010-2020). The policy's mission *is to provide the highest possible level of health services to all people in Uganda through delivery of preventive, curative, palliative and rehabilitative health services at all levels'.* There are other policies in the health sector designed to contribute realization of this mission.

> *However, Government will not deliver on this promise unless the current levels of mismanagement of public resources is addressed. It was therefore imperative that this study was done to look critically at how the health policy is being implemented so that a diagnosis is made on the causes of resources mismanagement and guide elaboration of respective solutions.*

This report is critical analysis of the fundamental cause of the persistent tendencies of corruption and resource mismanagement in health sector. This report identifies of policy implementation and enforcement gaps that have fundamentally precipitated corruption in the health sector in Uganda and provides a consensus from stakeholders on recommendations to address them.

1.2 Definition

A policy audit is an examination and evaluation of the adequacy and effectiveness of the sector's system of delivery on its mandate, regulations as well as the quality of performance in carrying out assigned responsibilities that are geared towards realizing its policy goals or strategic direction.

1.3 Methodology

1.2.1 Scope

The audit has looked at four main areas of policy audit: reliability; integrity of performance; compliance to internal controls and external audits as well as regulations, plans, procedures; safeguard of assets and efficient use of resources. In each of these the focus was on effectiveness in execution of mandate and statutory responsibilities in ways that do not compromise performance.

1.2.2 The Process

This policy audit has been mainly a desk review of sector performance and review reports validated by interviews with key players in the health sector. This report has been summarized into a policy brief to the Ministry of Health with recommendations to tackle gaps identified.

2. Policy Issues Identified to Address Resource Mismanagement and Corruption Tendencies

Issue 1 Government Financing of Private Not-For-Profit Hospitals that Provide Private Care Services

PRIVATE Not-for-Profit health centres are historically critical to health care service provision. Most of these PNFP centres are faith-based and others are supported externally by national and international agencies and organizations. From the 1960s toward 1980s it became economically difficult for most PNFP units to provide universally free health services. Recognizing the complimentary role played by PNFP service providers, Government has since 1980s supported PNFP hospitals with wage subventions, non-wage recurrent expenditure and a range of medical supplies. Since mid-1980s these PNFP hospitals have provided private services for specialised care where a fee is charged on admission.

Government allocation to PNFP is 7% of the total health sector budget. PNFP institutions provide 25-35% of the sector outputs and the net contribution of PNFP units' expenditure is 20% of all reporting. For instance, between 2010 and 2015, PNFP units have conducted 33-38% of all recorded deliveries. **(Regulatory Impact Assessment for National Health Policy 2010-2020).**

Uganda demographic health survey of 2011 showed that most rural households predominantly use government hospitals while urban and wealthier ones use private hospitals and 'private wings of PNFP facilities. Cutting health spending to district health centres (as has been the case between 2011 and 2014) while maintaining subsidies to PNFPs is viewed by most stakeholders who reported to this audit as 'not pro-poor' and disproportionately advantages the private sector that is already charging high fees and drug prices – due to the high quality of service they also provide.

> *"Since the PNFP receive public funds, the public expects them to be able to undergo a full audit of the funds they receive annually from Government but also to what use they put the private earning they annual receive privately since they are beneficiaries of tax-payers' money".*

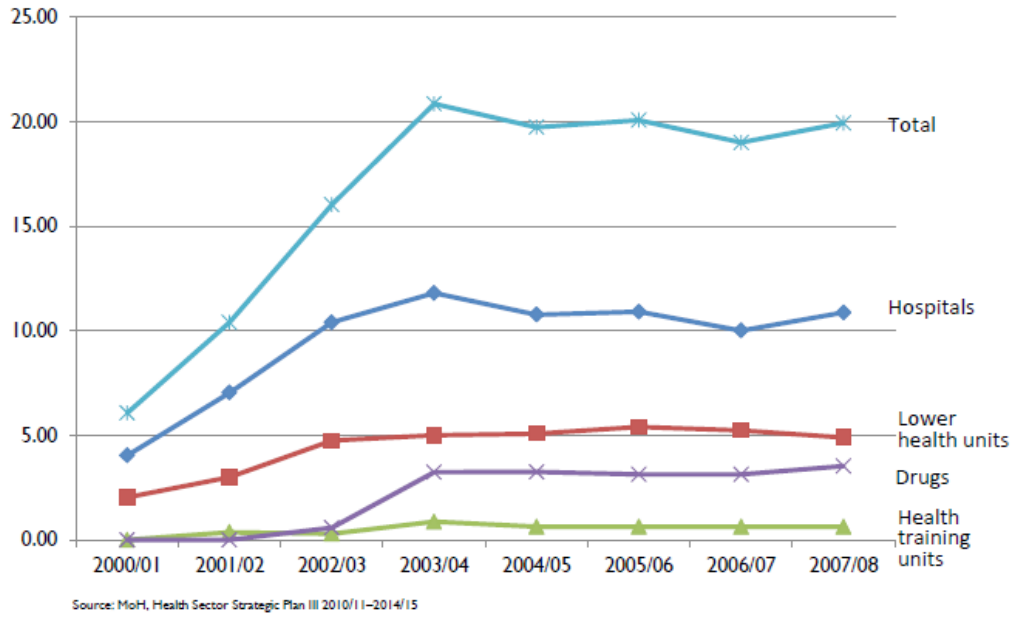


Figure 1: *% Spending on PNFP by Government*

In the private sector, payment of services by households is mainly on a fee-for-service basis. The fee-for-service payment mechanism has contributed to the problem of cost escalation in Uganda, and may partly explains the increasing OOP payments in Uganda, especially considering that PNFPs and PFPs are left to individually determine the service fee rates. It is important to note that apart from the fiduciary management arrangements within the public sector, Uganda has not developed institutional capacity for purchasing and regulation of pricing of services in the private sector. Relatedly, the quality of health care services purchased from the private sector providers remains unmeasured and not documented.

As seen from the graph above, from 2003, PNFP spending has included up to 20% of allocation from government with more than half going to large PNFP entities (mainly Nsambya, Rubaga, Lacor and Mengo. Other spending is to lower units that are public and not for profit, direct subsidy or purchase of drugs and support to institutions that provide training for nursing assistants and midwifery. Whereas government for instance provided subsidies to the PNFP entities amounting to 69.3 billion (7% of the national budget) in FY 2014/15, little is recorded on how much these institutions received as revenue from their private wings. While the National Health Policy calls upon Government to formalize commitments with the PNFPs through memoranda of understanding (MoUs) and service level agreements – this has not yet been done. There is concern that government is unable to recoup from its investment. The tax payer is subsiding a structure that is receiving private incomes and yet registered as a Private Not for Profit entity.

> *Government in the coming policy should clarify the incentive policy framework for PNFPs to bring clarity to the levels of investment needed to expand service provision using resources that PNFPs receive annually from Government.*

In this regard, the report makes the following conclusions:

a) While Government should maintain support to PNFP hospitals mainly the big four: Nsambya, Rubaga, Lacor and Mengo, they must be mandated to fully disclose the volume received as revenue from private wings and their plans to government on expenditure assignments for this revenue.

b) That PNFP health units disclose in entirety their source of income and balance sheets quarterly for public information and fiscal transparency and not just the funds received from government but privately as well;

c) Government places ceilings for service functions in an attempt to protect citizens from extortion and medical bills higher than average public service cost;

d) Government should provide updates on services provided by all hospitals so that specialised care sources are known below which admission is controlled or referred to lower level health centres (ANC visits and immunization for instance can be restricted to lower level units).

e) Corporate firms that are providing public health services as social corporate responsibility must undergo same rules as above.

f) There are proposals under the new health financing strategy 2016 that government institutes a Results Based Financing (RBF) Unit: The expectation is that this should build a framework of how Government will work with other relevant structures to develop standards for service provision and be involved in accreditation of providers from whom services will be purchased.

Below is an illustration of the overall sector ownership of health facility per category with PNFPs alone providing 17% by 2012 – a proportion expected to have risen by 2016. However, it is important to note that not all PNFP entities receive national budget support.

Table 1: Facility Ownership in Uganda (By Level of Care)

Level	Ownership				Percentage (Level)
	Public	***PNFP/ NGO***	***PFP***	***Total***	
Hospital	63	64	20	**147**	3%
Health Centre IV	170	15	8	**193**	4%
Health Centre III	916	264	70	**1,250**	24%
Health Centre II	1,695	520	1,395	**3,610**	69%
Total	2,844	863	1,493	**5,200**	100%
Percentage (Ownership)	55%	17%	29%	**100%**	

Source: Health Facility Inventory 2012

Issue 2 Inacuracies in Disease Burden Data at District Level

Poor follow-up systems and low level of facilitation for data management at the district level has in most cases caused complacency in records keeping. While the Health Management Information System (HMIS) has ensured that data is routinely collected at health centres and analyzed to draft commodities, drugs and equipment lists, gaps in the quality assurance of this data remain. There is need for more rigor on arrival predictor indices and data from a disease burden perspective (supported by a Disease Early Warning System) to work along the Average Monthly Consumption (AMC). AMC alone as an indicator alone is weak in reporting on drugs needed to especially for areas that face emergencies due to droughts and floods (mainly eastern Uganda). **What was consumed this month may not necessary predict drug requirements for the next month.** Uganda has over the last two decades seen a rise in the prevalence of non-communicable diseases (NCDs) now constituting about 25% of the total disease burden. Because of limited resources and capacity to record patient data at HCs with NCDs, and an overall weak surveillance system, information available is very uncertain and limited. A further challenge is while National Medical Stores (NMS) has improved in maintaining proper procurement plans in accordance with the stock replenishment policy, update of this data relies on the work of stock managers at various districts (some who are not doing their work as expected according to NMS data office. NMS is forced to use unreliable AMC system which some districts do not even/comprehensively comply with.

According to Health Public Expenditure Tracing Survey Report (2014), up to 13 districts (Kapchorwa, Kalangala, Yumbe, Kampala, Isingiro, Kabale, Mubende, Lira, Namayingo, Buliisa, Kyenjojo, Apac, and Abim) continued to receive drugs and other supplies way above their estimated 'pull' requirement due to limited rigor in analysis at the facility level of specific required supplies. For instance, **the only Emergency Obstetric care assessment report available is for 2004 and deliveries to support EmONC has been mainly on estimates**. This is why items like resuscitation kits for children are in short supply in most health facilities.

The Ministry of Health is supporting efforts for quality assurance within HMIS to ensure that data inaccuracies are minimized. On the budget side, work is on-going to update: population size, fixed allocations to health sub-districts, poverty and mortality rates, hard-to-reach areas to cover additional costs and population per health facility at different levels since some health units serve more than one district. General hospitals have a stand-alone allocation criteria and that for allocation to health sub-districts. All this will ease the issues of equity and data inaccuracies.

Issue 3 Institutional Structure Overlaps that Compromise Oversight

As stated in Uganda's decentralization framework, the role of the Ministry of Health is policy formulation, standard setting and quality assurance, capacity development, technical support; provision of nationally coordinated services such as epidemic control, monitoring and evaluation of overall sector performance, and resource mobilization (MoLG, 1993). It is at structures below the ministry where the situation is problematic. The complex and in some cases intertwined structure and related regulatory framework has created overlaps that compromise oversight in some cases:

i. Decentralization put in place a bottom up-approach where plans come from the bottom. However, at the top they face competition for resources and what is budgeted for is only what can be implemented leaving performance gaps due not matching local needs with available investments (for instance, a health unit may need fuel for a generator more than drugs);

ii. District Service Commissions often prefer to fill positions that require expert knowledge from natives of the respective district which is constraining to service delivery compared to if it was open to any Ugandan national.

iii. Salaries need to match effort. Some HC IIIs that conduct hundreds of deliveries get much lower than HCIVs that conduct same or less number deliveries in the same district.

The Ministry of Water and Environment and Ministry of Health continue to share roles on sanitation but at the district and sub-district level clarity and distinction of roles remains grey. Same is the case on the distinction between roles of NDA and UNBS on medicines and medical equipment quality assurance, or whether Uganda should continue to maintain both the Uganda AIDS Control Program and the Uganda AIDS Commission. To avoid conflict of interest, this report calls upon government to put oversight, inspection and recruitment under their respective key institutions and some proposals have been put down below:

i. All public servants that occupy positions under appointment should not service on Management Boards they oversee;

ii. The Health Service Commission should take over the role of recruitment of health service staff from the Public Service Commission and District Service Commission;

iii. Under the decentralization of the payroll system by the Ministry of Finance, all payments on the straight through system should be pre-approved by the Ministry and finally approved by the Health Service Commission before payment is made.

Issue 4

Gaps in Regulation of Procurement, Disposal and O&M of Infrastructure Stock

THERE is a clear and elaborate procedure under the policy and regulatory framework on procurement of human resources for health as well as medicines, equipment and supplies. The concern however is that Government has concentrated more on provision of new investments, setting up of new facilities and less on repair and maintenance of existing stock.

> *Most stakeholders appreciate that NMS has gone a long way in improving efficiency through bulk purchase and distribution to health facilities. It also suffices to note that the stocks out levels have reduced. However, the challenge remains on construction of health units, procurement of equipment and ambulances.*

Unfortunately, most public officials continue to misuse public resources especially vehicles and ambulances for private gain contributing to their depletion, wear and tear. Most do so aware that they will gain from their disposal where they are bought off during very confined and 'secretive' and rushed auction processes. The report condemns use of ambulances to carry goods and use of public vehicles since their repair is a burden of the tax payer. At the same time the report calls upon government to increase allocation towards the following key items:

i. Allocating more funds for routine maintenance of health facility equipment, buildings and vehicles.

ii. Repair of equipment especially hospital bed, water pumps and pipes and other clinical equipment;

> *Government Standing Orders should be upheld. Where a vehicle is used outside office hours, the duty bearer must report in writing the specified time and circumstances. Under no circumstances shall public vehicles transport unauthorized persons and goods.*

Disposal of Drugs and other commodities

The MoH has guidelines that show the procedures that govern disposal of equipment and drugs. For instance, drugs that are six months before the end of the shelf-life cannot be supplied to health facilities. There are still drugs that are still being supplied without regard to buffer stock levels; as such, certain drugs are in excess of the one year's requirement while others are under-stocked. There were huge stocks of expired drugs within districts. (Health Sector Annual Sector Performance Report 2013). According to the OAG report 2015, Section 1.8 of the World Health Guidelines for the Safe Disposal of

Unwanted Pharmaceuticals in and after Emergencies Interagency 1999 outlines the consequences of improper disposal or non-disposal of expired pharmaceuticals. However, inspection of Muyembe Health Centre IV revealed that the Health Centre had expired TB drugs estimate at 500 kilograms. The expired drugs may be diverted for resale to the general public. The drugs were also not properly stored as can be shown by the photograph below.

In this particular case, a Non-Governmental Organization (NGO) called GREEN LABLE had been contracted by Ministry of Health and USAID to collect and destroy expired items but the operations stopped in 2014. NMS had been informed and the district had budgeted for an incinerator. The OAG advised the Accounting Officer to liaise with Ministry of Health and National Medical Stores (NMS) and have the expired drugs disposed-off and more done to ensure incinerators are built at all district levels.

Poor Procurement and Contract Management

Contract management has been a challenge not just for the health sector but across government mainly because there are few service providers that deliver high quality works at the cost government resources can procure. With this reality a lot of shoddy work takes place. Connivance between contractors and procurement officials is rife. Photos like one at the bottom of this page show challenge and outcomes of such a process.

Figure 2: *Roof that crushed at a Health Center in Katakwi due to irregularities in procurement*

Figure 3: Photos showing low level of functionality of health units

Butangasi HC II, in Busia district

Kubo HC II, in Busia district

Inadequate beds in Kawolo hospital in Buikwe showing two patients on one bed

Mugasiya HC II in Busia district

Government needs to address the issue of functionality of the current health facilities before embarking on construction of new ones especially now that there is at least one health unit per Sub County. This will require investment in specialized care additional clinical equipment and staff at HCIIIs and HCIVs. Most respondents who spoke to this study held the view hold that the current investment at HCIIs is being wasted as no much care is being provided. HCIIs can be transformed into social health points for communities where the referral system can be based and be left only to conduct health events like public dialogues, immunization and emergent responses. The resources saved would then boost the functionality of the HCIIIs and HCIVs. Secondary there are strong views from this study that with more public private partnerships, it is possible for government to provide services jointly with private providers especially during emergencies.

> *"Massive construction of health units across the country has cost the tax payer billions of shillings yet their functionality remains low* - Alice Alaso, Chairperson of the PAC of 9th Parliament

The current policy should revert to addressing the challenges of service provision inside the health unit - staffing, medicines, supplies and health care support facilities and halt new set-ups in the interim.

Issue 5

Restore Cost-Sharing and Expedite National Health Insurance Scheme

LITTLE has changed ever since government abolished cost sharing in public hospitals in 2001. While this policy increased access and was largely praised as pro-poor, it created a demand that the current public health system could not match with the quality of service expected. Public health facility in-charges that spoke to this study noted that in essence the scrapping of cost-sharing became a disincentive to the public health service provision. The private sector flourished as the government hospital could not match their innovation speed of delivery and easy access.

Overcrowding at health units is a sign of increase in demand for the service on the one hand and deficiency to meet the demand on the other. As a consequence, unscrupulous private service providers have flourished across the country some providing poor and unqualified service. Because the licensing structure and supervision of private clinics has been poorly resourced – most citizens have relied on them as the first contact for care and public service extension as a proportion of all care fell from 77% in 1990 to the current 50%. The rest is provided by the private sector – which is paid for.

Service	HC11 ('000)	HC111 ('000)	HC1V ('000)
Present recurrent cost need	**2,984.0**	**10,153.0**	**26,560.0**
Available funds	2,085.0	4,170.0	8,341.0
Annual cost Gap	899.0	5,983	18,219.0
Funding Gap %	30%	59%	69%
No. of units nationally	2,197	1,096	177
National Gap	**1,975,103**	**6,556,368**	**3,224,763**

Source: Consultant Analysis based on HSSP II Reporting

As seen from the table above, the current cost implications to finance the minimum standards as deduced by a report done by National Planning Authority in 2014 for HC II, HCIII and HCIV showed that UGX 11.7 billion non-wage gap per month is required at present.

With cost-sharing	HC 11	HC111	HC1V
Patients/day	162	115	80
Cost per visit	500	1,000	1,500
Month days	30	30	30
Revenue	24,300,000	3,450,000	3,600,000
No. Units nationally	2,197	1,096	117
Total	5,338,710,000	3,781,200,000	421,200,000

As can be seen from the table before, UGX 9.5billion per month would go to health units with cost-sharing of UGX 500 at HC II, UGX 1,000 at HC II and UGX 1,500 at HCIII. This would generate at the current number of health facilities which would almost close the current financing gap in the earlier table of UGX 11.7bn per month. However, it is important to note that public is already paying a lot more to (mainly adhoc and unlicensed clinics) every day in this country for services that they know are lacking in public health centers.

In essence cost-sharing has never been really scrapped. Private wings in public hospitals essentially mean that a good service will demand a price. Government should have known that basic care can be free but comprehensive care provided at a subsidy – MoH staff (2015)

There is a concern that most of the service providers in the private market place are providing health services for profit and mainly at unregulated prices.

> *"In Uganda you can be charged any amount of money to see a gynecologist or a dentist and because of you don't have all the information, you can't negotiate"* CEHURD Staffer who spoke to this study.

Private players that have taken the due process to have their operations fully licensed have had to pay extremely high taxes and a long list of requirements to get certified while a few others have set up pharmaceutical show-rooms and clinics without following the due process. While public health service officers have a right to carry out business, the fact that doctors and health administrators can operate private clinics and pharmaceutical businesses unabated, creates room for diversion of public drugs, clinical commodities and supplies for private business or sale.

Government should look at expediting the implementation of the national health insurance scheme so that those who are able to enroll can pay premiums to access health care at certain levels while government uses this revenue to expand service delivery as is being done in Rwanda. Those outside the scheme can continue to access free services at the level of care government is able to provide.

Other concerns relate to preferential treatment that is being accorded to foreigners for profit medical service providers at the expense of local clinics and hospitals. This is seen in the disparities with which the policy on foreign direct investment has been administered. Tax holidays and other waivers being accorded to investors should also apply to local investors in the health sector as well.

Photo: *Mulago Hospital maintains a strong private wing at the same time providing free public services.*

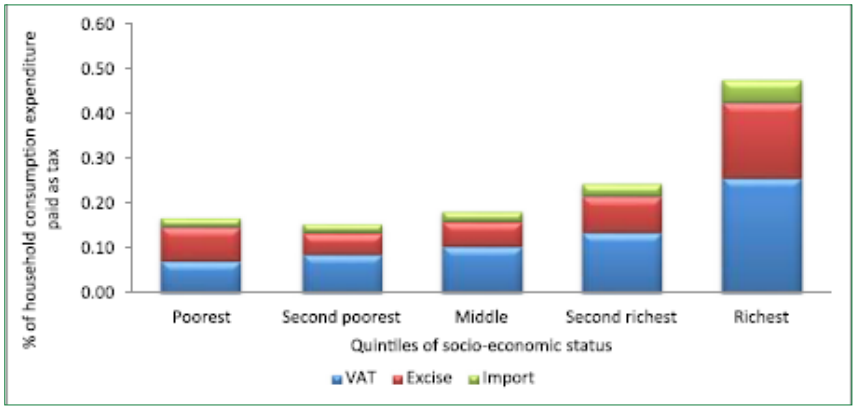
Issue 6

Lack of Clarity of Tax Exemption Policy for Health Service Imports

SUPPLY of veterinary, medical, dental and nursing services is listed by Uganda's tax body (Uganda Revenue Authority) as tax exempt but private service providers decried this not being the case. High import tariffs, boarder clearance fees and other bureaucracies have created substantial red-tape for private health service providers exemplified by the case below.

"I graduated from Makerere University as a dentistry surgeon after four years of intense studies and one-year attachment at Mulago Hospital. I was told all medical supplies are tax exempt so I raised money for a high quality dentistry chair from Japan on-line. Going to the details I found no exemptions were there after-all. I paid for its shipment to Mombasa, paid 18% VAT, paid CIF, paid 6% withholding tax, paid 13% clearance fees and UGX 800,000 for its transport from Mombasa to Kampala. On the first day of operation, KCCA closed the clinic for non-payment of service fees. On paying the fees they announced new on-line systems and I had to start all over again. It took me 3 months and 1 week to get started and millions of taxes - Proprietor of Neptune Dental Services, Kampala.

If government was to subsidize health care services it would make it easy for private sector to operate since they would be charged income taxes on profit returns to URA. At present, taxing private health sector providers has increased out-of-pocket cost for citizens and the policy is counterproductive. Since government is not able to provide a stock of care for all citizen it should accept certain critical aspects from taxes to make services locally available and stem the transit to Nairobi and India for medical care and boost the local economy instead.



Due to high cost of private care, the richest quintile can access specialized care shown in percentage of household consumption on paid medical services. This means that for poor households whose health consumption rate is below 10%, the affordability of care will rest on what government can freely provide, or what a person they are dependent upon can purchase for them. The fact that the richest are spending only 20-30% of what proportion is in tax paid for services. Had exemption been there this rate would have moved into private investments and disposable incomes.

Issue 7 Absenteeism, Acceptance of Informal Payments and Bribery

Informal Payments and Bribes

Uganda has been ranked 139th out of 168 counties in the 2015 Global Corruption Perceptions Index (TI, 2015), dropping three places compared to the previous year. Transparency International puts the corruption perceptions index at the national level at 25 out of a score of 100, indicating that Uganda has a high propensity for corruption. According to the same report 69% of the Ugandan respondents said corruption is generally on the increase with 52% saying it increased a lot over the past one year.

Due to low pay, low provision of opportunities to upgrade, inadequacy of housing and a breakdown in provision of key equipment and commodities, demotivated health workers have in some cases taken bribes and other informal payments to recompose their lack.

Most times health workers seek payments from patients to 'support them access' the treatment faster in the line; or seek informal payments for drugs; or help patients to dodge consultation fees (especially in PNFP entities). The challenge is not unique to the health sector. It's a generic result of a system that has dissatisfaction of public service and corruption that has woven itself in the fabric of society. There have also been reports of admission of patients in private wings who pay high fees that are not accurately recorded in the hospital receipting system. Others have been cases where patients have been referred to private clinics and hospitals for services they would have otherwise received at lower cost in government hospitals.

Absenteeism

According to a Transparency International report on triggers of corruption 2014, about 40% of doctors and 50% of nurses receive full payment when they were actually at work half of the time. Health officials abscond from work for mainly three reasons. Inability to commute all the time from home to health unit due to a lack of housing near the workplace. Lack of clinical equipment with which to work causing demotivation and redundancy while at work and a focus on other gainful activities that require staff to be away from post. To tackle absenteeism, some HCs have added a reporting list (sign-in and out ledger) where payment is computed for only the time the worker was on post.

Stakeholders call upon health unit in-charges to refrain from charging fees higher than the formally stated price and that punitive action is taken against extortion and bribery. Secondary, staff in health units and hospitals are expected to be on post as scheduled unless otherwise stated in writing and authorization. It is important that health inventory include a timesheets system against which salaries are paid to check absenteeism.

3. Study Recommendations

Overall, progress has been to improve the health sector but gaps remain. The sector remains susceptible to tendencies of corruption as chapter 2 has shown. There are a host of recommendations that need to be made to tackle corruption and its tendencies in the sector:

3.1 GOVERNMENT FINANCING OF THE PRIVATE NOT-FOR-PROFIT HOSPITALS

PNFPs have reported and accounted for funds they have received by Government to which the Office of the Auditor General has referenced and documented in the Annual OAG report. PNFP hospitals are however not obliged to report on other income sources from their establishments (some are mainly faith-based) and other partners local and international. However, since PNFPs receive public funds the public expects them to undergo a full audit of the funds they receive (including from private wings) so that there is accountability for tax payers' money and its investment. There should be a clearer policy framework governing PNFP financing and accountability for clarity on the extent to which taxpayers' money incentivizing PNFPs is used and better so to expand and improve health service provision.

A2 REPORTING OF INACCURATE DATA ON DISTRICT DISEASE BURDEN

Due to a limited rigor in the analysis of disease burden and its reporting, some districts have continued to receive drugs equipment and supplies in amounts that super-match their real requirements. Poor follow-up and low levels of facilitation for data management at the district level has in most cases caused complacency in records keeping. While improvements have been made by the Health Management Information System (HMIS) to ensure data is routinely collected at health centres and analyzed, gaps in quality assurance remain. There is need for further capacity building to elevate efficiency of stock managers at district level to improve data quality.

A3 INSTITUTIONAL STRUCTURAL OVERLAPS THAT COMPROMISE OVERSIGHT

While the setting up of institutions and mandates is clear, there is need of clarity of roles especially on oversight in instances where there are overlaps. For instance, most stakeholders observed that the Director General of Health Services should not be sitting on NMS Board and at the same time supervise NMS as an entity under her oversight as this would tantamount to conflict of interest. While the Ministry may be keen on hands-on management of the sector, most of the stakeholders felt that at no time should any official sit on a board he/she supervisees.

A4 PROCUREMENT, DISPOSAL AND O&M FOR HEALTH INFRASTRUCTURAL STAFF

Most stakeholders appreciate that NMS has gone a long way in resolving the challenges of drug stock-outs by increasing efficiency through bulk purchase and distribution of drugs and other critical medical supplies to health facilities.

The challenge however remains on disposal of used stock. It was recommended that Government allocates more funds to disposal of expired and used stock since some of it has found its way to private clinics – hence posing a health hazard to society. Secondly, the audit condemns acts of use of public vehicles and ambulances to carry private goods and calls on duty bearers to ensure that Government Standing Operational Procedures are strictly followed.

There is consensus that since the level of care at HCII level is very low, resources should be lifted to increase the functionality of HCIII and HC IVs so that HCIIs are transformed into health contact points for outreaches, public health days, immunization and emergent response centers.

A5 RESTORATION OF COST-SHARING

This policy audit calls for expedited implementation of the public health insurance framework so that premiums are paid for a longer term service in public health units for persons who can afford a certain threshold of care per annum as government maintains free access for those unable to be covered by insurance.

A6 TAX EXEMPTION FOR PRIVATE SERVICE PROVIDERS

The policy audit confirmed that the tax incentives that Government has put in place for private players, has not been effected. To bring down the cost of care (mainly specialized care like eye clinics, dentistry and cancer treatment) Government will have to make it less costly for private players to import key equipment to help in providing the needed services. The audit calls upon the Ministry of Health and Uganda Revenue Authority to ensure that tax exemptions for importation of key medical equipment and supplies are enforced to reduce to cost of care.

A7 ABSENTEEISM AND ACCEPTANCE OF INFORMAL PAYMENTS AND BRIBES

This audit calls upon all health unit in-charges to refrain from charging informal fees than formally stated and that punitive action is taken against evidence of those who do. Secondary, staff in health units and hospitals are expected to be on post as scheduled unless authorized to be off duty. It is important that a health staff and all resource inventory is kept to include a strictly followed timesheet record system against which salaries are paid.

Annex 1: Participants in Consultative Meetings

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Annex 1: About Us

Anti-Corruption Coalition Uganda (ACCU) is a national umbrella membership organization that brings together 17 likeminded Civil Society Organizations (CSOs) and activists in the fight against corruption in Uganda. It has a network of nine (9) Regional Anti-Corruption Coalitions (RACCs) in Uganda. ACCU was formed on August 1999 as a brainchild of 10 organizations and individuals who had tried to fight corruption in their individual capacity but their efforts were inconsequential. These include Uganda Debt Network, MS Uganda, Oxfam GB, Transparency International – Uganda, FIDA – Uganda, Uganda Women's Network (UWONET), DENIVA, UCAA, FABIO and UNATU. The coalition then existed as a loose arrangement until 2003 when the Annual General Meeting sitting at Human Rights Network (HURINET-Uganda) took the decision to have it formally registered as an independent body.

In 2004, ACCU was registered with both the NGO Board and the Registrar of Companies to become a body corporate with powers to sue and be sued; and with perpetual succession and a common seal. Since inauguration, ACCU has been surviving on donor support and membership subscriptions. ACCU started with support from MS Uganda as the main donor and as years went by, ACCU started receiving funds from Action Aid Uganda and DANIDA. To date, ACCU has a consortium of donors ranging from DGF, Action aid Uganda, UNDP, Care Uganda, Dan Church Aid, Partnerships for Transparency fund, Twaweza amongst others.

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