A MONITORING REPORT OCTOBER 2007-MAY 2008

A RWENZORI REGION HEALTH SECTOR PERFOMANCE REPORT

Kabarole Research & Resource Centre

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KEY TERMS USED IN THIS REPORT

Yellow Star Rating	This was a 5 year program of the government of Uganda 2000-2006 to improve quality of health care services through a system of supervision, certification and reward. Facilities with the yellow star meet 35 standards for quality care set by the government of Uganda; for example equipment supplies and drugs, clean and safe services, toilets and environment etc[1]
Health Consumers	Individuals who seek medical care from health centres
In-charge	This is the overall supervisor of the health unit at the level of doctor (HC IV) clinical officer (HCIII) , enrolled nurse or registered nurse (HC II)
Access treatment	The ability to get necessary drugs and diagnosis
Health facility	Place where patients seek treatment and medical advice
Out-patient	Some one seeking medical care while commuting from home
In-patient	Some one admitted (usually overnight) to a health facility for close supervision
Social inclusion	Involving all groups with interests in health sector management such as women, youth and PWDs
Minimum health care package	It includes interventions that address the major cause of the burden of disease such as malaria, TB and HIV/AIDS and is a cardinal reference in government planning for the health sector

Health Sub-District- also works as a District Health centre where referral is made from lower health facilities like HC II, HC III.

Health Centre IV- facility offering maternity services (including caesarean), operating theatre, laboratory testing, inpatient admissions: located at county level.

Health Centre III- facility offering laboratory testing, family planning services, maternity services, emergency treatment: located at sub-county level.

[1] DISH brochure on Yellow star program 2000-2006.

Health Centre II- with an enrolled nurse or registered nurse in charge, this facility offers outpatient care, malaria treatment: located at parish level.

LIST OF ACRONYMS AND ABBREVIATIONS

ANC	Ante-natal care
CSO	Civil Society Organisations
CDRN	Community Development Resource Network
CPFs	Community Process Facilitators
DDHS	District Director of Health Services
FGD	Focus Group Discussions
HC	Health Centre (e.g. HC II, HCIII, HCIV)
HFs	Health Facilities
HMIS	Health Management Information Systems
HSD	Health Sub District
HSSP	Health Sector Strategic Plan
HUMC	Health Unit Management Committee
KRC	Kabarole Research and Resource Centre
LC	Local Council
MOH	Ministry of Health
NGOs	Non Government Organizations
NMS	National Medical Stores
OPD	Out-Patient Department
PDC	Parish Development Committees
PHC	Primary HealthCare
PPEM	Private Public Expenditure Monitoring
PRMT	Poverty Resource Monitoring and Tracking Tool

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EXECUTIVE SUMMARY

This report presents findings of a Health facility monitoring exercise conducted in four districts of the Rwenzori region[2]. The main objective of the survey was to measure the effectiveness of government and private expenditure in the health sector. This was achieved by; analysing the impact of the strides taken by Government in bringing health services closer to the communities, establishing the effectiveness of the health facilities in responding to community health needs, identifying the perception and responsiveness of both health service providers and consumers towards the quality of health services delivered and it was also to draw feasible recommendations towards improving health service delivery.

Sample size used; The monitoring involved visiting 24 health facilities, which included health centres levels II, III & IV and hospitals. These included, government owned, NGO and privately operated Health facilities. A sample of 295 health service consumers who had sought medication from these health facilities within the period of 6 months before were interviewed and 36 community meetings with members in areas of location of visited health facilities were held.

Tools used; Information was gathered using Public Private Expenditure Monitoring (PPEM) tools developed by Civil Society Organizations and Ministry of Finance, Planning and Economic Development. The tools were developed after realizing that different stakeholders used different tools for monitoring public expenditure, which resulted into difficulties in aggregation of data from different sources. Thus, there was lack of a united front for addressing issues on policy makers' agenda, especially at national level. It is anticipated that if PPEM tools were adopted by different stakeholders, aggregation of data from different levels i.e. regional and national level will facilitate the engagement of CSOs in public policy formulation and review. Other techniques used in data collection involved observation, participatory community tools including the pot diagram, the poverty tree and face-to-face interviews with key informants. Data was processed, presented and analysed using EPIDATA, Excel SPSS soft wares.

Constraints to the monitoring exercise; Selection of health facilities for monitoring exercise was subjective as it was based on the areas PRMT was implemented which limited the scope and coverage especially Health Centre IIs. Another challenge was that some Health Centre IIs were not in use e.g. Kasinde health centre II in Rubingo parish Karambi Sub-County were not operational by the time of data collection. There was also a difficulties collecting adequate information concerning financial and drug supplies. Some medical personnel conversant with the information were often missing at the health centres

[2]Kyenjojo, Kabarole, Bundibugyo and Kamwenge

The monitoring unveils latent issues that directly or indirectly affect the health sector performance and alterations in health consumer behaviour in the region. Gathering information from different levels was to help understand the perceptions of health service users about the quality of services received and problem areas that should be addressed to improve the quality of health care provided. Information from the Health Facilities was to contribute towards understanding the conditions under which health facilities in the Rwenzori region are managed and operated.

This monitoring report also recognizes the role of the government and other development actors in improving the health sectors especially in bringing services closer to the communities and the introduction of free medication in government supported health facilities. There is clear evidence that access by the poor to health services has improved since the abolition of user fees (Deininger and Mpuga 2004b).

The report accordingly highlights key areas that need to be improved and recommend possible ways of improving general service delivery in the sector. A number of issues concerning the performance of the health sector emerged from the survey.

Bringing services closer; About the strides taken by Government in bringing health services closer to the communities, it was observed that much as hospitals were located in urban areas, there was a fair distribution of HC IVs in the rural areas too. The monitoring exercise identified that rural communities access services from all levels of health centres although health facilities most visited by the communities were at HC II and HC III which were actually ill equipped while others had no drugs at all especially HC IIs.

Limited access to Services; access to health services in Uganda is limited to only 49% of the households, however in the monitoring exercise only 23% of the households were in access to health centres. Some people (14.6%) still seek home medication; while 52.9% of the consumers had sought treatment from other sources including private clinics and traditional while 9.5% could not afford any form of service.

Commonly visited health facilities; The commonly visited health service source was the government supported health facilities since they offered free services. The monitoring exercise indicated that health service consumers who had sought treatment elsewhere, had failed to get treatment from such health facilities due to either absence of the service providers at the sites when services were demanded (this was especially at HC II and III) or due to the fact that most of the health facilities did not have staff quarters.

Burden of diseases on communities; the findings indicate that out of the 295 sampled households 52.9% of them had at least another family member from the same household had fallen sick in the same period and gotten treatment. This has a negative impact on

the government's drive to increase production and household incomes as outlined in the prosperity for all plan.

Time taken to be served; On average, a patient would spend, 54 minutes before accessing a health service provider. It was also found out that patients in the rural areas could not access medical services beyond 6 pm or very early in the morning. The monitoring exercise also showed that a patient would visit a public health facility for about 8 before deciding to use other alternatives including self medication using herbal medicine. The monitoring exercise also showed that 50% of the Health Centres closed for lunch break and while others opened after a short interval and the majority took long hours to open while others could hardly serve people after lunch break. This was very common at health centre II and III.

Power and water; 20% of health centres lacked any form of power supply for providing light especially at night. There was lack of clean water in at least 20% of the health centres. It was also observed that 29% of the health centres visited relied on harvested rain water, and during the dry season they run without and this is a threat to the hygiene of the centre yet the region is gifted by many rivers that could be tapped using the gravity flow system.

Diagnosis and Equipment; it was found out that only 12 out of 24 health facilities had malaria laboratory test services and these were mainly at hospital and Health Centre IV. Health Centre IIs and many health centre IIIs could not carry out this test as they did not have resources in terms of human resource and equipments to do so.

Drugs and medical supplies; There was a recorded absence of drugs in most health units visited with major reasons being delayed supply by National Medical Stores and selling of these drugs by some medical personnel especially those involved in the delivery of drugs to the facilities. This was also confirmed in Bundibugyo district where one medical personnel was arrested after forging figures for the medical supplies to one of the facilities. This contradicts the general policy objectives of the national health financing; to ensure full accountability and transparency in the use of resources allocated to the health sector (Ministry of Health National Health Policy, p.12, 1999).

Accessibility to Drugs; it was found out that out of every 10 patients that visited health facilities, only 5 could have access to full medication, 4 received partial treatment of the required medication while 1 out of 10 gets nothing. This implied that the at least 5 out of 10 people that visit a health centre are required to buy medicine elsewhere. This leaves the rural communities in uncertain situation given their unpredictable sources of income. It was also found out that of some of the health centres, consumers are charged yet the services are supposed to be for free. This was very common at health centre II & III.

Staffing of Health facilities; Understaffing was reported as high in most of the health centres. This has led to employment of unqualified staff. The report indicates that two out of five patients visiting health units were not examined and were sometimes given drugs administered by untrained staff. Three out of ten patients were not told how to use the treatment offered and 39% of the patients were not informed about their medical conditions before they were given drugs. This problem is also as a result of inadequate time given due to the number of waiting patients in some of the centres but also because the administering officers in some of the places are not trained to do the job. This is further worsened by the absence of an in charge directly responsible for monitoring the performance of health workers. Another problem observed was that only three out of ten medical staff members could be identified as medical personnel by their uniform and a name tag. This makes it difficult for people to know who was responsible for what.

Social and economic status; still affects the way services are rendered at Health Centres though the practice of first-come-first-serve still is supposed to take precedence in exception of emergency cases. The monitoring exercise established that a person with a higher social status would be served before an emergency case. The consumers thought that patients' rights lay with those who either had money or were knowledgeable enough to demand for their rights.

Planning and Management for Health facilities; Through committee meetings, it was revealed that communities were not involved in planning and management processes of the health centres. Among other reasons given were; inactive Health Unit Management Committees, some of which had expired and others chose not to involve the communities. This tendency does not correspond to the intentions of the national health policy where community empowerment and active participation in the management of their local health services is emphasized (Ministry of Health National Health Policy, page 13, 1999).

Recommendations

In the end, after 6months of monitoring and studying the situation in the health facilities, the team would like to make the following recommendations at different levels;

The Ministry of Health

1. **Decentralization of the drug distribution centre -**Government should decentralize the drug distribution centre (National Medical Store) by creating regional stores to reduce delays in supply and increase efficiency in the drug usage and reduce wastage mainly at both National Medical Store (NMS) and health facility level.
2. **Branding of drugs;** in order to get rid of drugs mysteriously disappearing from the centres, the team would like to recommend that the ministry of health should brand drug with inscriptions such as "property of the government of Uganda, or ministry of Health" to prevent them from being stolen.

3. **Diagnosis and Equipment -** Ministry of health should equip HC II & III in term of equipments especially malaria testing kits which are lacking. There is a challenge in relation to the diagnosis of patients at all health centre levels. Where there is availability of equipments for diagnosis of diseases like malaria, the existing personnel are either unable to conduct the tests due to insufficient skills to do so or technical [personnel to conduct these tests had been assigned other duties. This was very common with health centre IVs. At HC II & III, there was total lack of such equipments. The secretary of health and education Bundibugyo district noted with great concern as said, "Medical personnel are using hands to test for malaria and have on many occasions ended up giving wrong prescription to patients. This has also led to misuse of drugs".

4. **Mainstreaming the policy of comprehensive nursing -**There is need for Government to quickly mainstream the policy of comprehensive nursing (for both men and women) in training institutions to solve the problem of staff shortage especially in the maternity wards. Shortage of such personnel has greatly affected expecting mothers in rural areas who have had untold challenges with the few midwives attached to the health facilities. As a result many women have shunned way from their services in preference to the traditional birth attendants with limited skills and equipments to handle them.

5. **Put in place a statuary law that empowers HUMCs -** Ministry of health should revisit/put in place a statuary law that empowers HUMCs just like for education management committees by the ministry of education which provides for education management committees to take ownership and decisions in the delivery of education services. It was found out the law on the health management committees is weak and needs to be revised.

6. **Medical Personnel Staffing Structure -** Government should revisit the medical personnel staffing structure to provide for medical personnel at the lower HCs (III & IV) – to respond to increasing medical service consumers especially at HC III & IV. It was actually revealed that health workers at these health centres work more than those at the hospitals since they worked in shifts.

"The structure assumes that since only 20 maternity beds are allocated to HC III wards, and two maternity officers, then the number of service seekers would be proportional to the beds, which is not actually the case. This has resulted into nurses leaving HCs for hospitals because of big numbers".

In-charge from one of the health centres in Kamwenge district.

7. The Ministry of Health should urgently intervene in the problem of "absentee doctors' by posting doctors (just like the central government has done with the

CAOs) and when they leave for further training; their jobs should be advertised and refilled. This will address the current shortage of doctors in most of the health centers who go for further studies but don't return and their jobs are not filled yet straining the sector. The ministry needs to consider recovering monies paid to them when they don't return to their jobs.

The Ministry of finance Planning and Economic Development

8. Government through the ministry finance should restate the policy of staffing for medical workers at the health units. This would help reduce the rate of late coming for work and early closure of the health facilities. Hard to reach areas have one or no doctors because they resent the quality of services in those areas such as Bundibugyo and Kamwenge

9. Increase the Ministry of Health budget from the current budget of 457 billion and provide for **Preventative Health care and** gradually reduce on the curative medical care that was adapted from the colonial government. This with time will reduce the number of patients seeking medication and hence reduction in the demand for medical staff required. On the one hand, budget increment can provide for accommodation descent accommodation facilities in the bid to increase on the availability of a health worker at the centre.

Local Governments and Health Departments

10. **Drugs and Finance -** District health centres should regularly display latest drug consignment and other resources including finances right from District, health centre and community notices boards for public viewing. This will in the long run increase on transparency and ownership of the health centres by the service consumers.

11. **Planning, Management and Supervision -** The districts need to adopt multi-sectoral approach in involving medical personnel HUMCs, the politicians, DHO plus the RDCs' office (this recently proved efficient in the mobilisation of communities towards the fight against ebola virus in the Rwenzori region).

12. **District Internal Auditors and IGG -** The IGG/ auditor general must show interest in the performance of the health sector – by regularly auditing and prosecuting culprits that steal drugs and other services from the health facilities up to the lowest level. For the district internal auditors, they need to audit beyond figures in books of accounts but emphasise social and physical accountability in the community.

Community level and Health Management Committees

Monitoring of health facilities by HUMCs - The findings indicate that it is an important role for the community to be involved improving service delivery especially when they are involved in monitoring, and supervision of service delivery. Health Unit Management Committees should be strengthened and health personnel should take keen interest in monitoring the trickle down effect of the services offered in the sector. HUMC should monitor the extent community members are involved in the utilization of health services, the extent to which communities are involved in the monitoring of the health facility services (funds, medicine, manpower, quality of output etc and how the communities can be involved in the decision making process of priorities in the health facility. Monitoring inventories by HUMCs should be carried out at least twice a year.

Induction of HUMCs must involved medical personnel, and local councils I, II and III in to understand their roles but importantly for collective responsibility purposes and ensuring accountably of the health centres.

District local governments and Health Departments

Increasing supervision of service delivery; A lot needs to be done by the health department in improving its supervision especially at health centre II, III and IV to improve service delivery as this was largely found to be lacking hence poor delivery of health services.

Conclusively, the government has taken commendable strides to bring health care services closer to the poor. However, there is the need to establish the gap in relation to maintenance, availability of drugs, qualified medical personnel, proper supervision and management systems, among others. These are a number of factors that should be considered in addressing Health challenges and the need for concerted efforts from development actors.

The poor at village level still bear the brunt of exploitation by medical workers because they are less informed about their rights. Factors that contribute to such behaviours need to be investigated and necessary disciplinary action taken.

CHAPTER I

Introduction

The Rwenzori Region

The Rwenzori region is part of the east African west rift Valley and straddles the equator along the boarder between democratic republic of Congo (DRC) and western part of Uganda. It is a heterogeneous society comprised of the Bakonzo, Batooro, Bakiga, Bamba, Basongora, Batuku, Babwisi, Banyabindi and Bafumbira among others.

The region is comprised of five districts; Bundibugyo with approximately a total population of 212,884 people, Kabarole 359,180 people, Kasese 532,993 people, Kamwenge 295313 people, Kyenjojo 380362 people. (Uganda population census 2001-2005)

There are various forms of land use in the region; most of the land in the region is under small-scale farmland. The Rwenzori region is predominantly an agricultural region with most of the land under small-scale farming but with a marked large scale cash crop production in tea for Kabarole; coffee and cotton in Kasese and cocoa in Bundibugyo.

About Kabarole Research and Resource Centre

Kabarole Research & Resource Centre is an indigenous non-governmental/non profit making organization, which has been operating in the Rwenzori region of Uganda since its inception in 1996. KRC's integral approach to development is geared towards the transformation of the social, political and economic spheres of the people in the Rwenzori region and Uganda at large. It involves the grass root communities in identifying their needs, designing possible solutions as well as monitoring and assessing their own progress. At the same time KRC encourages the communities to monitor and assess public and private service delivery in their areas.

In the process of helping communities monitor service delivery KRC has introduced the Poverty Resource Monitoring and Tracking (PRMT) tool. The PRMT conceptual framework builds on a Community Based Monitoring and Information System where information flow is permitted through a number of supportive structures at different levels in the local government framework up to the national centre after which a back flow of information is permeated through the same structures. The mantle of the system lays in the grassroots communities in their villages and their regular assessment of the use of poverty eradication programs and projects.

The PPEM Tools at its origin

In 2006 the Ministry of Finance and Economic Development started collaboration with private development actors, including NGOs, to develop a tool which could be used to monitor public and private development programs as well as inform policy making processes at the national level. This monitoring exercise therefore, was carried out to assess the performance of the health sector in the Rwenzori region using the PPEM tools. KRC's experiences with the use of the PRMT and the Community Based Information Management System, developed by Uganda Debt Network, have been a point of departure for the collaboration with the Ministry of finance, planning and economic development in developing the Public Private Expenditure Monitoring (PPEM) Tool.

National Background Information

Poverty reduction

The government of Uganda has been implementing a poverty reduction strategy since 1997. The main focal point of the strategy is economic growth, macro-economic stability and investment in universal primary education, primary health care, and agricultural extension. The national Poverty Eradication Action Plan (PEAP) is currently being revised and at the same time it is expanded to serve as the national development framework. In pillar 5 of the PEAP, which emphasizes Human Development and thereby health, the Government mentions various priorities of the health sector for example the necessity to increase per capita expenditure on drugs and supplies and the need of recruitment and deployment of health workers (Ministry of Finance, Planning and Economic Development, 2004/5-2007/8, 2004:167).

The health sector in Uganda is running under the 10-year health policy developed in 1999. According to Dr. Odaga and Dr. Lochoro of Caritas Uganda, the Health Sector Strategic Plans (HSSP), which is a part of that policy, are instruments in the health sector component of the overall development framework of PEAP (Budget Ceilings and Health Units Uganda, 2006:4). The overall goal of the health policy is: "Attainment of good health by all people in Uganda in order to promote a healthy and productive life" (Ibid).

The policy of good governance

In the 1999 report of the Uganda Participatory Poverty Assessment Project it was revealed that there was widespread consumer dissatisfaction with both the quality of service and the confusing array of official and unofficial charges being demanded in public health facilities. These findings were also highlighted in the National Integrity Survey (WHO, no year, and p.5). The problem of charges being demanded in public health facilities is addressed in the PEAP where it is stated that: "The consequences for the poor can be catastrophic, because they can be denied access to vital services because they are not able to pay the relevant bribe

even though the service is meant to be free" (PEAP 2004/5-2007/8, 2004:128). According to W.H.O this problem should be understood as a consequence of low wages:

"Salaries and conditions of service for health workers, though improved of late, remain far from adequate and paying a living wage remains an issue. The consequent problems related to the widespread diversion of public resources (staff time, drugs, equipment, fees collected), euphemistically referred to as "dual employment" or "survival strategies of health workers", are among the biggest challenges facing the sector. Staff morale and performance in general remain low" (WHO, no year: 9).

The Government addresses the problem of corruption through an anti-corruption plan which includes strengthening the judiciary and holding public hearings; recruiting more accountants and auditors; undertaking extensive reform of procurement procedures; increasing public awareness through public debates and hot lines; and fostering a free and active media. This has lead to several resignations and senior civil servants and government ministers have been convicted and jailed for their offences (WHO, no year, and p.5).

The Uganda National Minimum Health Care Package

In 1998 the Uganda Participatory Poverty Assessment Program (UPPAP) identified ill health as the most frequently cited cause and consequence of poverty. To address ill health, Uganda implemented the HSSP, which focuses on the implementation of the Uganda National Minimum Health Care Package (UNMHCP) to control communicable diseases such as malaria, sexually transmitted infections, HIV/AIDS, and tuberculosis among others.

Findings of the 1999/2000 socio economic survey showed that many people who fell sick especially from malaria/fever did not get treatment at health clinics. In the survey it was also estimated that 23% of the population still practiced self medication while 8% did not seek any form of medication. It also showed that 36% of pregnant mothers delivered in health facilities while 21% did not receive any care at all. In rural areas, more than 20% of women delivered at home with neither a trained staff nor a traditional birth attendant (Ministry of Finance Planning and Economic Development, 1999/2000).

As a component of the UNMHCP the Government abolished user fees in public health facilities in 2002, which have lead to an increase in the use of public health care services especially by the poor (for more information see: Evaluation of National Budget Support; Birmingham University, 2006:70). With the abolition of user fees the health facilities have experienced problems in the supply of drugs, with stock-outs of medicines increasing, and concerns over the effect on the motivation of staff, though it should be mentioned that there is an increase in the number of posts filled in health facilities (Ibid, 2006:73). It should be noted that it is a policy of the Government to make sure that at least 50% of the budget for units below the hospital level is earmarked for drugs (PEAP 2004/5-2007/8, 2004:165).

Access to health care services, qualified health care staff and medicines are components of health care system. Of these three components, medicines are of special importance for

various reasons; they save lives, improve health, promote trust and participation in health services, they are very costly. Communities quite understandably, equate the quality of health care primarily with the availability of basic essential medicines. (Uganda Pharmaceutical Sector Baseline survey 2002). Acknowledging this fact Uganda adopted a national drug policy (NDP) to contribute to the attainment of a good standard of health by the population, through ensuring the availability, accessibility and affordability at all times of essential drugs of appropriate quality, safety and efficacy, and by promoting the irrational use.

According to the 2007 report of the parliament budget committee, the priorities of the health sector are under funded by 34.3billion. The current per capital expenditure requirement for drugs is 4$ but the government is only able to allocate 1.68$ leaving a short fall of 1.5 $. In their report to the 2007/08 budgeting process, the committee noted that, in an attempt to reach a bare minimum of 3$ the ministry of health was lacking 29billion shillings. The committee noted that they were concerned about the continued under funding of the national drug budget.

"The Committee notes that despite the reflection of drugs, reproductive health and human resources as key priorities for the past years, there is persistent lack of drugs in government health facilities especially lower health centres and hospitals which benefit the majority of the poor. There is also absence of medical doctors in health centre IVs and health workers especially at the lower health units" (Recommendations of the parliamentary budget committee, 2007:21-22).

Despite the strides to increase the health sector budget over time, the amounts of resources allocated to the health budget have remained small. In the FY 2000/01 the expenditure of the sector was shs.208.82 billion and it increased to 315.93 billion in the FY 2001/02. At that time the HSSP has just been launched and much of the expenditure went into the construction of new health units as well as into the implementation of the National Minimum Health Care Package. (Evaluation of the general budget support Uganda-country report 2006 Pg 73-79)

In the FY of 2006/07 the figures was down to 242.62bn and it was only expected to increase to 251.31bn in the FY 2007/08 (Recommendations of the parliamentary budget committee, 2007:21). In the 2007/08 national budget, the Government emphasized the need to prioritise the delivery of the Uganda National Minimum Health Care Package including the enhancement of sexual and reproductive health and rights with a focus on improving maternal and child health, malaria control, immunization, sanitation, community mobilization and HIV/AIDS (Budget Speech, 2007:23). The exact budget for the FY 2007/08 is not mentioned but an allocation of 11 billion Uganda shillings for recruitment and provision of drugs at health centre IIIs as well as 8 billion shillings for rehabilitation of referral hospitals was made in the budget (ibid).

Decentralization of the health system

A policy of the Ugandan Government is to decentralize the health sector in order to bring health service closer to the communities, as well as enable them to participate in the planning and implementation of the primary health system through e.g. Health Unit Management Committees. This policy is in line with the Alma Ata declaration where it is emphasised that, community participation should be a key emphasis at the primary health care level (Alma Ata, 1978: Section 4).

As a means of decentralization, Uganda is divided in a 5 tiered local government structure, with the District Local Council 5 (LC5) at the pinnacle, LC4 at county level, LC3 at sub-county, LC2 and LC1 at parish and village levels respectively. The decentralization of basic services, including health, follows this structure. Uganda is now divided into over 80 districts and the health care system is aligned to the administrative structure described below;

Table 1.1: Administrative Structure and the Corresponding Health Structure

Description	Local council lev	Health structure
Village	I	Health centre I
Parish	II	Health centre II
Sub county	III	Health centre III
County as sub district or consti	IV	Health centre IV
District	V	District/general hospital

Terms of Operation of different level of Health Facilities

Health centre I

In some parts of Rwenzori, health centre I has not been operational, with no physical structures and qualified health personnel. However in some districts like Kamwenge, village health teams have been established to work as health centres 1 at that level. These comprise trained village members who offer basic health services for example malaria drugs and mobilise people for health activities. These work voluntarily in conjunction with local councils at village.

Health centre II

These like any other government health centres open from 8:00am and close at 5:00pm. They often open on public holidays, Sunday and Saturday for emergency cases. These centres offer only out patient services. They are considered to be closer to the community and located at parish level. At this level an enrolled nurse or a registered nurse is the in charge. Only outpatient services are offered and referral to health centre III is done for complicated cases.

Health centre III

This is located at sub county level; it offers out patient services with maternity ward. Complicated cases at this level are referred to health centre IV, the unit opens at 8:00am and works 24 hours, it offers simple laboratory services like malaria tests, maternity and the clinical officer is the in charge at this level. This health unit has a yellow star rating file. Referral at this level is made to health centre IV.

Health centre IV

This also acts as a health sub district; it is located at district level. It works 24hours and offers maternity services, has a theatre, a laboratory, x-ray, caesarean section etc, the unit should have a yellow star file; at this level a medical doctor is the in charge. Referral at this level is made to regional or national hospitals

District/General Hospitals

These are divided into district hospitals, regional referral hospitals and national referral hospitals. They offer all that services mentioned above. This level should at lease have more than two medical doctors

Main Objective of the Monitoring exercise

To measure the current effectiveness of government and private expenditure in the health sector

Specific objectives included

- To analyse the impact of strides taken by the government in bringing health services closer to the community.
- To establish the effectiveness of the health facilities in responding to community health needs.
- To identify the perception and responsiveness of both health service providers and consumers towards quality health service delivery.
- To draw feasible recommendations geared towards improved health service delivery.

Coverage, Scope and Survey Design

The monitoring exercise was conducted in four districts of the region namely Kabarole, Kyenjojo, Bundibugyo and Kamwenge. These districts were purposively selected as areas implementing the Poverty Resource Monitoring and Tracking tool (PRMT). So were the sub-counties within the selected districts. In Kamwenge, Nkoma and Mahyoro sub-counties were selected, Bubukwanga and Nduguto sub-counties from Bundibugyo formed part of the monitoring exercise, in Kyenjojo, Kyegegwa and Nyantungo sub-counties

were included and in Kabarole three sub-counties i.e. Bukuuku, Kibiito and Kisomoro were selected.

Information in these sub counties was collected at health facility level that is health centre IVs, IIIs and IIs from counties, sub-counties and parishes respectively. At district level, data was obtained from hospitals. Two hospitals were visited in Kabarole, where PMRT activities were adopted and one hospital was visited in Bundibugyo. The other districts did not have hospitals. All together, 24 health facilities were visited by the research team. It should be noted that each health facility was only been visited once.

According to the Ministry of Health Statistical abstract (2002), there is a total number of 104 health facilities in the 4 districts, as shown in Table 1.2.

Table 1.2: showing Health Facilities by Category

District	Hospitals	HC IV	HC III	HC II	Total
Bundibugyo	1	1	2	16	20
Kabarole	3	2	11	12	28
Kamwenge	0	2	7	10	19
Kyenjojo	0	3	18	16	37
Total	**4**	**8**	**38**	**54**	**104**

Sources: Health Statistical abstract (2002),

Stratified sampling design was used at first stage to identify health service consumers by health facilities' visited and the actual respondents within a village or parish randomly selected. A total of 295 health service consumers were interviewed and it was revealed by the survey that 80% of the respondents had actually visited the health facilities within a period of 3 months before the monitoring exercise was done. This helped in determining the validity of the opinions given by the respondents.

Data at community level was collected through Focus Community meetings to assess the level of community participation in health sector service delivery. In total 36 community meetings were conducted to inform the monitoring exercise. The District Directors of Health Services (DDHS) in the 4 districts were interviewed to provide information concerning the performance of health facilities particularly in the mentioned sub-counties.

Tools Used in Data Collection

The PPEM tools were used in the process of data collection. As mentioned, the PPEM tools bring together both private and government development actors to monitor the performance of various sectors, in this case the health sector, and can be used to give feedback at all levels and are hence an instrument which can be useful for policy review.

The tools capture data at three levels i.e. at individual level, the health facility level and the community level. Information was captured using questionnaires from health service

consumers, health facilities and community meetings. Observations were also used in order to verify some of the answers to the questions in the tool.

Constraints

The selection of health facilities was based on the areas where PRMT was implemented which limited coverage of Health facilities especially Health Centre IIs. At the same time it was found that some Health Centre IIs were not in use which, in addition, affected the sample of Health Centre IIs included in the monitoring exercise, for example Kasinde health centre II in Rubingo parish Karambi Sub-County was not operational by the time of visit.

There were several difficulties related to the collection of adequate information concerning financial and drug supplies. Another constraint was that some of the medical personnel conversant with the information were often missing at the health centres. Making appointments with these persons was difficult as they could not be accessed easily. Another constraint was poor record keeping which made it difficult to get representative information on drugs and finances. A consequence of the poor record keeping was that some health centres did not make any registration of the number of patients accessing treatment.

Some health workers were of the opinion that we could be government spies interested in knowing the failures of health units. This led to low levels of participation by most health workers and absenteeism when meeting for appointments. There was also a very high absenteeism of in-charges yet they were considered knowledgeable in providing information concerning health units. Information concerning drugs, financial expenditure was in most cases not filled when the in charge was not present at the health facility.

CHAPTER II

Social Demographic Characteristics

Health service consumers

A total of 24 health facilities were visited by the research team of which 41.7% are located in Kabarole, 25% in Bundibugyo, 20.8% in Kamwenge and 12.5% in Kyenjojo. These proportions are relatively equal to the distribution of the health facilities within each district.

Of the total of 295 health service consumers that participated in the monitoring exercise, Bundibugyo and Kyenjojo were represented by 25.4% each, Kabarole by 25.1% and Kamwenge by 24.1%. The participants came from 78 different villages.

The average age of the health service consumers was 36 years with the youngest aged 14 years and the eldest aged 85 years and there was an equal representation of service consumers by gender.

Community meetings held

A total of 36 community meetings were held in the four districts; 15 in Kamwenge, 8 in Kabarole, 7 in Bundibugyo and 6 in Kyenjojo. The community meetings were used to monitor 24 health facilities which ranged from Health centre IIs to hospital. The total number of community members[3] that participated in these meetings was 588 of which 223 (37.9%) were female and 365 (62.1%) were male. On average there were 16 people in each community meeting of whom at least 5 were female. This was done to ensure fair presentation of the views in relation to different needs by gender.

Categories of the health service consumers

Information concerning marital status, religious affiliation and levels of education was considered by the monitoring exercise. We find that various factors, such as those mentioned, affect human attitudes and behaviours when it comes to utilization of health services. Data in Table 1 shows a summary of the characteristics of the people interviewed.

[3] Community members that participated in these meetings composed of peasant farmers, local council leaders, religious leaders, parish chiefs, teachers, and members from community based organisations (CBOs).

Table 1: Health Services Consumers' Marital, Religion & Education Level

Aspect	Status	Number	Percentage
Marital status	Single	67	22.7
	Married	213	72.2
	Divorced/separated	1	0.3
	Widowed	14	4.7
Religious affiliations	Protestants	127	43.1
	Catholics	100	33.9
	Moslems	25	8.5
	Seventh-day-Adventists	27	9.2
	Pentecostals	7	2.4
	Other affiliations	9	3.1
Education level	No formal education	41	13.9
	Not completed primary	109	36.9
	Completed primary	54	18.3
	Ordinary Level	66	22.4
	Advanced level	5	1.7
	Post secondary level	20	6.8

As it can be seen in Table 1, married individuals constituted the majority (over 72%) of the health services consumers in the four districts. This implied that the married people in the communities visited constituted the majority of the health service seekers and this could have been as a result of either taking their children, in most cases considered vulnerable to diseases or themselves falling sick, thus rendering them frequent visits to the health facilities. Findings a head also showed that children below five years of age ranked second in visiting health facilities for medication (See Table 8).

It can also be observed that most of the health service consumers were either Protestants or Catholics, accounted for by 77% of the participants. Others included Moslems, seventh-day-Adventists and Pentecostals. Although the findings indicated that actually the religion of an individual did not influence accessibility and utilization of the serviced delivered at the health facilities.

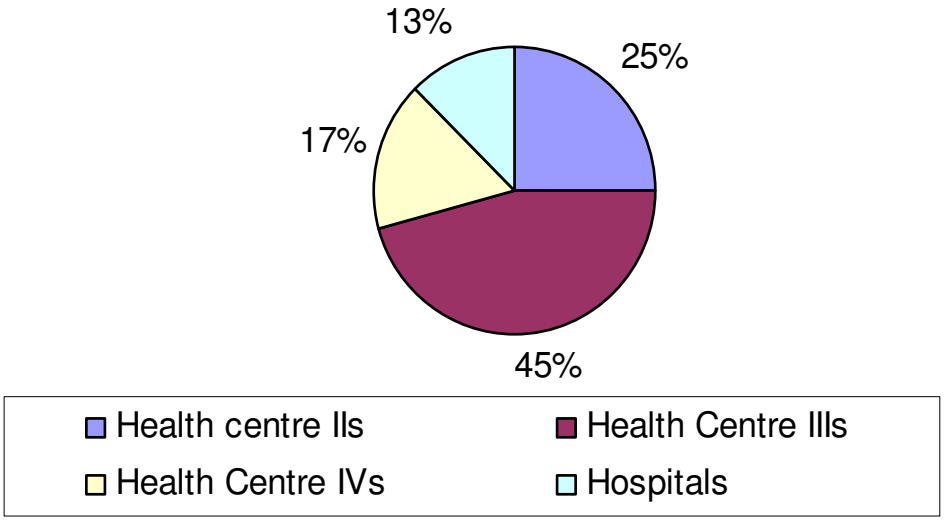
In relation to educational background of the service consumers, it can be seen that approximately 6 out of 10 had attained up to primary education level while 1 in 10 did not have any formal education background. This meant that most of the service consumers who sought healthy services in most government supported and public health facilities were persons with little or no educational background. This could be attributed

to the fact the uneducated or people with little educational hardly have stable incomes and hence often seek medication from such public health facilities.

Categorization of the health facilities visited

The health facilities included in this monitoring exercise ranged from health centre II to hospital. As seen in figure 2, HC IIIs were most visited by the service consumers while hospitals were the least visited. This partially explains the distribution of most community members who actually reside in rural areas where health centres are located. This precisely explains the role that health centres especially those located in the rural areas are playing.

Figure 2: Distribution of respondents by Health Unit Level Visited



However, hospitals play a tremendous role in responding to referrals from other health units. The monitoring exercise shows that Health centres III, II are closer to the community and sometimes cases that warrant referral to HC IV or hospitals are handled at lower level health centres because of the long distance between the lower health centres to the hospital. This implies that they need to be fairly equipped with the essential supplies in order to handle some emergencies in case of eventuality given the difficulties of transportation in rural areas.

CHAPTER III

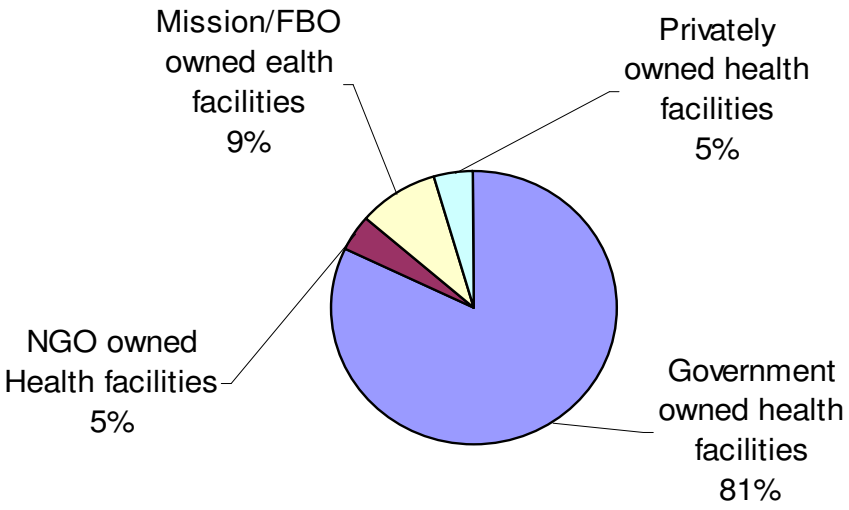
Strides to Bringing Health Services Closer

This chapter looks at the efforts made by the Government and other stakeholders in bring public health mainstream medicinal services closer to the people with special consideration to the rural poor communities. Here, issues of ownership of health facilities, distribution of health facilities by location i.e. in terms of rural and urban settings, characteristics of the health facilities, the availability and accessibility to other health care sources as well as the frequently visited health care sources will be presented.

Ownership of the health facilities

The delivery of public health services in Uganda is a partnership between a numbers of stakeholders as observed from the national health policy of Uganda. As can be seen in Figure 3, there are various players in the delivery of health services in the Rwenzori region.

Figure 3: Health Facility Ownership



It was observed that most (80.6%) health service consumers had visited government owned health facilities, followed by missionary/FBO owned (11.1%), privately owned (5.6%) and only 2.8% NGO health facilities. This shows that government supported healthy facilities are playing a key role in providing public health services to the communities because of free service besides reduced distances travelled.

Distribution of health facilities by locality

Geographical accessibility to healthcare facilities in Uganda is so far limited to only 49% of the households in terms recommended distance of within 5 kilometres from homesteads (Ministry of health national health policy, no year: section 1.5). The rural population, where the majority of the poor live, is further constrained in terms of access to healthcare by distance, geographical, physical features such as rivers, marshes and hills. Only 42.7% of the parishes in the country have access to any form of health facility (Health Facility Inventory, 2000). Even where the facilities exist, access to basic elements of the healthcare package is far from optimal. As a result of many years of civil strife and neglect, there is a massive back log of dilapidated infrastructure which compromises efficiency and discourage utilization. In addition, the quality and range of care that is provided at existing health facilities still requires a lot of improvement.
According to the Ministry of Health Policy Report (2002), accessibility to health care has been limited due to geographical factors. Rural communities were particularly affected mainly because health facilities were mostly located in towns along main roads. Therefore to achieve the overall objective of the health sector, the policy was to reduce mortality, morbidity and fertility. This was said to be achieved by ensuring that health facilities were located in those areas considered under-served, and in accordance with the long-term National Health Infrastructure Development Plan.

In relation to this, the monitoring exercise obtained information related to the location of the Health facilities in terms of rural or urban setting. Of the Health facilities visited by the monitoring team, 83% of them were mainly health centres II and III located in the rural areas while 17% were located in the urban areas and these were mainly HC IVs and hospitals as seen in Table 2.

Table 2: Distribution of Health facilities by Locality

Health facility Level	Facility by Locality		Total
	Urban	Rural	
Health Centre IIs		6 (26.1%)	6 (26.1%)
Health Centre IIIs		10 (43.5%)	10 (43.5%)
Health Centre IVs	1 (4.3%)	3 (13%)	4 (17.3%)
Hospitals	3 (13%)		3 (13%)
Total	**4 (17.4%)**	**19 (82.6%)**	**23 (100%)**

The health policy emphasizes equal distribution of health services throughout the country to ensure effective access by all sections of the population to the National Minimum Health Care Package. Therefore, much as hospitals are located in urban areas, there is a fair distribution of HC IVs in the rural areas too. The monitoring shows that rural communities' access services from all levels of health centres although the

health facilities most visited were HC IIs and HC IIIs. It is observed that the government indeed has strived to extend services closer to the communities irrespective of factors involved.

Characteristics of the health facilities in relation to Yellow star rating

The monitoring examined the characteristics of health facilities in terms of the yellow star[4] knowledge and rating. The yellow star rating program was started by the government of Uganda in 2000 with an aim of improving the quality of health services at Health centre III and IV through a system of supervision, certification and recognition. It also aims at promoting utilization of facilities at these health centres and increasing client satisfaction.

Examination of health workers at health centres III and IV on their knowledge on the yellow star rating and the level of the facility, it the monitoring exercise showed that 71% of the health facilities had a yellow star rating. This implied that 7 out of every10 HC III and IV visited qualified by standards for quality care set by the government.

However, most health facilities visited by the research team did not meet the set quality standard of the yellow star. Indeed, local ownership and sustained quarterly supervision, as some of the components identified by the program itself, could be a contributing factor which could change the deterioration of the services in health facilities that initially had a yellow star.

While 25% of HC III and IV did not have any yellow star rating, some health workers in these facilities did not even know about the program.

Availability and accessibility to other health care sources

The last two decade (1990-2000) has witnessed the use of traditional and alternative medicine. This has also been widely used in Uganda, sometimes in isolation or, as in the case of many patients, to complement mainstream medicine in the prevention, diagnosis and treatment of a wide range of ailments. A number of factors had led to their growth and these included; accessibility, affordability and the desire for alternative medicine when service consumers felt that main medicine had somehow failed them.

Given this background we considered it important to look at the availability and accessibility to other sources of health care and service providers among the communities. To achieve this, the monitoring team investigated if the respondents, as

[4] Health Facilities with yellow star meet all 35 standards for quality care set by the Government of Uganda among them; *Essential equipment, supplies & drug, *Clean & safe services toilet and environment, *Respectful, well trained health workers always available, *Emergence transport, * Privacy and confidentiality, *Regular immunization services, * Less than one hour wait to see a health worker *Accurate record keeping. Health workers who * list to you and give you all the information you need, *always wash their hands between clients * give clients the collect treatment and *give regular education talks.

well as other members of their households, had acquired treatment from alternative sources during the same period.

The findings indicated that within the households of the 295 health service consumers, 52.9% of them had at least another member of their household who had fallen sick in the same period and gotten treatment. This means that a lot people are regularly falling sick which in turn affect the production levels hence the need for quality medical attention.

The commonly visited health service source was the government supported health facilities since they offered free services. The second most used health service source was the privately owned facilities, which includes drug shops as accounted for by 14.6% of the participants. Other health care sources were as indicated in Table 3.

Table 3: Participants and their household members by Sources of Health Care Sources

Source of Health care	Age category by Percentage		Total %age	Remark
	Below 18 yrs	Above 18 yrs		
No one else fell sick in the household			47.1	
Home self medication	3.4	1	4.4	- Had some drugs home
Visited the traditional/spiritual healers	1.7	1.7	3.4	- Had personnel relationship with service providers - Health service providers were not available at the centres
Visited privately owned providers	7.5	7.1	14.6	- Health service providers were not available at the centres - Availability of drugs at the private providers - Convenient distances travelled to private providers - Had personnel relationship with service providers
Pharmacists/drug shops	4.4	3.4	7.8	- Good quality services provided - Convenient distances travelled - Availability of drugs
Government health facilities	8.5	11.5	20.0	- Provided free treatment - Availability of drugs - Convenient distances travelled
NGOs	1.4	0.3	1.7	- Health service providers were not available at the centres - Convenient distances travelled
Community health workers	0.7	0.3	1.0	
Total	**27.6**	**25.3**	**100**	

Generally the monitoring exercise found out that the health service consumers who sought treatment elsewhere, had failed to get treatment from government supported health facilities. The most significant reason sited by service consumers for not accessing treatment from public health facilities was the absence of health service providers at the

sites when services are demanded. In this exercise, acknowledged that the trend of usage and accessibility to allopathic medicine is steadily increasing as a result of offering the minimum health care package free of charge compared to previous years, when medicine was purely private. However, the some of barriers to access to medication here is limited supplies attributed to many factors among which corruption impacts most. This has resulted into some people sometimes paying if they wanted medicine, especially at HC II level during scarcity of supplies.

Frequently Visited Health Care sources

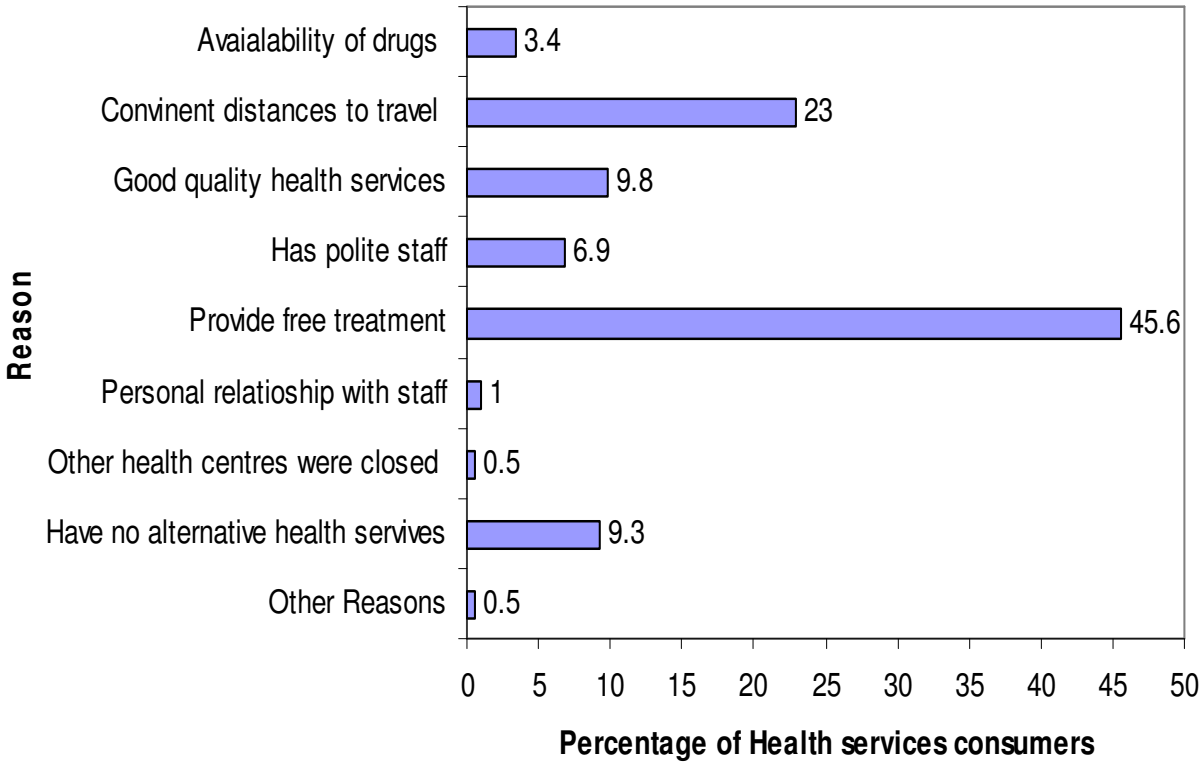
Information was collected on the usage of the various health care sources by assessing the number of times service consumers had visited the various sources mentioned in Table 3. The monitoring exercise/monitoring also looked at the age brackets of the clients who visited these sources. The analysis showed that the most commonly or frequently visited source of health care providers was the government supported health facilities as can be observed in appendix 1.

It was also revealed that people aged 18 years and above were the majority consumers of the medical services as accounted for by 54% of all those who had visited the various health sources, of which 43.9% had received services from the public supported health facilities. Children aged five years and below were second in terms of frequency to the Health care sources. The monitoring exercise showed that a patient would visit a public health facility about 8 times yet getting nothing before thinking about other alternatives.

Health service seeking behaviour at government health centres

The monitoring exercise also looked at the reasons as to why patients or health service consumers preferred to go for treatment in government supported health facilities.

Figure 5: Reasons for choosing public Health facilities for Treatment



As seen from Figure 5, service consumers preferred to use public health facilities mainly because they provided free services as supported by 45.6% of the respondents. This could be due to the fact that, most of the consumers were low income earners, given their educational background and merger peasantry sources of income. This actually explains for the frequencies made to a health facility even with absence of supplies at the health centres.

Another reason given as to why the participants chose to seek services from these health facilities was that the distance from their homes to the health centres were convenient. These two reasons are in line with the government's strategy of extending free services closer to the people i.e. within a distance of 5kms as clearly indicated in the Ministry of Health National health policy (section 1.5). It was also acknowledge by some respondents that some public health centres provided good and quality services, much as others said to have had no alternative.

Hours of operation of the health facilities

The monitoring exercise constituted some variables that measured actual opening and closing hours of the health facilities in relation to the level of service utilization and consumer satisfaction levels. It was often alleged that most health facilities in the region delay to open during morning hours and closed very early when the services are still needed. This can contribute to poor health service delivery. Therefore to assess this, information was collected from the visited health facilities in relation to the time and Table 4 shows the summary of the findings

Table 4: Functionality of the Health facilities by hours of operation on Week days

District	Name of facility	Opening time	Closing time
Bundibugyo	Bubukwanga HC III	8:00am	Between 4:00 pm to 5:00 Pm
	Butama HC II	8:00am	5: 00 Pm
	Kakuka HC III	8:00am	4:00 pm
	Bukangama HC III	8:00am	6:00 pm
	Bundibugyo Hospital	Operates 24 hours a day (Does not close)	
	Karugutu HC IV	Operates 24 hours a day (Does not close)	
	Nyahuka HC IV	Operates 24 hours a day (Does not close)	
Kabarole	Bukuuku HC IV	Operates 24 hours a day (Does not close)	
	Buhinga Hospital	Operates 24 hours a day (Does not close)	
	Kabonero HC II	8:30 am	5:00 pm
	Kasunganyanja HC III	8:30 am	5:00 pm
	Kicuucu HC II	8:00 am	5:00 pm
	Kiguma HC II	8:00 am	5:00 pm
	Kisomoro HC III	9:00 am	5:00 pm
Kamwenge	Bihanga	8:00 am	4:30 pm
	Bukulungu	8:00 am	5:00 pm
	Rwamwanja HC III	8:30 am	5:00 pm
	Mahyoro	9:00 am	5:00 pm
Kyenjojo	Kingarare HC III	10:00 am	5: 00 Pm but some times closed as early as 1:00 pm
	Kyegegwa HC IV	8:00am -90:00 am	5: 00 Pm
	Kyenjojo HC IV	8:00am	5: 00 Pm

This monitoring shows that while some health facilities operated 24 hours[5] in a day, others closed down between 4:30 Pm and 6:00 Pm on week days and then opened for services between 8 o'clock and 9 o'clock in the morning.

[5] These were all hospitals visited and some HC IVs.

Variation in Time

According to the health workers interviewed, variation in time from the official opening and closing time was between 30 minutes and 1 hour. It was also found out that many health service consumers did not know the opening and closing time of their health facilities. However, those who were aware said that the opening time of the health units, varied from some few minutes from the actual opening time to as far as 3 hours sometimes while the closing time varied from the official closure time up to 5 hours before official closure time. This implied that many patients in the rural areas could not access medical services beyond 6 pm. Hence in trying to fulfil the gaps arising from inadequate health services, those who can afford, seek treatment from alternative service providers like the traditional or spiritual healers and drug shops, among others

The major reason given by the health workers as to why there was time variation in operation was that the health staff lived far away from the health facilities as some of the health facilities did not provide accommodation for them. This can also be explained the fact that out of 100 patients who sought treatment from these health facilities, 8 found the health facilities closed. It was also mentioned by both service providers and service consumers that some health facilities had fewer patient cases[6] which would make them close earlier than the official time as supported by 1 out of 10 health workers and by 3 out of 10 health service consumers.

Time management by health workers

At the meetings conducted with members of the community, concern was raised on the way health workers managed their official working time. We were informed that workers reported for work very late and also retired from work very early on a regular basis. This was reported to be a common practise by most health workers and the practise was seen as much worse among those on night duties in the health facilities that operated 24 hours in a day. Therefore, for effective service delivery, there is need for supervision on the performance of the health workers especially those working with government supported health facilities.

Health facilities' functionality at lunch time

The monitoring exercise had a provision for assessing the way business was conducted at the health facility during lunch hours. A face to face interview with the health facility respondent was conducted to assess the functionality of the health facilities during lunch time. This basically looked at what actually took place at the facilities during lunch time. Information was got about the facilities that broke off for lunch time, in terms of how long it took to re-open. Long hours of closure during lunch intervals imply that facilities do not promote proper service

[6] Mainly HC IIs

provision to the consumers. Table 5 gives a summary of closure interval during the lunch period. The government policy stipulates that HC II open at 8:00am and close at 5:00pm, other Health Centres III, IV and hospitals work 24 hours because they offer out and inpatient services.

Table 5: Health facility by Duration of Closure at Lunch Time

Duration of Closure	No. of Health facilities	%age
Did not close	12	50.0
15 minutes	2	8.3
20 minutes	1	4.2
30 minutes	1	4.2
45 minutes	1	4.2
60 minutes	7	29.2
Total	**24**	**100.0**

The monitoring exercise showed that 50% of the health facilities did not close during lunch time interval and these were mainly hospitals and HC IVs and few HC IIIs. While other health centres broke off for lunch in an interval of between 15 to 60 minutes. However, it was observed from the service consumers that nearly all the health facilities[7] they visited often closed during lunch time. And while some would open after a lunch break within less than one hour's interval, others remained closed up to a period of 3 hours while others hardly opened after lunch, especially HC IIs and some HC IIIs. This pattern of operation therefore weakens the Governments efforts towards improving health services among the rural communities given that fact the most rural peasants relied on public health facilities for medication.

The monitoring exercise unveiled that health facilities that did not close during lunch hours had their staff members work in shifts. Some of those that closed would serve the waiting patients before closure while others made their patients wait until after lunch interval.

Functionality of health facilities on weekends and public holidays

The monitoring exercise also assessed the level of services provision to patients by public health facilities during weekends and public holidays, in terms of whether they served communities on such days. Table 6 gives a summary of the finding on how the health facilities operated on weekends and public holidays.

[7] Including HC IVs & IIIs besides IIs

Table 6: Operations of the Facilities during Weekends and Public Holidays

Hour	Saturdays		Sundays		Holidays	
	%age by Opening time	%age by Closure time	%age by Opening time	%age by Closure time	%age by Opening time	%age by Closure time
Did not open	33.3	33.3	45.8	45.8	37.5	37.5
24hrs (inpatient)	33.3	33.3	33.3	33.3	33.3	33.3
Emergency only	8.3	8.3	12.5	12.5	4.2	4.2
8:00 am	4.2				12.5	
8:30 am	8.3		4.2		4.2	
9:00 am	8.3		4.2		8.3	
10:00 am	4.2					4.2
12:00 noon		4.2				
1:00 pm		12.5		4.2		8.3
2:00 pm						4.2
5:00 pm		4.2				4.2
5:30 pm		4.2		4.2		
6:00 pm						4.2

The monitoring exercise revealed that 33.3% of the health facilities[8] provided services to communities 24 hours on weekends and public holidays. Between 33.3% and 45.8% of the facilities did not provide services to the communities on such days and HC IIs were observed to be the majority under this situation. Between 4.2% and 8.3% provided services on those days on emergency cases only.

> *"It is advisable that HC IIIs and IIs open on Sundays and public holidays for emergency cases. HCs with In-patient arrangement should shift their working arrangement after 6pm". DHO from Bundibugyo*

[8]Hospitals, some HC IVs, and HC IIIs

Time Taken For a Patient to Be Served

The monitoring exercise shows that there was variation in the opinions given by the health workers and health service consumers about time taken before a patient could be attended to. As seen in Table 7, health workers' suggestions showed that a patient should only wait for a short time (26minutes) before being attended to, while the health service consumers said that one would spend, on average, close to an hour (54 minutes) before attention was given as indicated in Table 7;

Table 7: Time Taken for a Patient to be served

Time taken before a patient is attended to	Minimum	Maximum	Mean	Std. Deviation
Patient average waiting time in minutes according to Health Workers	5 mins.	80 mins.	26 mins.	20.01
Patient average waiting time in minutes according to Health services consumers	10 mins.	302 mins.	54 mins.	48.8

Some health service consumers said that it took them 302 minutes or 5 hours before they were attended to at various facilities irrespective of the level. This implied that utilization and consumer satisfaction levels of the services provided was affected by time taken to access services. This is mainly caused by the inadequate and insufficient labour force employed in the sector.

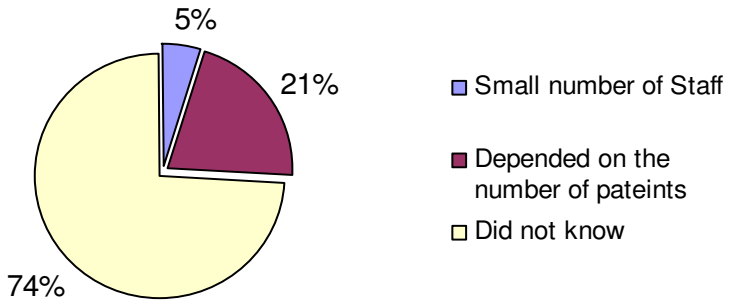
Causes of variation in the standard patient waiting time

According to health staff at all health levels, variation in patients' waiting time before accessing treatment was due to two reasons and these were;

1. Variation depended on the number of patients seeking medical treatment and the available staff to attend to them. Meaning that if there were few patients waiting then, one would be attended to in the shortest time possible and vice versa.
2. The department or section where a patient sought treatment. In health units some sections of treatment attract more patients and therefore clients are likely to take a long time before getting services as compared to those sections with fewer patient cases.

Analysis of the health consumers' views about variation in patients' waiting time showed that 7 out of 10 consumers did not know why there was variation in time from the standard waiting time. Other reasons given were as shown in Figure 6.

Figure 6: Reasons for variation in standard waiting Time



Health facilities' attendance information

Information collected from the health facilities included statistics taken from all patients of all age categories, total number of people seeking family planning services, total number of antenatal care patients and the number of deliveries at the facilities in the last six months before the survey was carried out. Table 8 gives an average number of records registered for clients in the last 6 months before the survey was carried out.

Table 8: Health Facilities' Clients' Statistics in the Previous 8 Months

Facility	Total no. of attendances (including re-attendance)			Total who sought Family planning	Total who sought Antenatal care	Total who sought Deliveries
	<1 year	1-4 years	5+ years			
Health centre II	6	1,157	3,543	153	87	0
Health centre III	6	1,740	3,860	1,556	346	35
Health centre IVs	5	4,897	8,241	16,142	623	212
Hospitals	6	5,016	11,702	22	1,561	1,024

The monitoring exercise shows that most of the people who seek treatment at all levels of health facilities are those above 4 years of age, much as children between 1 and 4 years are equally many at all levels. The total number of patients that visited health facilities depended on the level of health facility i.e. hospitals registered more while HC IIs registered relatively fewer clients. However issues of family planning were handled mostly at health centre level. With growing

numbers of clients seeking such services, is a good indicator that rural communities are equally concerned with increasing population pressure on the scarce resources, like land. There was some utilization of antenatal care and delivery services even at lower levels. These all call for improve service deliveries to even cater for the emergencies when at HC II. However, it is important increased supplies go along with well trained personnel.

Laboratory Tests conducted at Health Facility Level

The monitoring exercise also looked at the specific laboratory tests conducted at various health facilities visited and those that were referred elsewhere. The monitoring exercise also looked at the state of the laboratory facilities at the centres and laboratory tests record management. Table 9 shows a presentation of the various tests conducted at different facilities.

Table 9: Tests, & State of Laboratory and Record keeping by Health Facilities

Aspect	Test/Opinion	Level of Health Facility				Total
		Health Centre II	Health Centre III	Health Centre IV	Hospitals	
Laboratory test conducted	Malaria	1	8	4	2	15
	TB		4	4	2	10
	Intestinal worms	1	6	3	2	13
	Haemoglobin		2	3	2	7
	HIV		3	4	1	8
	STI/STD		5	3	1	9
Tests referred to other testing facilities	Malaria	2	2	1		5
	TB	1	5	1		7
	Intestinal worms		1			1
	Haemoglobin		1			1
	HIV		1			1
State of laboratory facilities	Not operational with no resources	5	3			8
	Operational with inadequate resources	1	8	3	2	14
	Operational with adequate resources			1		1
Record keeping and updating	Records kept & updated	1	6	4	2	13
	Records kept but not updated		1			1
	Not kept at all	1				1

The monitoring exercise shows that approximately only 6 out of 10 health facilities had malaria laboratory test services and this were mainly at health centre III level while very few centre IIs would carry out these test as they did not have resources in terms of human resource and equipment to do so. The tests for TB, haemoglobin and HIV services were found at health centre IV, hospitals and some few health centre IIIs. It can also be observed that health centre III made many references to other facility level laboratory tests mainly because, they did not have sufficient resources to handle testing services.

Financing of Health facilities

According to the Ministry of Health national health policy, the government was to develop and implement a sustainable, broad-based national financing strategy that would be geared towards ensuring effectiveness, efficiency and equity in the allocation and utilization of resources in the health sector consistent with the objectives of the National Poverty Eradication Plan. It further stipulates that all financial transactions using Government funds (including central Government and donor transfers to local authorities and locally generated resources will be administered strictly within the financial regulations of Government).

As mentioned in chapter one, according to the parliament budget committee, the health sector is under funded by 34.3 billion. It was also mentioned in chapter one that a problem of bribes within the health sector is mentioned in the PEAP. According to the PEAP the service is meant to be free and practises of bribes is seen to affect the poor.

In relation to this, the monitoring exercise looked at the financing aspect of the health facilities in terms of sources of finances, amount received and its purposes in the last six month before the monitoring was carried out.

In the data collection process, it was observed that most health facilities (hospitals and some HC IVs) were not interested in revealing their sources of funding and the actual amounts received. This was especially observed among the hospital officials who looked at provision of such information as a very tedious process and fear of the repercussions. This discovery leaves a lot questions in relation to efficiency of the systems in planning to address such needs for planning purposes. Focus should be on involving local communities to monitor health budgets and drug usage. This will not only promote transparency and accountability but also good record keeping in health units.

Table 10: Sources of Finance for Health facilities by October 2007

District	Name of the Health Facility	Central Government amount	Local Government amount	Donor amount
Bundibugyo	Bubukwanga HC III	495,000.00	-	-
	Bukangama HC III	550,000.00	-	-
	Kakuka HC III	147,500.00	-	-
	Karugutu HC IV	1,900,000.00	-	-
	Nyahuka HC IV	3,500,000.00	-	-
Kabarole	No health facility in the district was able to disclose its finances from the above sources			
Kamwenge	Rwamwanja HC III	-	160,000.00	-
	The rest o the health Units did not reveal their finances and sources			
Kyenjojo	Kyegegwa HC IV	1,159,4487	-	1,352,000
	The rest of the health Units did not reveal their finances and sources			

However, from those that were able to give some information as seen in Table 10, it can be observed that Health facilities in Bundibugyo district were fairly free in providing financial information and their sources of funding. From the information gathered it was revealed that the private sector was not active at all in supporting health facilities financially. However, over time it has been revealed that it is still a challenge to achieve full financial accountability and transparency in the use of the resources as emphasised under the health financing objective of the Uganda national health policy.

Expenditures by Health Facilities

Based on the data collected from the health facilities in relation to finances and expenditures, it can be observed that there was a big challenge in obtaining financial and expenditure data. This problem was very severe especially at hospital level for reasons not clear to the research team. This rendered it difficult to have a concrete report about the financial and expenditure status at various health units

Table 11: Expenditures by Health facilities by October 2007

District	Name of the Health Facility	Central Government amount	Local Government amount	Donor amount
Bundibugyo	Nyahuka HC IV	900,000	-	-
	Bubukwanga HC III	567,500	-	-
	Bukangama HC III	550,000	-	-
	Kakuka HC III	87,100	26,400	-
	Karugutu HC IV	-	-	-
Kabarole	All the health facilities in the district did not provide data on expenditures made			
Kamwenge	Rwamwanja HC III	212,000	-	-
	All of the other health facilities in the district did not provide data			
Kyenjojo	Kyegegwa HC IV	457,000		988,000
	All of the other health facilities in the district did not provide data			

However information was provided by some health facilities especially from Bundibugyo at centre levels III and IV. These expenditures were made on various issues like allowances for outreach services, wages, stationary, environmental health or public health and transport.

Investments

The monitoring exercise looked at the investments which had taken place at the health facilities in the previous six months in terms of buildings/structures which had been added or repaired, boreholes made, water tanks and fencing of the health facilities. The monitoring exercise showed that out of 24 facilities visited, 8 had some new[9] rooms ranging from 1 to 8 either completely constructed (accounted for by 4 facilities) or partially completed (accounted for by 4 facilities). One health unit had completed constructing one new water tank in the same period interval. It was also found that 1 facility had placed a new fence on its premises while another one had repaired its fence within the same period. Other investments made during the same period were as summarised in Appendix VI which included both repairs and purchases made.

[9] Most of the new developments took place at Health Centre III and IV

Other characteristics of the health facilities

The monitoring exercise looked at the renovations and new constructions made at the health facilities in the last six months before the survey was carried out and who was involved in terms of material support. Table 12 shows a summary of renovations constructed at various health facilities.

Table 12: Facilities Constructed or Renovated at the Facilities

Unit	Opinion	No.	%age	Provider	%age	Benefit
Toilets (6)	Yes, constructed	3	12.5	Government	33.3	Separate toilets for staff & health service consumers
	No	21	87.5	NGOs	66.7	
Maternity wards (7)	Yes, constructed	6	25.0	Government	50	Space for deliveries
	Yes, renovated	1	4.2	NGOs	50	
	No	17	70.8			
Sources of water facilities	Yes, constructed	1	4.2	Government	100	Constant water supply
	Yes, renovated	1	4.2			
	No	22	91.7			
Staff housing facilities (1)	Yes, constructed	1	4.2	Government	100	Staff are close to health facilities
	No	23	95.8			
Sources of power unit (4)	Yes, constructed	2	8.3	Government	33.3	Can now preserve medicine at the health centre
	Yes, renovated	1	4.2	NGOs	66.7	
	No	21	87.5			
Laboratory facilities (2)	Yes, constructed	1	4.2	NGOs	100	Increased space & privacy
	Yes, renovated	1	4.2			
	No	22	91.7			

The monitoring exercise shows that the Government and NGOs played an important role in improving health services in the region through renovations and construction of some of the required facilities, as the proportion of the health facilities that had been renovated or acquired new infrastructures was very small.

Essential problems faced at health facilities

The monitoring exercise shows that use of staff rosters was poor in most of the health facilities visited as some of them did not have them and even those that had, did not display them anywhere according to the observation made by the research team.

There was a challenge related to usage of patient's cards. All the visited health facilities did not have any numbers on the cards which makes monitoring the number of patients waiting for services hard.

It was also revealed that over 78% of the health facilities did not have suggestion boxes. This makes it hard for these facilities to get feedback and advice as most people prefer secret messages posted in suggestion boxes.

The monitoring exercise also revealed that some facilities did not have in-charges at all, e.g. Kasunganyanja health centre III in Kabarole district, In Kyenjojo Nyantungo Health III did not have an in-charge, this was also supported by 4 out of 10 service consumers who said they were not able to see the in-charge at the time they visited the facilities. The major reason given by service consumers as to why they were not able to see the in-charges was that they were not always available at the health facilities.

Charges and Payments by Patients

As mentioned earlier the health sector faces problems of under funding as well as corruption which is affect the implementation of government policies. It was discovered that some health facilities, especially in the rural areas, charged service consumers. A testimony on this was given by the Bundibugyo RDC were he said that a certain community was being exploited by the In-charge of a health centre, who was charging them for the services. The monitoring exercise also revealed that at least 1 out of every 10 public health facilities charged patients whenever the medical supplies were out of stock and these were mainly at health centre II, III, and IV level.

The monitoring exercise also gathered information on charges and payments made by service consumers and which items they were required to pay for. Tables 13A and 13B give a summary of the various items or services that patients were required to contribute to, or pay for as explained by the finding of the questionnaires and interviews done with the health workers and the consumers of the health services.

Table 13A: Services/Items and amount Charged by Health workers

Service/Item	No. of Facilities that charge patients out of 24		Average amount paid			
			HC II	HC III	HC IV	Hospital
Outpatient (new) OPD	4	16.7%	5,000	2,200	-	-
Outpatient (re-attendance) OPD	3	12.5%	5,000	500	-	-
Inpatient	4	16.7%	5,000	7,000	-	-
Health education	-		-	-	-	-
Immunisation	-		-	-	-	-
Antenatal care	2	8.3%	-	1,750	--	-
Family planning	-		-	-	-	-
Child delivery	3	12.5%	-	5300	-	-
Child delivery material	-		-	-	-	-
Laboratory testing for TB	2	8.3%	-	750	-	-
Laboratory testing for malaria	4	16.7%	1000	1000	-	-
Injections/syringes	-		-	-	-	-
Drugs (average)	3	12.5%	5000	2000	-	-
Blood	2	8.3%	-	1000	-	-
Ambulance services (fuel)	-		-	-	-	-
Exercise books	3	12.5%	-	100	-	-

Note: This information is inclusive of private and government health facilities

The findings shown in Table 13A and 13B showed a contradictory opinion about the charges made or fees paid by service consumers. While the health workers' did not acknowledge the problem of money being charged from the consumers as shown in Table 13A the service consumers' indicated that they where required to pay for many services as seen in Table 13B.

Table 13B: Services/Items and amount paid by Service Consumers

Service/Item	No. of Clients who were charge patients out of 295		Average amount paid			
			HC II	HC III	HC IV	Hospital
Outpatient (new) OPD	34	12.1%	10,000	2,600	9,200	0
Outpatient (re-attendance) OPD	18	6.4%	7,000	1,000	9,000	0
Inpatient	17	5.9%	10,600	10,100	4,800	0
Health education	0	0%	0	0	0	0
Immunisation	0	0%	0	0	0	0
Antenatal care	3	1.1%	500	500	0	0
Family planning	4	1.4%	750	100	0	0
Child delivery	18	6.4%	0	7,700	10,000	5,000
Child delivery material	10	3.6%	30,000	4,200	30,000	4,000
Laboratory testing for TB	9	3.2%	2,250	1,600	0	0
Laboratory testing for malaria	10	3.6%	5,600	1,900	0	0
Injections/syringes	10	3.6%	5,100	600	300	0
Drugs (average)	9	3.2%	4,000	1,200	0	0
Blood	7	2.5%	1,000	1,500	0	0
Ambulance services (fuel)	14	5%			10,600	20,000
Exercise books	34	12.1%	100	100	100	100

Note: This information is inclusive of private and government health facilities

With this nature of charges inflicted on to the rural communities where it has been observed that 5 out of 10 homes have at least more than one person in a single household following sick within a period of six, does not favour the rural poor peasants in terms of provision of farm labour and financial resources.

However, given a situation where one has to visit a government health centre eight times in search of treatment, is a big indicator that most members in the grass root communities have no financial resources. This has very often led to people resorting to herbs or hope for natural recovery.

Sections Consumers Pay For Services

The monitoring exercise looked at the sections or areas in which patients were required to pay the health facilities for the services as seen in figure 7.

Figure 7: Sections Where Service Consumers Paid

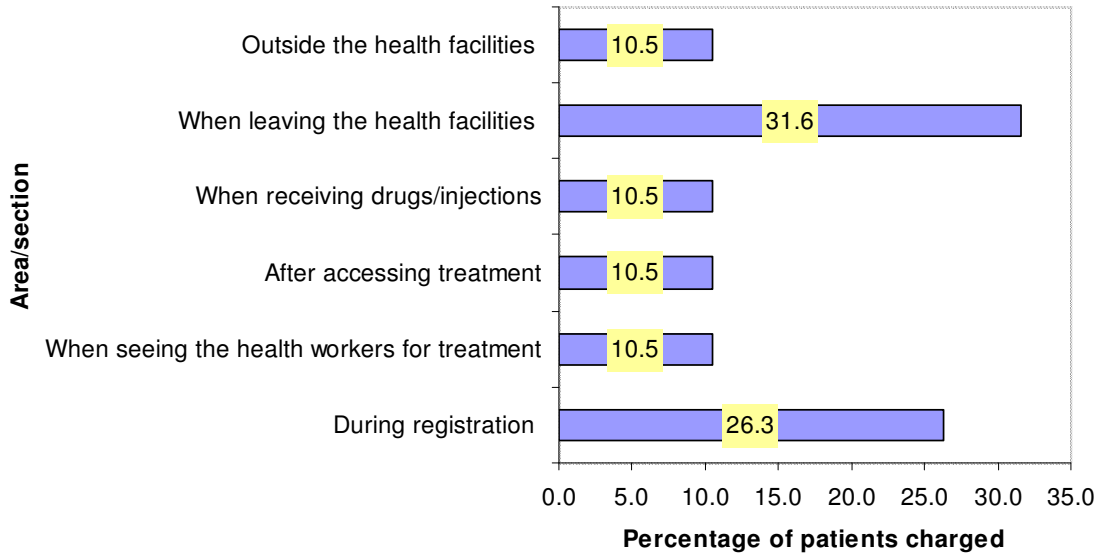


Figure 7 shows that most of the patients that had been charged for the services, paid when leaving the health facilities, followed by those that were charged for services during the registration process. As suggested by all those who had paid for the services, these payments were in financial form only.

Availability of drugs at health facilities

Data was collected on the availability of key essential medicines, duration of stock-outs, rational drug use, household health care seeking behaviour, and access to prescribed medicines. Appendix V shows the various drugs and their quantities that were available in some of the health facilities during the time of the visit by the research team.

According to opinions of half of the participants in community meetings, communities were not satisfied with the level of the availability of drugs at government health

centres because drugs were not regularly available at the centres and more especially essential drugs such as coartem was very scarce. Where as some participants said that there was total lack of drugs at their health facilities, a smallest number of the participants (9.1%) revealed that communities were satisfied with the availability of drugs because sick persons would only fail to get drugs if they did not have money to buy them. Note that this practice in government health units is a violation of the national policy because sick people who cannot afford buying drugs end up dieing. This is not in line with the government policy of bringing affordable services closer to the community. It is important to note that government health centres in Uganda are supposed to offer free medical services however the research discovered that some government health facilities charge patients when there is no drugs or even illegally as a side income

Accessibility and Utilization of Medicine

The monitoring exercise looked at how the health service consumers accessed and utilised the services provided in terms of medicine types provided and whether they got information on how to utilise them.

Table 14: Accessibility and Utilization of Medicine at Health facilities

Aspect	Opinion	%age
Given medication (N = 295)	Yes, given all drugs/injection	47.1
	Yes, but only part	44.4
	No	8.5
Type medicine given to patients (N = 254)	Tablets	90.6
	Syrup	3.1
	Injection	3.9
	Other	2.4
Reasons for not receiving drugs or injection (N = 25)	Health centres had no medicine	71.9
	Could not handle case, referred	3.5
	Didn't necessitate medicine	15.8
	Did not know	8.8
Told about received injections or drugs (N = 254)	Yes	80.3
	No	19.2
Told how to utilise medicine (N = 254)	Yes	70.1
	No	29.9
Received prescription form to obtain medication	Yes	54.9

elsewhere (N = 261)	No	45.1
Went elsewhere to buy medication after visit (N = 255)	Yes	54.9
	No	45.1
Referred to go to specific places to buy medicine (N = 56)	Specific clinics	53.6
	Specified pharmacy	21.4
	Other clinics	25.0
Had to bring buy and/or buy medicine (N = 295)	Yes	65.4
	No	34.6

The findings as in Table 14 show that much as almost haft the patients got full treatment at the facilities, some of them got partial treatment which was mainly due to the supplies which did not match the number of the service consumers.

However, it was also observed that some patients who got treatment from the facilities were not told about the nature of medication (type of drugs or injection) given to them while 3 in 10 patients were not told how to utilize the medicine. With the low education levels observed where most respondents had not even completed primary, leaves a lot to wonder effectiveness of service provided. This sometimes has led to drug poisoning and unfinished or completed dosage as a result of not understanding or misinterpreting the dosage.

The monitoring exercise also showed that many patients were directed by the health workers to access treatment from specific clinics outside the facilities as suggested by 5 in 10 service consumers. This situation calls for increased monitoring and supervision of the ownership and sources of supplies to these clinics as it has been known that some drugs lost from health centres under various circumstances, have often found its destination in such places.

The monitoring exercise also showed that at least 5 in 10 patients that visited the health facilities bought their own medicine. This implies that 5 in 10 people can be provided medicine for by the health centres. In some health units it was discovered that drugs delivered at the unit did not match the priorities of the communities and that the required ones were insufficient and not delivered to the units on time. In some health units of Kyenjojo (Nyantungo Sub County) and Kabarole (Kisomoro County) we encountered a pile of expired drugs to be disposed off because they did not match the needs of the community.

CHAPTER IV

Effectiveness of Health Facilities in Responding to Health Community Needs

Staffing levels of the health facilities

At health facility level, data was collected regarding the staffing of the health facilities and various categories of medical or health workers and their presence at the health facilities. In the monitoring exercise, it was found that, the visited hospitals and health centre IVs had at least a medical doctor posted to the centres.

According to the Ministry of health policy Uganda (Sept 1999), Health sub-District (HSD) objective, only hospitals and HC IVs were to have resident Doctors and core support staff including clinical officers, midwifes, anaesthetic assistants, laboratory assistants and community health assistants. Small basic operating theatres were also to be provided for emergencies.

In general the visited health facilities (24) in the four districts have 12 clinical officers, 15 enrolled midwives, 6 registered midwives, 18 enrolled nurses, 8 registered nurses 19 nursing assistants, 11 health assistants 1 dental assistant, 13 laboratory personnel and 2 trainees. This reflects inadequate health personnel in most health units visited and the need to improve the situation. In Kamwenge for example, Rukunyu health sub district lacked Anaesthetist, a lab assistant and Ophthalmology clinical officers during the period of monitoring.

Given the population ratios from each district in chapter one, there is absolutely a big gap in terms of medical personnel in the area. This partially explains for the long time taken before patients are served.

The In-Charge's Presence at the Health Unit

Opinions and reasons given by the health service consumers about the availability of the in-charge at the facilities were as summarised in table 15

Table 15: Presence of In-charge at Health facilities

District	Name health Unit	Presence of the in-charge at Health Centre
Kabarole	Bukuku HC IV	Always present
	Kabonero HC II	Always present
	Kasunganyanja HC III	Not available always
	Kibiito HC IV	Not always available
	Kicuucu HC II	Not always available
	Kiguma HC II	Not always available
	Kisomoro HC III	Always present
	Kyanyonza HC II	No sufficient evidence
	Rambia HC II	No sufficient evidence
Kamwenge	Bihanga HC II	Always present
	Bukurungu HC II	Always present
	Mahyoro HC III	Always present
	Rukunyu HC IV	No sufficient evidence
	Rwamwanja HC III	Always present
Kyenjojo	Kasina HC IV	No sufficient evidence
	Kiguma HC II	No sufficient evidence
	Kigaraale HC III	Did not have an in-charge
	Kyegegwa HC IV	No sufficient evidence
	Kyenjojo HC IV	Not always available
Bundibugyo	Bubukwanga HC III	Always present
	Butama HC II	Always present
	Kakuka HC III	Always present

Note: *This information is as per the findings during the monitoring period*

The monitoring exercise revealed continued absence of in-charges and qualified personnel at the health units, which has negatively impacted the performance of health centres. This was mainly observed in the Kabarole, Kamwenge and Kyenjojo health facilities. The in-charge plays an important role to monitor and supervise the day to day running of health centres. When workers stop showing up on time or all together, nurses are less polite and the level of sanitation reduces in the health unit it could be influenced by the absence of an in-charge. There is a clear message coming from the monitoring exercise that the in-charges of health facilities do not spend enough time at the health facilities. A common reason for an in-charge to be away was that they were attending training or a workshop some where out of the village or a district.

Facilities' Environmental Sanitation

The monitoring exercise also looked at the conditions of the health facilities in terms of the status of the facilities' floors, walls, furniture during the time of the visit by the research team and the smell of the health facilities. It was generally observed that most health facilities visited were fairly clean[10] much as some of them were seen to be dirty[11] especially those at health centre II level. Hospitals were seen to be comparatively cleaner as compared to other facility levels as presented in Table 16. This implied that in terms of maintenance and hygiene or environmental sanitation, there was need for most health facilities to improve especially at health centre IIs'

Table 16: Health facilities' Environmental Sanitation

Aspect	Opinion	Health centre II	Health centre III	Health centre IV	Hospitals	Total
Condition of floors	Clean				1	1
	Fairly clean	3	7	3		13
	Dirty	1	2	1	1	5
	Very dirty	2				2
Condition of Walls	Clean		1		1	2
	Fairly clean	3	6	1		10
	Dirty	1	2	2	1	6
	Very dirty	2				2
Condition of furniture	Clean				1	1
	Fairly clean	2	7	2		11
	Dirty	3	1	1	1	6
	Very dirty	1				1
Smell in the health facilities	Clean		1		1	2
	Fairly clean	3	5	2		10
	Dirty	1	3	2		6
	Very dirty	2			1	3

In line with this, information was also collected from the patients about their opinions on the cleanliness of the health facilities, furniture, whether the persons that

[10] Floor may have some dirt around the entrance, etc but appears to have been cleaned in the last two days.
[11] Floor has dirt in less trafficked areas and has not been cleaned in the last two days.

diagnosed patients were in their uniforms, lab coats or had their name tags on. Table 17 shows summary of the findings. The monitoring exercise showed that 3 out of 10 patients were treated by health staff who could not easily be identified as they did not neither dress in uniform nor had name tags[12].

Table 17: State of Health facilities' Equipments

Aspect	Opinion	%age
Cleanliness of Health facilities	Clean	54.1
	Fairly clean	37.7
	Dirty	7.2
	Very dirty	1.0
Status of Furniture	Clean	55.4
	Fairly clean	39.1
	Dirty	5.4
Workers dressed in uniform, lab coats or had name tags on	Yes, uniform and name tag	11.6
	Yes, uniform only	52.9
	Yes, name tag only	3.8
	Non of the above	31.5
Patients informed of their medical conditions	Yes	55.7
	No	39.8
	Did not remember	4.5
Patients cured after accessing treatment	Yes	70.1
	No, still undergoing treatment	9.5
	No, had to seek treatment elsewhere	15.6
	No	3.7
	Patient died	1.0

It was also seen that a number of patients or their next of keen did not get feedback from the health workers about their medical conditions as accounted for by 39.8% of the services consumers.

Sources of water and power at health facilities

According to the national health policy document, under the health care delivery system, one of the responsibilities of the district health care system is to ensure

[12] Such health workers mainly were at HC II and III.

provision of safe water and environmental sanitation at the public community health facilities among other things (National health policy 1999). In relation to this objective, the monitoring exercise looked at the availability of water sources at the various health facilities and their functionality. Table 18 shows the summary of the findings.

Table 18: Water Sources and Functionality at the Health facilities

Source of Water	Sources working now			%age by water source
	Working well	Working but faulty	Not working at all	
Didn't have			4.2	4.2
Piped or tap	16.7	4.2	4.2	25.0
Borehole	4.2	4.2		8.3
Rain tank	12.5	16.7		29.2
Ponds /rivers and streams	4.2	16.7		20.8
Others	4.2	4.2	4.2	12.5
%age by Functionality	**41.7**	**45.8**	**12.5**	**100.0**

The monitoring exercise revealed that 4.2% of the facilities[13] did not have any water source and in 12.5% of the facilities[14] either their water sources were not operational or they did not have them at all. This implied that health facilities which did not have any form of water source experienced difficulties in providing satisfactorily services to their communities. However, 29.2% of the facilities visited relied on harvested rain water usually stored in the tanks, implying if there were no sufficient rainfalls, or dry periods, they experienced difficulties in getting water for utilization. It was observed during the research monitoring exercise that some health facilities had piped water sources, but some were not operating by the time of this monitoring exercise. They had either broken down or had been disconnected due to failure to pay bills. Observed also was that 20.8% of the facilities relied either on ponds, rivers or streams as water sources. These sources are unsafe especially if the water is to be used by the patients.

The monitoring exercise also looked at the sources of power, and as seen in Table 19, 33.3% of the facilities[15] had power challenges as they were observed to have no power source. Generally there was shortage in cheaper power sources, like electricity, as it was discovered that out of 24 health facilities visited, only tree were using electricity. This will inevitably affect the ability of health facilities to offer services at night.

[13] Mainly HC IIs
[14] HC IIs & IIIs
[15] HC IIs and Hospitals used mainly grid power, some HC IVs & III had solar panels.

Table 19: Health facilities by Sources of Power

Source	Level of Usage	Total	%age
No source at all		8	33.3
Solar panel	Source not used	9	37.5
	Most used	9	37.5
	Second most used	3	12.5
	Least used	3	12.5
Grid (electricity)	Source not used	20	83.3
	Most used	3	12.5
Generator	Source not used	18	75.0
	Most used	2	8.3
	Second most used	2	8.3
	Second least used	1	4.2
	Least used	1	4.2
Bio-gas	Most used	2	8.3
	Second least used	1	4.2

The monitoring exercise observed that the most convenient power source adopted by most of facilities was solar energy, much as its usage was still below average among the visited facilities and limited to preserving (refrigerator) and sterilising equipments.

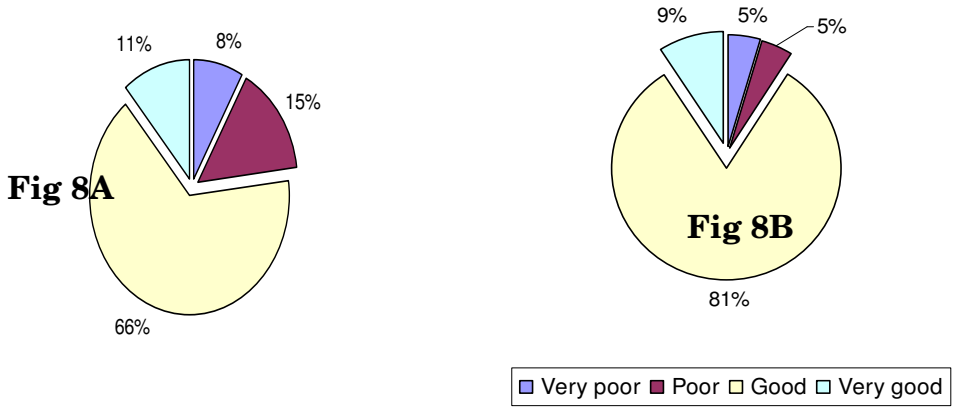
CHAPTER V

Perception and Responsiveness of Service Providers and Consumers towards Quality Health Service Delivery

Health worker - patient relationship

The National healthy policy considers social values in the health care sector paramount (MoH national health policy, 1999). In its objectives the policy notes that government will promote a harmonious working relationship between decision-makers, service providers and beneficiaries. Based on this policy, the monitoring exercise sought to assess the health worker-patient relationship.

Figure 8: Distribution of participants by Health worker–Patient Relationship



The health worker-patient relationship was said to be generally good as accounted for by 66% of the health service consumers and 81% of the health workers with references to figures, 8A and 8B for health service consumers and providers respectively.
It is important to note that our visit to most health units, especially those that had not been monitored for a long period of time, was an eye opener and encouraged some workers to assess their performance.

Reasons given for the existing health worker–patient relationship

The health service consumers said that the good relationship that existed between them and the health workers, accrued from health workers who were not abusive as said by 67.8% of the service consumers. Other service consumers said that their health facilities had professional staff.

Those who sited poor health worker-patient relationships said that it was mainly due to lack of drugs at the health facilities.

Conduct and behaviour of health providers

As mentioned in chapter one, community meetings were held in order to include the opinion of the community members on their level of involvement in, and opinions on the health system in their areas. According to the responses of those who participated, most community members were satisfied with the behaviours of the health workers since they treated people with respect. However in other meetings, some communities were dissatisfied with the conduct and behaviour of their health workers as they felt patients were not fairly treated or handled as the health workers were very arrogant in most cases.

Fairness in treatment

The monitoring exercise looked at the fairness, treatment and accessibility to services by communities in terms of; the extent to which patients did receive equal treatment irrespective of economic, social status, age, sex and type of disease, the extent patients did have access to the best treatment according to the capacities of the facilities, whether patients received humane treatment i.e. lives, bodies and personality were respected in the course of their treatment, and whether the most vulnerable groups (pregnant women, children, the elderly and those in critical condition) were given priority to access health services.

Most of the communities involved in this monitoring exercise were of the opinion that patients received equal treatment irrespective of the economic, social status, age, sex and type of disease. It was generally observed that a patient received treatment according to their sicknesses. However, it was stated that in certain circumstances, rich personalities and politicians were favoured. In such circumstances and during the period of limited supplies, again, it is the very poor individuals to suffer since they can not afford private medication.

It was expressed by the community members that there were general satisfaction with the access to the best treatment according to the capacities of the facilities. It was experienced that patient's rights were adhered too by the health workers much as there were few health workers and resources and the facilities are small with few equipments.

However, some members of the communities were dissatisfied because of the delays and neglect that was observed among some health workers. It was also emphasised

here that patients' rights were with those who were knowledgeable and those whose economic statuses were sound.

As mentioned, the area of humane treatment, i.e. if lives, bodies and personality were respected in the course of their treatment, was discussed at the community meetings. The critical area which came up was that some women who came for antenatal services were abused and some health workers were arrogant. Those who were satisfied pointed out that despite the inconsistent medical supplies the health workers provided humane treatment to communities.

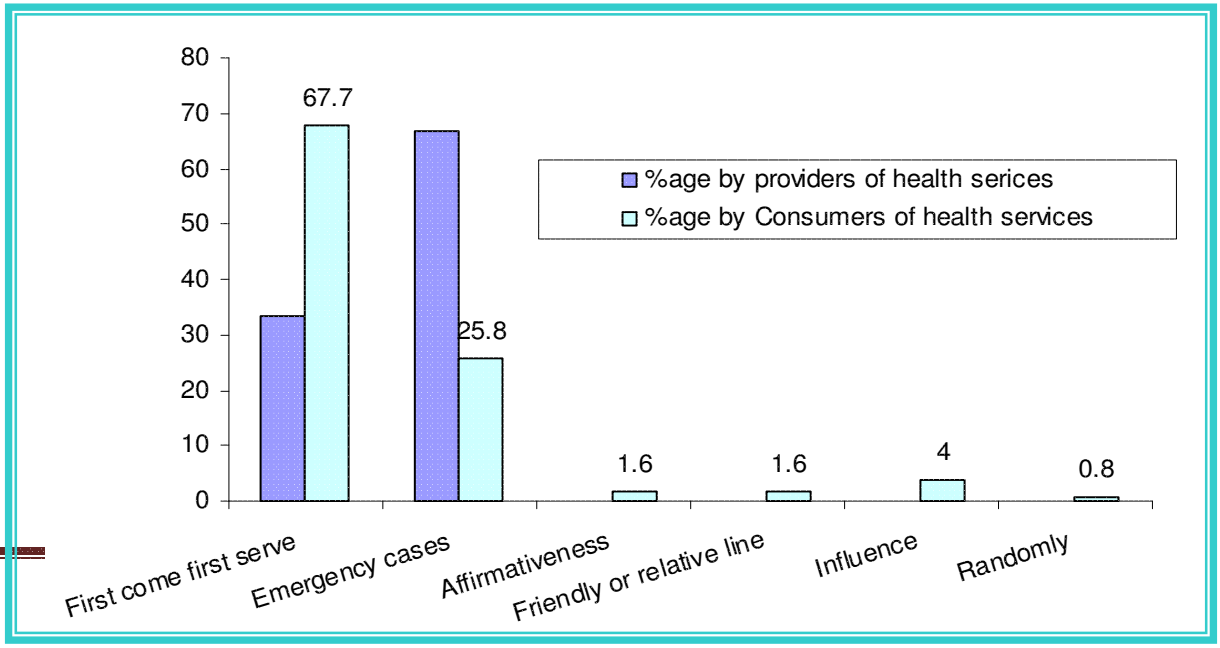
And lastly on the issue of whether the most vulnerable groups were given priority to access health services, the community meetings showed that most communities were not satisfied with the way health workers handled vulnerable groups, especially expecting mothers.

Order of Health service Provision and Consumption

The monitoring exercise looked at the common methods used by the health facilities in serving communities which included among others; first come first serve procedure, emergence case prioritization, and affirmativeness, on friendly or relative basis, influential or on random tendency.
The monitoring exercise showed that there were two predominantly applied procedures in providing health services to communities and these were;

1. Serving patients based on emergency cases which was highly prioritized by the health service providers and;
2. First come first serve basis as was suggested by most of the service consumers as shown in both figure:9 and the table showings the ranking in Appendix II

Figure 9: Used approaches in Health Service provision and Accessibility



As mentioned earlier, it was explained that some of the health workers served their clients based on their level of influences in communities. This implied that much as the emergency case procedure was said to be the first priority, it was most likely that in certain instances, such cases would not be served in the quickest time possible due to the presence of influential persons at the facilities. For example one member of the research team pretended to be a patient in one of the health centres in Kamwenge, while smartly seated on the waiting chair, the nurse inquired if she needed help and indeed she was helped, bypassing a young child with a bleeding wound. Because of the way she looked that commanded public respect and she was able to be worked on before any one else.

The practice of first come first serve is more suitable for health units with a clear sitting arrangement. In instances where people come and stand around the unit it is very difficult to tell. This approach can best be improved by issuing cards indicating numbers of patients who came earlier.

Measures to Ensure "First Come First Serve"

The measures put in place to ensure that apart from emergency cases, the method of "first come first serve" was adhered to, was by use of sitting order arrangement by waiting patients as suggested by 90.8% of the services consumers. Other methods used are included in Table 20.

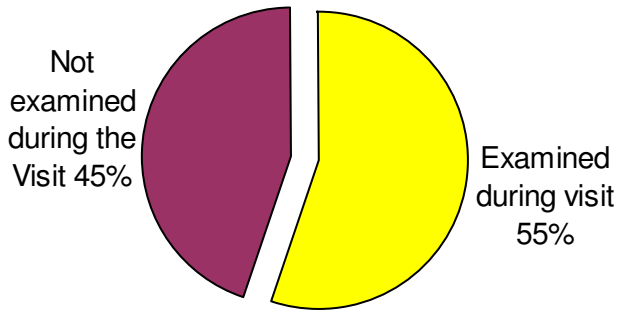
Table 20: Measures to ensure "First come first serve" at Health facilities

Measure ensured	No. of Participants	%age
Number of waiting cards for patients	22	8.0
Monitoring by the HUMC	9	3.3
Monitoring by the in-charge	17	6.2
Monitoring by LC leaders	10	3.4
Seating arrangement	265	90.8

Diagnosis of patients

The monitoring exercise gathered information from the health service consumers about how patients were handled in the process of diagnosing their problems. This was in terms of; availability of the in-charge at the facilities during the time patients went for treatment, whether patients were diagnosed and asked some questions in relation to their problems on their visit to the facilities among others. Note that a more thorough discussion on the role of the in charge is presented in the previous chapter.

Figure 10: Patients Examined at the Health facilities



It was also found that about half the number of clients that visited health facilities was not examined[16] before they were treated as in Figure 10. Treatment of a patient without diagnosing can lead to application of wrong treatment, which further puts them at risk as compared to those diagnosed. This situation occurred most among patients that did not find the in-charge at the health facilities.

Analysis of the designation of health officials that examined patients showed that enrolled nurses played a vital role as accounted for by 33.1% of the service consumers who had been examined. These were followed by the clinical officers as noted by 20.7% of service consumers.

Table numbered 21 gives a summary of the various health officials that take part in diagnosing patients at the various facilities.

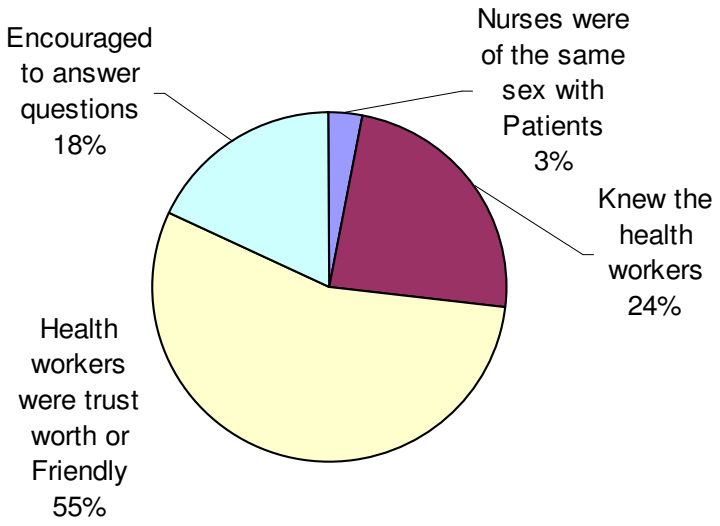
[16] Nearly all health centres did not have sufficient equipments to diagnose clients.

Table 21: Information Related to Patients Diagnosis at Health facilities

Aspect	Opinion	%age
Patients examined by	Clinical officers	20.7
	Medical officers	11.7
	Enrolled midwives	4.8
	Registered midwives	3.4
	Enrolled nurses	33.1
	Registered nurses	7.6
	Nursing assistants	8.3
	Health assistants	5.5
	Laboratory workers	2.8
	Did not know them	2.1
Workers asked patients some questions during diagnosis	Yes	91.9
	No	8.1
Workers handled patients with respect	No, they were rude to patients	9.9
	No, they were indifferent to patients	1.9
	Yes, handled patients with respect	88.2
Felt worker who examined patients paid attention to their problems	No, the workers were not interested	9.3
	Yes	38.5
	Yes, workers were interested & asked questions	52.2
Felt free & expressed themselves to workers that examined them	No	6.8
	A bit but the workers were inpatient	5.0
	Yes & the workers encouraged patients	88.2

The monitoring exercise showed that the major reason why some patients felt free to express themselves to the health workers while being diagnosed was due to the trustworthiness the patients had in health workers. This was observed from the friendliness staff had with patients as suggested by 55% of the service consumers as seen in Figure 11. The other reason was due to the fact that patients knew some of the health workers who examined them as suggested by 24% of the health service consumers that had been examined.

Figure 11: Reasons Patients were Free with Health Workers at Facilities



Observation of Patients' Rights

According to the findings, most community members were satisfied by the way patients' rights were observed by the health workers. However, some community members were partly satisfied with the way health workers handled patients because only those patients who were knowledgeable had their rights observed. Other health workers handled patients according to their economic status especially when it comes to expensive and uncommon drugs. At some health facilities, patients' rights especially pregnant mothers were violated by abusive health workers.

Others community members felt that their rights were abused by government because they did not have any public health facilities in their parishes while some facilities were not operation and no clear feedback given to them.

Essentials Provided by Patients

The distribution of health facilities by items like books, syringes etc, brought by patients for medical visits are as summarised in Table 22.

Table 22: Distribution of Health facilities by things brought by patients

Item carried by Patients to Health centres	Opinion	No.	%age
Syringes	Yes	2	11.1
	No	16	88.9
Drip/ IV fluids	Yes	1	5.6
	No	17	94.4
Child delivery sheets (mackintosh)	Yes	2	12.5
	No	14	87.5
Exercise books for writing prescriptions	Yes	14	77.8
	No	4	22.2
Cotton wool	Yes	1	5.9
	No	16	94.1
Soap	Yes	3	20
	No	12	80

Note: This information is inclusive of private and government health facilities

The monitoring exercise shows that the common asset that most health service consumers carried along when visiting health facilities was an exercise book where prescriptions were documented for the patients.

CHAPTER VI

Community Participation in Health Service Delivery

The monitoring exercise looked at the participation of the community in terms of; the extent to which they are involved in the planning processes through the Health Unit Management Committees, the extent community members were involved in the utilization of health services, to what extent the communities were involved in the monitoring of the health facility services (funds, medicine, manpower, quality of output etc). Also considered was how the communities have been involved in the decision making process of their priorities in the health facilities and how effectively and constructively communities received and gave feedback on the quality of services offered by health facilities. Presentation of the findings was based of the scoring that ranged from either no practice, dissatisfaction, partly satisfied and completely satisfied with comments.

Planning Processes

About communities' involvement in planning through Health Unit Management Committees, majority of the participants in the community meetings said that there was no practice by Health Unit Management Committees to involve the communities in the planning process of the health facility. This was due to the following factors;

1. That either no one was aware or communities were not involved in the planning process by HUMCs.
2. There were no health facilities' planning meetings held due to poor and inactive HUMC.
3. Communities were not participating in the planning process because HUMCs had expired.
4. It was also seen that some communities were not involved in the planning process simply because their health facilities were not yet operating.

However, some participants expressed that they were partly involved in the planning process much as their views were not reflected in the plans made at the health facility.

Monitoring of the Health Services Provided

In relation to communities participation in monitoring of the health services provided, the monitoring exercise through community meetings revealed that there was no practice at all of involving the communities in monitoring health services provided. Reasons given for the above opinions were;

1. There was no avenue for community members to participate in monitoring health services.
2. Some community members were not interested in monitoring health services as they did not know the benefit of this exercise
3. Some communities thought that health facilities were supposed to be monitored by people who leaved nearby health centres.

However, some participants were partially satisfied with the monitoring done by the local leaders and some sections of the community members. The challenge was on the feedback process which was not effective and sometimes not done by the monitors.

Communities' Participation in Decision Making

About, communities' participation in decision making process at health facilities, majority of the participants in the community meetings said that there was either no practice or they were dissatisfied with the level of involvement of communities' participation in the decision making process about their priorities in the health facilities. The comments given to support these views were that;

1. There were no decisions taken by the communities about priorities in service delivery at the health facilities.
2. It was also observed that communities were not consulted in the day today management of the health facilities.
3. Some of the participants believed that the decisions made by the HUMCs were not taken seriously by the workers at the health facilities

It was observed that some facilities (3 facilities) did not have Health Unit Management committees (HUMCs)[17]. The monitoring exercise also reveals that much as most health facilities had the HUMCs, most of them were non functional based on the fact that 6 of them had not had any meeting in the last six months while 11 had held only between 1 and 2 meetings in the same period. HUMC meetings are very important in improving services at the health facilities as it was observed that for those that held HUMC meetings, they had discussed various issues such as renovation of the structures, sanitation and water availability challenges at the facilities, the quality of the services rendered at health facilities and concerns of understaffing. As a result of these meetings, some actions were taken that included among others; some structures were renovated, there was lobbing done at government level, some workers were warned and had improved on time management and service provision improved, all efforts were geared towards improving service delivery.

[17] While some HUMCs were said to have expired and new ones were to be elected, some community members did not know why the unit did not have these committees.

Support Institutions in the Community

The monitoring exercise looked at the institutions/organisations that provided direct support to health facilities as a way of improving service delivery to the communities. Table 23 shows the institutions that provided support to health facilities and the various areas of support that included; mobilization, sensitisation and advocacy, monitoring of the health services, making of the bye-laws and direct service delivery.

Table 23: Health facilities Supporting Institutions in the Community

Institution/organisation	No. of Health facilities supported		Areas and No. of health facilities given support by mention institutions or organisations							
			Mobilization, sensitisation & advocacy		Monitoring		Bye-laws		Service delivery	
District health teams	7	29.2%	3	1 2.5%	3	12.5%	1	4.2%	1	4.2 %
Local council IIIs	7	29.2%	6	25%	2	8.3%				
Local council IIs	4	16.7%	4	16.7%	1	4.2%				
Local council Is	11	45.8%	11	45.8%	1	4.2%			1	4.2 %
HUMC	8	33.3%	6	25%	5	20.8%			2	8.3%
Village health teams	6	25%	1	4.2%					5	20.8%
Community based-based resource persons (CBHW, PDCs, Drug distributors, teachers, etc)	8	33.3%	5	20.8%	2	8.3%			6	25%
CBO/groups (women, youth, PWDs, PLWHA etc)	5	20.8%	5	20.8%					1	4.2 %
Other health service providers (PNFPs, PHP, TCMP)	4	16.7%							4	16.7%
NGO/FBO	9	37.5%	3	1 2.5%	2	8.3%			5	20.8%

The monitoring exercise revealed that Local Council I supported health facilities more than any other institution especially in the areas of monitoring service delivery and sensitization of communities about various issues related to health services. It was also seen that NGOs/Faith Based Organisations (FBOs) played a vital role as they had supported 39.5% of the health facilities in the same period in mobilization, sensitisation and advocacy, monitoring of the service delivery and in delivering services directly to people.

Challenges and constraints of Supportive Institutions

In most cases health facilities have supportive institutions based in the community or at the health facility itself. Supportive institutions like District health teams, Local councils, village health teams are very important for effective service delivery at community level. However these institutions face a number of challenges which hamper their effective participation the table below implores that challenges and constraints of these supportive institutions

Table 24: Challenges and constraints of Supportive Institutions

Institution/organisation	No. of Health facilities supported		Constraints/challenges of supporting orgs by health facility									
			Inadequate funding/ other resources		Inadequate skills		Inadequate health information		Limited commitment		Unrealistic expectations	
District health teams	7	29.2%	4	16.7%			1	4.2 %	5	20.8%	1	4.2 %
Local council IIIs	4	16.7%	2	8.3%			2	8.3%	2	8.3%	1	4.2 %
Local council IIs	2	8.3%	1	4.2 %			1	4.2 %	1	4.2 %	1	4.2 %
Local council Is	9	37.5%	1	4.2 %			1	4.2 %	3	12.5%	4	16.7%
HUMC	5	20.8%	4	16.7%			1	4.2 %			1	4.2 %
Village health teams	6	25%	2	8.3%	1	4.2 %	2	8.3%	1	4.2 %	1	4.2 %
Community based-based resource persons (CBHW, PDCs, Drug distributors, teachers, etc)	6	25%	3	12.5%			1	4.2 %	2	8.3%	2	8.3%
CBO/groups (women, youth, PWDs, PLWHA etc)	3	12.5%	3	12.5%			1	4.2 %	1	4.2 %		
Other health service providers (PNFPs, PHP, TCMP)	2	8.3%					1	4.2 %	1	4.2 %		
NGO/FBO	4	16.7%	1	4.2 %			1	4.2 %	1	4.2 %	1	4.2 %

Solutions to the Challenges

Some solutions were identified by various health facilities for the above mentioned challenges and constraints of the institutions and organisations that supported the facilities visited. The solutions were given based on the category of the challenges.

For the case of inadequate funding and other resources, the health facilities suggested the following as solutions;

1. There was need to increase lobbying for health financial support, this statement was supported by 25% of the 24 health facilities visited.
2. There was need to increase communication and monitoring between the supporting institutions, communities and the health facilities.
3. For the case of inadequate skills by some of the supporting institutions the health workers suggested that there was need to sensitize the leaders (local councils and the like) mainly through training them in issues related to health service delivery and consumption.

Concerning the inadequate information, health workers suggested the following as solutions to the challenge;

1. There was need for increased communication on a regular basis between the health workers of the health facilities especially the management and the supporting institutions or organisations to boost information flow and awareness creation.
2. There was also need to sensitize local leaders about the importance of information especially in relation to utilizing and availability of the health services to their communities.
3. Some health facilities suggested that there was need for more allowances and facilitation in order to boost information flow between health facilities and supporting organisation in achieving maximum and proper services availability and utilization among communities. However, the factor of allowances has been observed to be a killer factor in promoting community participation in own development. It is recommended that communities take up community initiatives as their own affairs and not waiting for facilitating in terms of allowances.

On the issue of limited commitment, the following options were suggested as solution to the challenge;

There was need for increased cooperation and supervision of the various services provided by both the health facilities and supporting institutions.

Lastly on the issue of unrealistic expectations, health workers suggested that there was need for increased communication between the supporting institutions and the health facilities. This would help especially the local leaders to be sensitized about the service delivery mechanisms and the role of support institutions to communities.

Public Information Provision by Health facilities

The National health policy emphasises the need to intensify information, education and communication activities to improve health awareness, effect desired changes in knowledge, attitude and behaviour (including health seeking behaviour) directed towards the prevention and control of the major health problems and in promoting health lifestyles. (MoH national health policy, 1999)

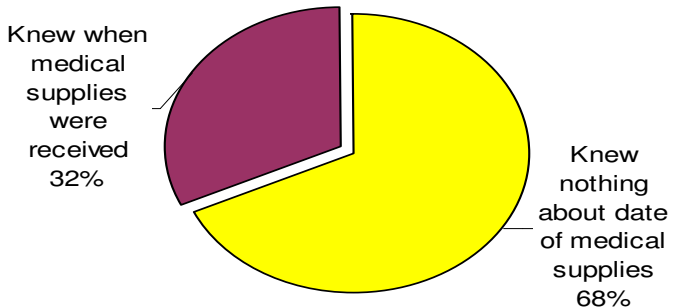
The monitoring exercise looked at how the health facilities were providing information to the public in relation to the services provided. The following opinions were given by the visited health facilities on the issues considered to be for public consumption as seen in Table 25.

Table 25: Health Service Public Information Provision

Aspect	Opinion	No. of Health facilities	
Information about services provided	Yes	24	(100%)
Information about new deliveries on drug	Yes	16	(66.7%)
	No	8	(33.3%)
Information about community health rights & obligations	Yes	11	(45.8%)
	No	13	(54.2%)
Information about family planning services	Yes	20	(83.3%)
	No	4	(16.7%)
Information about HIV/AIDS services	Yes	21	(87.5%)
	No	3	(12.5%)
Information about malaria services	Yes	24	(100%)
Information about immunization services	Yes	22	(91.7%)
	No	2	(8.3%)
Display of PHC funds	Yes	8	(33.3%)
	No	16	(66.7%)

The monitoring exercise shows that information concerning services provided e.g. information on malaria, immunization, HIV/AIDS and family planning services was very well provided according to the health workers in nearly all the health facilities visited. The analysis shows that much as the health facilities said to have provided information to consumers, the findings from the service consumers show that 7 in 10 had no information or were not aware when medical supplies were availed to facilities as shown in figure 12.

Figure 12: Knowledgeable about the Medical Supplies



This implied that most health facility officials were not keen in providing information about the medical supplies. This was seen to be the actual situation by the fact that very few (12.1%) of the health services consumers suggested that they came to know about medical supplies through either posters or health staff. Other sources of information about medical supplies as suggested by those who had information about medical supplies were as seen in Table 26.

Table 26: Sources of Information on Availability of Medical Supplies

Source of Information	No of Participants	%age
Experience from visits to Health centres	13	14.3
Patients who visited Health centres	17	18.7
Local Council chairpersons	24	26.4
Announcements in public places	8	8.8
Health facilities ' staff	7	7.7
Posters at the Health facilities	4	4.4
When the vehicles were delivering drugs	18	19.8
Total	**91**	**100**

The monitoring exercise also showed that 81 out of 100 patients that visit health facilities for treatment are aware that the medical services were supposed to be freely provided, while 19% did not know. Although some sources of information were mentioned by the health centre staff on how patients got to know that services in government health centres are for free, few health service consumers did not know that government health centres were supposed to provide services freely.

Information on Essential Medicines and Supplies

Access to health care services, qualified health care staff and medicines are components of health care system. Of these three components, medicines are of special importance for various reasons; they save lives, improve health, promote trust and participation in health services, they are very costly. Communities quite understandably, equate the quality of health care primarily with the availability of basic essential medicines. (Uganda Pharmaceutical Sector Baseline survey 2002)

Acknowledging this fact Uganda adopted a national drug policy (NDP) to contribute to the attainment of a good standard of health by the population, through ensuring the availability, accessibility and affordability at all times of essential drugs of appropriate quality, safety and efficacy, and by promoting the irrational use.

The monitoring exercise also looked at medical supplies to the health facilities, their availability, especially during the time of the monitoring exercise, and quality of the medicine by the end of the stock. Information concerning medical supplies was derived from the stock cards kept at the health facilities. Some of the considered essential supplies and drugs were; erythromycin, chloroquine, Cortrimoxazole/ Septrin (tablets) Quinine, Mebendazole, Coartem, Paracetemol, Fansidar, ORS, measles vaccine, DPT vaccine, Depo-provera, condoms, syringes. It was observed that in some health facilities especially II and III stock cards for medical supplies are not well updated. In some health facilities records for supply do not tally with expenditure. **Appendix V** gives the summary of the findings on some of the essential medical supplies given to the various health facilities in the region.

Table 27: Public Health Information Provision by Health Facilities

Aspect	Strategies used in providing update Health Public Information about Health facilities Services										
	Posted outside clinic %	Posted in room %	Posted in Villages %	Verbally by staff & patients %	Thro. HUMC %	Village Health Teams %	Thro. LC.Is, religious & community leaders %	In out reach progs. In communities %	Thro. Volunteers from communities %	Thro. Medical staff when patients visit %	Posters displayed in the health facilities %
Services provided	50	20.8	8.3	75	8.3	4.2	33.3				
New drug deliveries	4.2			58.3			20.8				
Community health obligations		4.2		37.5		4.2					
Family planning								12.5		75.0	25.0

Effective and Constructive Feedback

Information on how effectively and constructively communities gave or got feedback on the quality of services offered by the health facilities was collected through community meetings. Majority of the participants said that there was no practice used at the facilities to give or get feedback about the quality of services offered, these sited lack of a clear system of getting feedback on their opinions about the services provided and their providers at the health facilities. However, some participants said that communities were partly satisfied by the way feedback was given because HUMCs did not report back about the services provided at the health facilities. While least of the participants said that they were completely satisfied with the way feedback was being given, though the feedback its self was not sufficient enough about the services provided.

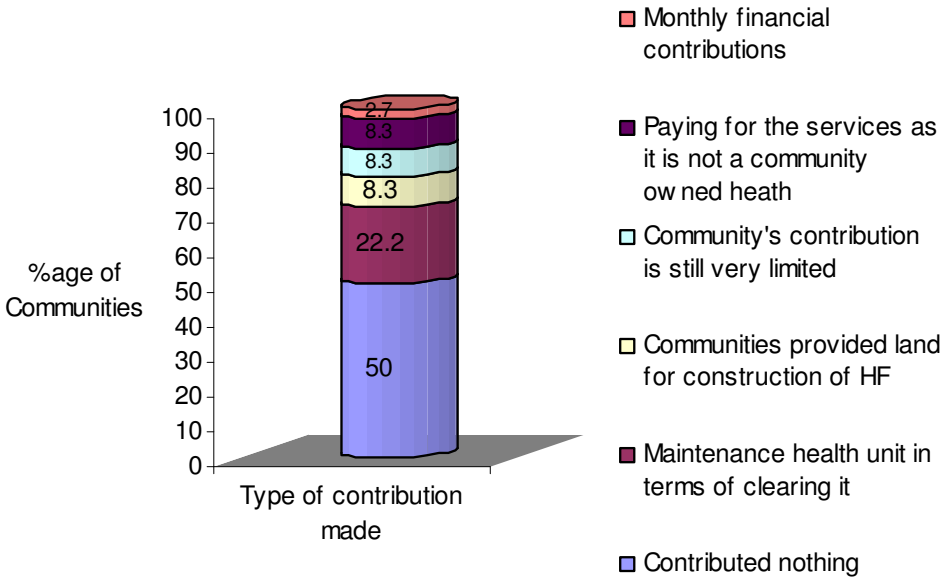
Table 28: Health Worker Information Dissemination on Patients' Rights & Obligations

Rights Issue	Response	No. of Health facilities / workers		%age by Opinion		Reasons
Free health care (No charges)	Spontaneous	6	(25.0%)	Agree	87.5	Have drug stocks
	Prompted	15	(62.5%)	Disagree	8.3	PHCs' funds delay while NGOs charge Patients
	Don't know	3	(12.5%)	No opinion	4.2	NGO charge patients
Patients should be attended to within 1 hour	Spontaneous			Agree	70.8	
	Prompted	20	(83.3%)	Disagree	20.8	Understaffing, heavy workload and some workers late
	Don't know	4	(16.7%)	No opinion	8.3	
Right to confidential treatment i.e. the staff should not be talking about patients' health or illness with other people	Spontaneous	3	(12.5%)	Agree	91.7	But there are not enough facilities
	Prompted	17	(70.8%)	Disagree		
	Don't know	4	(16.8%)	No opinion	4.2	
Right to be examined in privacy	Spontaneous	4	(16.8%)	Agree	87.5	But there is limited space and equipments to apply
	Prompted	18	(75.0%)	Disagree	4.2	Patients of the opposite sex
	Don't know	2	(8.3%)	No opinion	4.2	
Polite treatment to patients & its attendants without discrimination i.e. on the first come-first serve basis	Spontaneous	4	(16.8%)	Agree	100	But recruitment policy is bad
	Prompted	18	(75.0%)	Disagree		
	Don't know	2	(8.3%)	No opinion		
Right to receive information on the drugs received at the health facilities and how they are utilized including the result of examination	Spontaneous	4	(16.8%)	Agree	95.8	But difficulties in mobilizing patients and communication gap
	Prompted	18	(75.0%)	Disagree		
	Don't know	2	(8.3%)	No opinion	4.2	

Community contribution towards health facilities

This looked at the local contributions communities made towards the activities carried out in the health facilities both monetary and non monetary. And Figure 13 shows the contribution made by percentage of the communities.

Figure 13: Contributions by Communities



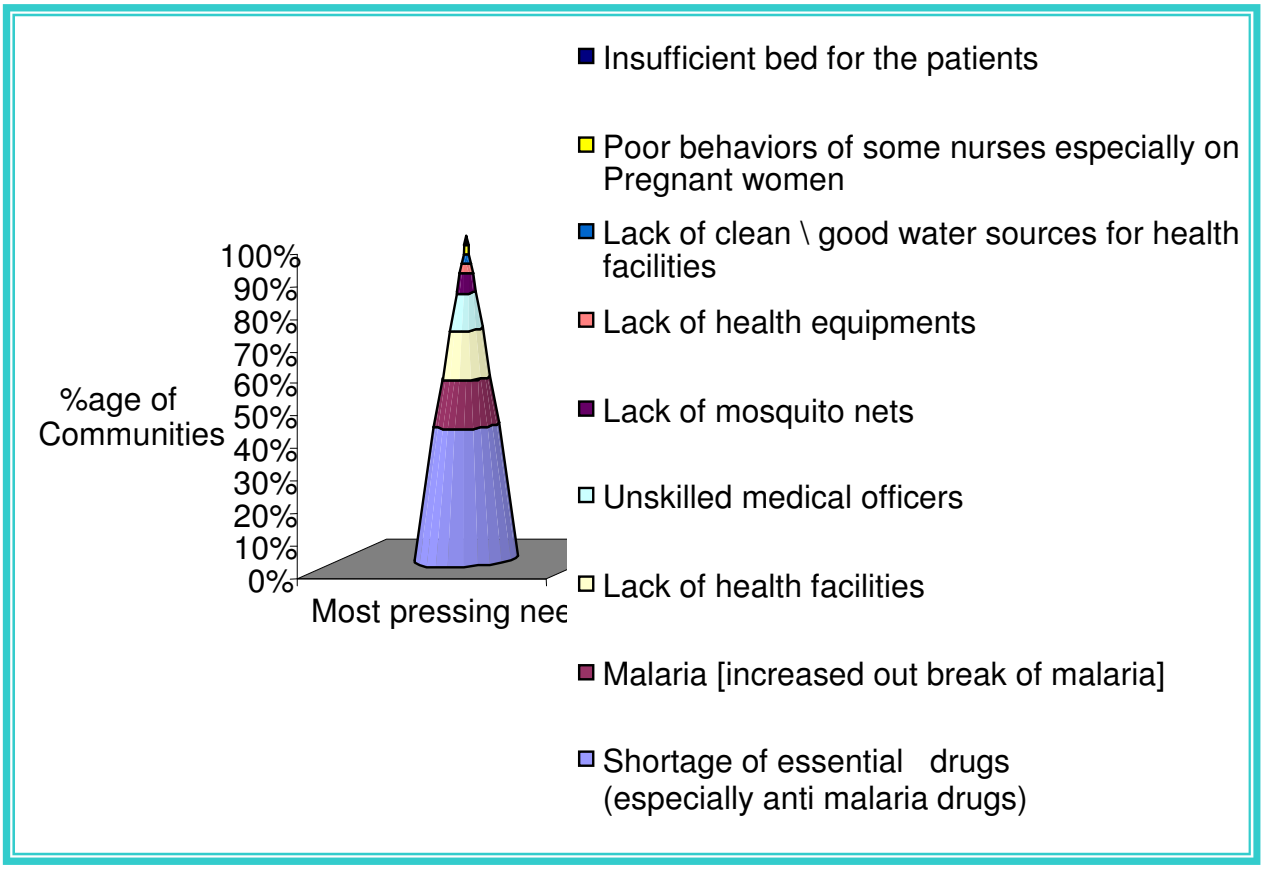
The monitoring exercise revealed that, the communities' contribution towards health facilities maintenance was very small. It was seen that, the few communities that contributed, did so mainly in fixed items like land for the health facilities. This generally meant the sense of ownership of the health facilities by the communities was low. This in term also helps to determine the level of efficiency that Health centres respond with to the needs of the participants or communities.

It is high time that communities became owners of the health facilities and government should put in place a strategy to transfer ownership of health centres through empowering the Health Unit Management Committees.

Pressing Needs, Issues or Challenges

Through community meetings, communities suggested the most pressing health needs. Shortage of drugs in government health units was common in at least 6 out of 10 parishes that had public health facilities. The assessment of the most pressing health related challenge faced by the grass root communities in the last 6 months, was shortage of the most essential drugs like the anti malaria drugs as seen in Figure 14

Figure 14: Most Pressing Challenge



KEY ISSUES

- ✓ There is low and uneven distribution of health services. Majority of the consumers interviewed travelled long distances to get medical treatment, others self medicate while some went to traditional healers. Trained health workers are inadequate in numbers, unevenly distributed, and generally poorly motivated

and supervised. Many of the key health centres are grossly understaffed especially in rural areas where the majority population live.

- ✓ Access to health services in most sub counties visited is still very poor, a sub county often has one health centre III and Health centre II at parish level. However a sub county has more than twenty villages with vast number of people. The national health policy emphasises the need to have health services closer to the community, while in sub counties like Nkoma in Kamwenge, Nyantungo in Kyenjojo and Ndugutu in Bundibugyo, health centres are inadequate, people trek long distances to get to a health centre. In Nkoma for example only 1487 people can access health services with in a distance of 10 kilometres.

- ✓ Monitoring at lower level health facilities is very minimal. In some areas, health centres III and II have never been visited by the inspector of health services. In such health centres it was observed that staff motivation and performance is generally low.

- ✓ Keeping financial and drug records remain a big challenge in some health units. Most records are not updated; drug supply by National Medical Stores (NMS) and Joint Medical Stores (JMS) is sometimes delayed. Health centres often run out of essential drugs for almost a month as told by one in charge at health centre III in Kamwenge, during the research visit.

- ✓ Accessing antenatal care for pregnant women is still a challenge given the distance pregnant mothers have to travel to access these services. Amongst the rural illiterate, most mothers deliver from traditional birth attendants. This increases their chances of dieing especially in cases of obstructed labour which a Traditional Birth Attendant can not handle.

- ✓ Under staffing in health centres was very alarming and needed urgent attention from development actors. Some health centre IIs visited employed senior four drop outs who also acted as on job trainees to administer drugs to patients. Though they play a fundamental role at this level, they lack skills of administering medicines because they are not trained. Positions not occupied by qualified aides are remaining vacant in some health centres visited.

"*There is a problem of understaffing in Bundibugyo for example Bundibugyo hospital has 1 doctor in a hospital supposed to have 5 doctors, Kikyo health center IV has a clinical officer Nyahuka employs volunteers, Generally Bundibugyo has about 35% of the needed human resource and majority of these are Nurses and clinical officers .There are few very Doctors and mid wives in the district*". As said by the DHO Bundibugyo in an interview

- ✓ Majority of the health facilities visited had poor physical infrastructures. In places like Kamwenge where earthquake is rampant, some buildings have developed cracks, a case of Bukurungu HC II in Kamwenge where a cracked building had become a health hazard during the research period. Toilets have fewer stances compared to the number of patients; some of them are full to maximum, which poses a health hazard to people using them. Large part of health centre infrastructures remains dilapidated and poorly equipped.

CHAPTER VII

Possible Recommendations for Improved Service Delivery

This chapter draws possible recommendations and strategies drawn from each chapter and sharing meetings with the district stakeholders where the montiring was carried out, with a focus to improving service delivery in the health sector. In the analysis we made links to the national policy and the recommendations from World Health Organization. It is important to note that problems at national level may correspond to the problems faced in the Rwenzori region. In drawing recommendations we draw a link between our key findings i.e. Provision of free treatment by government health centres, provision of information related to sources of funding and the actual amounts of money received, opening and closing time of health units should be keenly monitored. Understaffing, employment of under qualified staff and absence of an in-charge are other areas that the research deemed very important to consider if satisfaction levels are to improve. We have also categorized recommendations according to specific areas of intervention i.e. concerned ministries, and district level.

Specific recommendations to;

The Ministry of Health

1. **Decentralization of the drug distribution centre -**Government should decentralize the drug distribution centre (National Medical Store) by creating regional stores to reduce delays in supply and increase efficiency in the drug usage and reduce wastage mainly at both National Medical Store (NMS) and health facility level.
2. **Branding of drugs;** in order to get rid of drugs mysteriously disappearing from the centres, the team would like to recommend that ministry of health should brand drug with inscriptions such as "property of the government of Uganda, or ministry of Health" to prevent them from being stolen.

3. **Diagnosis and Equipment -** There is a challenge in relation to the diagnosis of patients at all health centre levels. Where there is availability of equipments for diagnosis of diseases like malaria, the existing personnel are either unable to conduct the tests due to insufficient skills to do so or technical [personnel to conduct these tests had been assigned other duties. This was very common with health centre IVs. At HC II & III, there was total lack of such equipments. The secretary of health and education Bundibugyo district noted with great concern as said, "Medical personnel are using hands to test for

malaria and have on many occasions ended up giving wrong prescription to patients. This has also led to misuse of drugs". Ministry of health should equip HC II & III in term of equipments especially malaria testing kits which are lacking.

4. **Mainstreaming the policy of comprehensive nursing -**There is need for Government to quickly mainstream the policy of comprehensive nursing (for both men and women) in training institutions to solve the problem of staff shortage especially in the maternity wards. Shortage of such personnel has greatly affected expecting mothers in rural areas who have had untold challenges with the few midwives attached to the health facilities. As a result many women have shunned way from their services in preference to the traditional birth attendants with limited skills and equipments to handle them.

5. **Put in place a statuary law that empowers HUMCs -** Ministry of health should revisit/put in place a statuary law that empowers HUMCs just like for education management committees by the ministry of education which provides for education management committees take ownership and decisions in the delivery of education services.

6. **Medical Personnel Staffing Structure -** Government should revisit the medical personnel staffing structure to provide for medical personnel at the lower HCs (III & IV) – to respond to increasing medical service consumers especially at HC III & IV. It was actually revealed that health workers at these health centres work more than those at the hospitals since they worked in shifts.

"The structure assumes that since only 20 maternity beds are allocated to HC III wards, and two maternity officers, then the number of service seekers would be proportional to the beds, which is not actually the case. This has resulted into nurses leaving HCs for hospitals because of big numbers".

In-charge from one of the health centres in Kamwenge district.

7. The Ministry of Health should urgently intervene in the problem of "absentee doctors' by posting doctors (just like the central government has done with the CAOs) and when they leave for further training;

their jobs should be advertised and refilled. This will address the current shortage of doctors in most of the health centers who go for further studies but dont return and their jobs are not filled yet straining the sector. The ministry needs to consider recovering monies paid to them when they don't return to their jobs.

The Ministry of finance Planning and Economic Development

8. Government through the ministry should restate the policy of staffing for medical workers at the health units. This would help reduce the rate of late coming for work and early closure of the health facilities. Hard to reach areas have one or no doctors because they resent the quality of services in those areas such as Bundibugyo and Kamwenge

9. Increase the Ministry of Health budget from the current budget of 457 billion and provide for **Preventative Health care and** gradually reduce on the curative medical care that was adapted from the colonial government. This with time will reduce the number of patients seeking medication and hence reduction in the demand for medical staff required. On the one hand, budget increment can provide for accommodation descent accommodation facilities in the bid to increase on the availability of a health worker at the centre.

Local Governments and Health Departments

10. **Drugs and Finance -** District health centres should regularly display latest drug consignment and other resources including finances right from District, health centre and community notices boards for public viewing. This will in the long run increase on transparency and ownership of the health centres by the service consumers.

11. **Planning, Management and Supervision -** The districts need to adopt multi-sectoral approach in involving medical personnel HUMCs, the politicians, DHO plus the RDCs' office (this recently proved efficient in the community health mobilization towards the fight against ebola virus in the Rwenzori region).

12. **District Internal Auditors and IGG -** The IGG/ auditor general must show interest in the performance of the health sector – by regularly auditing and prosecuting culprits that steal drugs and other services from the health facilities up to the lowest level. For the district internal auditors, they need to audit beyond figures in books of

accounts but emphasise social and physical accountability in the community.

Community level and Health Management Committees

Monitoring of health facilities by HUMCs - The findings indicate that it is an important role for the community in improving service delivery especially when they are involved in monitoring, and supervision of service delivery. Health Unit Management Committees should be strengthened and health personnel should take keen interest in monitoring the trickle down effect t of the services offered in the sector. HUMC should monitor the extent community members are involved in the utilization of health services, the extent to which communities are involved in the monitoring of the health facility services (funds, medicine, manpower, quality of output etc and how the communities can be involved in the decision making process of priorities in the health facility. Monitoring inventories by HUMCs should be carried out at least twice a year.

Induction of HUMCs must involved medical personnel, and local councils I, II and III in to understand their roles but importantly for collective responsibility purposes and ensuring accountably of the health centres.

District local governments and Health Departments

Increasing supervision of service delivery; A lot needs to be done by the health department in improving its supervision especially at health centre II, III and IV to improve service delivery as this largely found to be lacking hence poor delivery of health services.

General Recommendations

1. **ringing health services closer to the community**

In bringing public health mainstream medicinal services closer to the people (in about 5 kilometre distance), with special consideration to the rural poor communities, there is need to analyse the aspects of ownership of health facilities, distribution of health facilities by location i.e. in terms of rural and

urban settings. Health centre II and III are crucial in bringing health services closer to the community however they are least facilitated in terms of medical equipments and personnel. The government should work towards strengthening these centres and monitoring their progress.

The government need to put in place strategies of strengthening initiatives geared towards improving service delivery at community level like the yellow star rating. Focus should be on how to ensure the ownership and sustainability of development programs started by the government where beneficiaries can manage them in the absence of the government. Findings from the monitoring exercise revealed that some health workers are not updated with information concerning yellow star rating, and in some health units the program is becoming less valued compared to when it had just started.

2.

Improve Health worker - patient relationship

The government through the ministry of health and district health department and working with other development actors should consider increasing the number of staff in health units depending on the patients served. A base line survey on the number of patients attended to in a month per health unit needs to be conducted to ensure sufficient staff are deployed in various health centres. NGOs and other service providers can contribute logistical and technical support of staff in the health sector.

Improving patient-health worker relationship in relation to observing patients rights, behavioural and social conduct of service providers warrants sensitization the health workers and the community on the importance of observing patient rights. Communities should be sensitized about their rights and what to expect at health facilities. There is significant need for strengthening human resource at health facilities and motivating workers to perform to their ability through motivational measures like building staff houses, renovating the dilapidated ones and respecting their monthly salary to be paid on time

3.

mprove drug supply at national level and monitor it's delivery up to the health facility

Drug suppliers like National Medical Stores need to improve on their delivery system to improve performance. District Director of Health Services need to work closely with local level health centres, to ensure services are delivered on time. It was discovered that some health centres at community level spend more than two months with out receiving drugs. National Medical Stores should deliver medicines as planned to reduce on stock outs.

It was noted in addition to the stock outs that, some workers at health centre II were not aware of Primary Health Care (PHC) funds. Some health workers at this level had spent more than two months with out getting their salaries. When the motivation of health workers is poor, there is a very high likelihood of misusing the little services in place like selling of drugs and other health equipments.

4.

mprove the effectiveness of health facilities to respond to health community needs

The in-charge plays a vital role i.e. when it comes to monitoring and supervision of health facility performance. When workers stop showing up on time or all together, nurses are less polite and the level of sanitation reduces in the health unit it could be influenced by the absence of an in-charge. To address the challenges of poor performance and responsiveness to community health needs, the in charge should be empowered to take disciplinary action on poor performance. He/she should be exemplary by reporting on time, delegating in case he is absent and giving accountability to the community and staff about his engagements through holding regular meetings at all levels. Staffing in health facilities is still demanding; there is need to recruit more staff in most health units of Kamwenge, Kabarole and Bundibugyo.

Communities need to be sensitized on the importance of utilizing health services especially pregnant mothers who often seek the services of traditional birth attendants.

General Conclusion

Understanding the general problems in the implementation of the National Minimum Health Care Package would help to counteract the possible challenges in the future. The NMHCP has a number of obstacles due to inadequacy of the services offered; for example the PHC funds are very negligible to cater for most of the

preventive aspects of health, Immunization services for example are not well done in most districts, due to low funds, the capacity of most districts to generate funds locally and their ability to contribute significantly to their own budgets is very minimal. The supply of the PHC funds is very irregular and in some cases it takes long to trickle down to the respective health centres this tantamount to a number of limitations in performing most of the planned activities and outreaches. There is irregular supply of fuel to carry out reaches, late payment of domestic arrears some aspects of which can be attributed to the central government delay in releasing funds.

This monitoring exercise, has established significant short falls mainly caused by inadequate supervision across all levels including National Medical stores, due to deliberate negligence on the part of officers, limited financing of the sector by the ministry of Finance Planning and Economic Development, thus affecting motivation of workers and frustration among service consumers. In addition, abuse of resource in the sectors has gone on with impunity and the auditor general, district and district internal and the inspector General of Government are doing a disservice to the sector.

APPENDICES

Appendix 1: Number of Visits made to Health Care Sources

Health care source	No. of visits	%age by age bracket			%age by Freq.
		5 yrs & below	6 to 17b yrs	18 yrs	
Health Centres & Hospitals	1	12.8	2.0	17.1	31.9
	2	2.9	3.5	8.4	14.8
	3	3.2	3.5	3.8	10.4
	4	1.7	1.2	5.2	8.1
	5	2.9	1.4	4.9	9.3
	6	0.3		0.9	1.2
	7			1.2	1.2
	8			0.6	0.6
	9			0.6	0.6
	%age by age	**22.1**	**13.5**	**43.9**	**79.5**
NGOs	1	0.6	0.3		0.9
	2			0.3	0.3
	%age by age	**0.6**	**0.3**	**0.3**	**1.2**
Private (for Profit)	1	1.4	0.6	0.3	2.3
	2	0.3		0.6	0.9
	3			0.6	0.6
	4			0.3	0.3
	5			0.3	0.3
	6	0.3			0.3
	%age by age	**2.0**	**0.6**	**2.0**	**4.6**
Traditional or spiritual healers	1	0.9		0.3	1.2
	2			0.3	0.3
	%age by age	**0.9**	**0**	**0.6**	**1.4**
Community health workers	1	0.3	0.3	0.3	0.9
	2	0.3			0.3
	6			0.3	0.3
	%age by age	**0.6**	**0.3**	**0.6**	**1.4**
Self treatment	1	0.6	0.3	0.9	1.7
	2	0.9	0.3		1.2
	3	0.6			0.6
	4	0.3		0.6	0.9
	5	0.3		0.3	0.6
	7			0.6	0.6
	%age by age	**2.9**	**0.6**	**2.3**	**5.8**
Government health facilities	1	1.7	0.3	1.2	3.0
	2			1.4	1.4
	3	0.3		1.2	1.4
	5	0.3			0.3
	6			0.3	0.3
	7			0.3	0.3
	9			0.6	0.6
	%age by age	**2.3**	**0.3**	**4.6**	**7.2**
%age Total		**30.7**	**15.3**	**54**	**100**

Appendix II: Ranking of Methods Used in providing Health services

Method	%age score by Health workers						Rank
	1	2	3	4	5	6	
First come first serve	33.3	58.3	8.3	0	0	0	**2**
Emergency cases	66.7	33.3	0	0	0	0	**1**
Affirmativeness	0	9.1	54.5	18.2	13.6	4.5	**3**
Friendly or relative line	0	0	5	35	30	30	**5**
Influence	0	0	35	30	35	0	**4**
Randomly	0	0	5.3	15.8	15.8	63.2	**6**
%age score by Consumers							
First come first serve	67.7	24.8	3.5	2.0	0.8	1.2	**1**
Emergency cases	25.8	63.1	8.3	2.0	0.4	0.4	**2**
Affirmativeness	1.6	2.4	50.8	13.6	30.0	1.6	**5**
Friendly or relative line	1.6	4.8	16.1	53.4	21.3	2.8	**4**
Influence	4.0	4.0	19.7	26.5	44.2	1.6	**3**
Randomly	0.8	0.8	1.2	2.0	2.0	93.2	**6**

The table above ranks the most used method in issuing health services to consumer

Appendix III: Services Provided by Different Facility Levels

Category of Service	Opinion	No. of Health Centres	%age	Days per Week
Outpatients care	Yes	24	100	Between 1 to 7 days
Inpatients care	Yes	13	54.2	7 days
	No	11	45.8	
Immunization	Yes	23	95.6	Between 1 to 7 days
	No	1	4.2	
Family planning	Yes	18	75	Between 4 to 7 days
	No	6	25	
Antenatal care	Yes	20	83.3	Between 1 to 7 days
	No	4	16.7	
Deliveries	Yes	16	66.7	Between 6 to 7 days
	No	8	33.3	
Laboratory services	Yes	16	66.7	Between 3 to 7 days
	No	8	33.3	
Dental services	Yes	6	25	Between 2 to 7 days
	No	18	75	
HIV/AIDS counselling & testing	Yes	17	70.8	Between 2 to 7 days
	No	7	29.2	
Outreach services	Yes	21	87.5	Between 1 to 5 days
	No	3	12.5	
Health education (excluding OPD)	Yes	20	83.3	Between 1 to 7 days
	No	4	16.7	
Family planning education	Yes	18	75	Between 1 to 7 days
	No	6	25	
Training of nursing aides or assistants	Yes	1	4.2	Only a few times in a year
	No	23	95.8	
Training community health workers	Yes	4	16.7	Only a few times in a year
	No	20	83.3	
Training traditional birth attendants	Yes	1	4.2	1 day
	No	23	95.8	

Appendix IV: Outreach Services and Associated Benefits and Challenges

Activity	No of HCs.	Benefits accrued	Challenges involved
Immunization (N = 21)	7	Reduced client load	Transport and facilitation allowances
	8	Improved coverage adherence	Shortage in medicine/vaccination supplies
	10	Reduced killer diseases	Transport and long distances to communities
	11	Improved sensitisation	
VCT (HIV counselling & testing) (N = 7)	7	Improved coverage adherence	Lack of facilities in the villages
Antenatal (N = 10)	3	Positive connection to communities	Lack of Facilitation allowance
Family planning (N = 3)	3	Increased access to services	Lack of transport and facilitation allowances
Dental clinic (N = 1)	1	Increased access to services	Lack of transport and long distances to communities
Home package distribution (N = 1)	1	Improved sensitisation	
Health education (N = 7)	3	Improved sensitization on prevention & community empowerment	Lack of transport and facilitation allowances
			Traditional beliefs
			Motivation and mobilization
	3	Reduced on killer diseases	Stigma
Home visits on HIV and TB (N = 5)	5	Improved coverage adherence	Lack of facilitation allowances

It is important to note that facilitation allowances have affected health service delivery at community level. The orientation has been paying staff facilitation allowance before they can go for field activities. In the absence of such facilities field activities are often cancelled.

Appendix V: Information on Essential Medical Supplies to Health facilities

Drug/Item,	Available at visit time by No. of HEALTH FACILITIESs		Quality at end of stock		Unit	Quantities of Items/drugs requested, received & brought forward in the last two quarters at the monitoring						
	Yes	No	Expiry time	Storage		Bal. Previous Brought foreword (n)	Bal. Previous QTR receipt (n)	Comment	Current Brought foreword (n)	Current Previous QTR requested (n)	Current Previous QTR receipt (n)	Comment
Erythromycin (n = 18)	4	14	In more than 6 months, (n=1) and in more than 1yr (n = 2)	Had poorly managed stores (n=1), Had well managed stores (n=2), Inadequate space (n=2) and Adequate space (n=4)	Tablets (n=7), bottles (n=1)and tins (n=5)	0 (9)	0 (2)		0 (7)	0 (5)	0 (5)	Have no had supplies since 2005 **(3)**
						7 (1)	2 (1)	No comment in all cases	5 (1)	1 (1)	1 (1)	No comment in all cases
							4 (2)		7 (1)	10 (1)	2 (2)	
							20 (1)		300 (1)	100 (1)	15 (1)	
							400 (1)		580 (1)	260 (1)	100 (1)	
							1000 (4)			1000 (2)	2000 (1)	
Chloroquine (n =18)	8	10	In 1 month (n=1), in more than 6 months (n=3) and more than 1 yr (n=3)	Had poorly managed stores (n=3), Had well managed stores (n=2), Inadequate space (n=3) and Adequate	Tablets (n=8) and Tins (n=7)	0 (6)	0 (5)	No comment in all cases	0 (9)	0 (11)	0 (8)	No comment in all cases
						7 (1)	1 (1)		9 (1)	1 (1)	2 (2)	
						9 (1)	3 (1)		13 (1)	6 (1)	5 (1)	
						23 (1)	5 (1)		41 (1)	1000 (1)	876 (1)	
						1047 (1)	200 (1)		1000 (1)	1600 (1)	3000 (1)	
						2500 (1)	1000 (1)		1042 (1)		5000 (1)	
						4100 (1)	2000 (1)		5000 (1)			

				space (n=2)		38000 (1) 3000 (1) 5000 (1)			22000 (1)			

Appendix V: Information on Essential Medical Supplies to Health facilities cont....

Drug/Item,	Available at visit time by No. of HEALTH Facilities		Quality at end of stock		Unit	Quantities of Items/drugs requested, received & brought forward in the last two quarters at the monitoring						
	Yes	No	Expiry time	Storage		Bal. Previous Brought foreword (n)	Bal. Previous QTR receipt (n)	Comment	Current Brought foreword (n)	Current Previous QTR requested (n)	Current Previous QTR receipt (n)	Comment
Septrine (n=18)	11	7	In more than 6 months, (n=3) and in more than 1yr (n = 6)	Had poorly managed stores (n=6), Had well managed stores (n=3), Inadequate space (n=2) and Adequate space (n=1)	Tablets (n=7), bottles (n=1)and tins (n=7)	0 (7) 3 (1) 5 (2) 1500 (1) 2000 (1) 3000 (1) 18000 (1)	0 (1) 1 (1) 4 (1) 8 (1) 10 (1) 15 (1) 30 (1) 3000 (1) 4000 (1) 5000 (1)	No comment in all cases	0 (8) 7 (1) 26 (1) 500 (1) 4000 (1) 13000 (1) 15000 (1) 41000 (1)	0 (6) 2 (2) 5 (1) 6 (1) 99 (1) 1000 (1) 13000 (1) 21000 (1) 215000 (1)	0 (5) 5 (2) 11 (1) 17 (1) 153 (1) 3000 (1) 4000 (1) 17000 (1) 35000 (1)	No comment in all cases

							7000 (1)					

Appendix V: Information on Essential Medical Supplies to Health facilities cont....

Drug/Item,	Available at visit time by No. of HEALTH Facilities		Quality at end of stock		Unit	Quantities of Items/drugs requested, received & brought forward in the last two quarters at the monitoring						
	Yes	No	Expiry time	Storage		Bal. Previous Brought foreword (n)	Bal. Previous QTR receipt (n)	Comment	Current Brought foreword (n)	Current Previous QTR requested (n)	Current Previous QTR receipt (n)	Comment
Quinine (n = 18)	7	11	In 1 month (n=1), in more than 6 months (n=1) and more than 1 yr (n=3)	Had poorly managed stores (n=2), Had well managed stores (n=3), Inadequate space (n=1) and Adequate space (n=1)	Tablets (n=6), packets (n=1), Cartons (n=1), tins (n=5)	0 (8) 1 (1) 10 (1) 14 (1) 35 (1) 90 (1)	0 (8) 2 (2) 200 (1) 1000 (1) 2000 (1) 6000 (1) 7000 (1)	No comment in all cases	0 (8) 1 (1) 4 (2) 30 (1) 2000 (1)	0 (7) 2 (1) 23 (1) 40 (1) 66 (1) 2000 (1) 3000 (2)	0 (9) 100 (1) 1000 (1) 2000 (1) 3000 (1) 4000 (1)	No comment in all cases
Mabendazole (n=17)	12	5	In more than 6 months (n=4) and more than 1 yr (n=5)	Had poorly managed stores (n=5), Had well managed stores (n=2), Inadequate space (n=1) and Adequate space (n=1)	Tablets (n=7), and tins (n=7)	0 (4) 1 (1) 7 (1) 9 (1) 11 (1) 15 (1) 19 (1) 300 (1) 1000 (1) 3000 (1) 4000 (1) 11000 (1)	0 (3) 2 (2) 10 (2) 1000 (2) 2000 (1) 5000 (2) 10000 (1) 13000 (1) 20000 (1)	No comment in all cases	0 (5) 5 (2) 16 (1) 19 (1) 1000 (2) 2000 (1) 1000 (1) 15000 (1) 16000 (1)	0 (6) 3 (1) 8 (2) 13 (1) 2000 (1) 3000 (1) 14000 (1) 35000 (1)	0 (7) 11 (1) 2000 (2) 3000 (1) 4000 (2)	No comment in all cases

Drug/Item,	Available at visit time by No. of HEALTH FACILITIESs		Quality at end of stock		Unit	Quantities of Items/drugs requested, received & brought forward in the last two quarters at the monitoring						
	Yes	No	Expiry time	Storage		Bal. Previous Brought foreword (n)	Bal. Previous QTR receipt (n)	Comment	Current Brought foreword (n)	Current Previous QTR requested (n)	Current Previous QTR receipt (n)	Comment
Coartem (n=13)	6	7	In more than 6 months, (n=3) and in more than 1yr (n = 1)	Had poorly managed stores (n=1), Had well managed stores (n=1), and Adequate space (n=3)	Tablets (n=4), packets (n=2), Cartons (n=1), tins (n=2)	0 (2) 3 (1) 110 (1) 120 (1) 2850 (1) 8690 (1)	0 (1) 6 (1) 27 (1) 240 (1) 390 (1) 1770 (1) 8610 (1)	No comment in all cases	0 (6) 9 (1) 4890 (1)	0 (2) 6 (1) 26 (1) 90 (1) 540 (1) 1650 (1) 4050 (1)	0 (1) 1 (1) 6 (1) 140 (1) 1650 (1) 3300 (1) 6000 (1)	Did not include coartem or adults (n=1), all dosages included (n=4) & records unclear (n=1)
Paracetemol (n=17)	14	3	In more than 6 months, (n=1) and in more than 1yr (n = 11)	Had poorly managed stores (n=3), Had well managed stores (n=2), Inadequate space (n=3) and Adequate space (n=2)	Tablets (n=9), tins (n=6)	0 (8) 2 (1) 5200 (1) 8000 (1) 9000 (1) 22000 (1)	0 (2) 1 (1) 3 (1) 5 (1) 6 (1) 7 (1) 17 (1) 4000 (1) 5000 (2) 8000 (1) 10000 (1) 60000 (1)	No comment in all cases	0 (6) 1 (1) 5 (1) 16 (1) 3000 (1) 3820 (1) 5000 (1) 10000 (1) 177000 (1)	0 (2) 1 (1) 2 (1) 3 (1) 11 (1) 20 (1) 28 (1) 2000 (1) 3000 (2) 6120 (1) 10000 (1) 27000 (1) 340000 (1)	0 (2) 8 (1) 10 (1) 25 (1) 41 (1) 92 (1) 2000 (1) 3000 (1) 5000 (1) 5200 (1) 30000 (1)	No comment in all cases

Drug/Item,	Available at visit time by No. of HEALTH FACILITIESs		Quality at end of stock		Unit	Quantities of Items/drugs requested, received & brought forward in the last two quarters at the monitoring						
	Yes	No	Expiry time	Storage		Bal. Previous Brought foreword (n)	Bal. Previous QTR receipt (n)	Comment	Current Brought foreword (n)	Current Previous QTR requested (n)	Current Previous QTR receipt (n)	Comment
Fansidar (n=17)	11	6	Expired (n=1), in 1 month (n=1), in more than 3 months (n=1), in more than 6 months (n=2) and more than 1 yr (n=4)	Had poorly managed stores (n=2), Had well managed stores (n=2), Inadequate space (n=2) and Adequate space (n=2)	Tablets (n=4), tins (n=6) and packets (n=1)	0 (8) 6 (1) 9 (2) 13 (1)	0 (5) 2 (2) 5 (1) 200 (1) 1000 (2) 5000 (1) 12000 (1)	No comment in all cases	0 (6) 1 (2) 3 (1) 4 (1) 5 (1) 7 (1) 1000 (1) 2000 (1) 4000 (1)	0 (6) 3 (1) 1 (1) 5 (1) 9 (1) 27 (1) 750 (1) 1000 (1) 2000 (1) 4000 (1)	0 (9) 1 (1) 2 (1) 9 (1) 30 (1) 1000 (1)	No comment in all cases
ORS (n=17)	13	4	In more than 6 months, (n=2) and in more than 1yr (n = 6)	Had poorly managed stores (n=4), Had well managed stores (n=2), Inadequate space (n=1) and Adequate space (n=2)	Packets (n=10)	0 (4) 50 (1) 103 (1) 300 (1) 375 (1) 480 (1) 901 (1) 1200 (1) 15000 (1)	0 (2) 50 (1) 75 (1) 100 (2) 300 (1) 400 (1) 500 (1) 700 (1) 1000 (1) 12000 (1)	No comment in all cases	0 (1) 50 (1) 77 (1) 94 (1) 100 (1) 300 (1) 350 (1) 500 (1) 700 (1) 725 (1) 849 (1)	0 (2) 25 (1) 50 (1) 177 (1) 200 (1) 250 (1) 300 (1) 611 (1) 765 (1) 18000 (1)	0 (5) 200 (1) 300 (2) 400 (1) 500 (1)	No comment in all cases

Drug/Item,	Available at visit time by No. of HEALTH FACILITIESs		Quality at end of stock		Unit	Quantities of Items/drugs requested, received & brought forward in the last two quarters at the monitoring						
	Yes	No	Expiry time	Storage		Bal. Previous Brought foreword (n)	Bal. Previous QTR receipt (n)	Comment	Current Brought foreword (n)	Current Previous QTR requested (n)	Current Previous QTR receipt (n)	Comment
Measles vaccine (n=10)	8	2	In 1 month (n=2), in more than 6 months (n=1) and more than 1 yr (n=2)	No store (n=2) Adequate space (n=1)	Bottles (n=4)	0 (1) 70 (2)	0 (2) 10 (1)	No comment	0 (2) 5 (1)	0 (3) 1000 (1)	0 (3)	Supplies are only for some days
DPT (n=10)	8	2	In 1 month (n=1), in and more than 1 yr (n=5)	No store (n=1), Had poorly managed stores (n=1), Had well managed stores (n=2), and Adequate space (n=1)	Bottles (n=4)	0 (2) 14 (1) 244 (1)	0 (2) 80 (1) 400 (1) 4040 (1)	No comment	0 (2) 23 (1) 28 (1) 76 (1)	0 (3) 250 (1) 1823 (1)	0 (3) 800 (1) 9100 (1)	Supplies are only for some days
Depo-Provera (n=16)	9	7	In more than 3 months (n=1), in more than 6 months (n=2), in 1 yr (n=6)	Had poorly managed stores (n=4), Inadequate space (n=1)and Adequate space (n=2)	Bottles (n=8), cartons (n=1)	0 (4) 3 (1) 75 (1) 220 (1) 300 (1)	0 (3) 50 (2) 100 (1) 200 (2) 400 (1)	No comment	0 (3) 20 (1) 25 (1) 200 (1) 210 (1) 250 (1)	0 (2) 35 (2) 100 (1) 200 (2) 250 (1) 275 (1) 600 (1)	0 (3) 30 (1) 200 (3) 800 (1)	Some do not offer family planning

Appendix V: Information on Essential Medical Supplies to Health facilities cont....

Drug/Item,	Available at visit time by No. of HEALTH FACILITIESs		Quality at end of stock		Unit	Quantities of Items/drugs requested, received & brought forward in the last two quarters at the monitoring						
	Yes	No	Expiry time	Storage		Bal. Previous Brought foreword (n)	Bal. Previous QTR receipt (n)	Comment	Current Brought foreword (n)	Current Previous QTR requested (n)	Current Previous QTR receipt (n)	Comment
Syringes (n=16)	12	4	In more than 3 months (n=1), in more than 1 yr (n=8)	Had poorly managed stores (n=3), Had well managed stores (n=1), inadequate space (n=1) and Adequate space (n=2)	Cartons (n=1), pieces (n=9)	0 (4)	0 (1)	No comment	0 (4)	0 (1)	0 (2)	No comment
						3 (1)	4 (1)		16 (1)	12 (1)	200 (1)	
						100 (2)	100 (1)		100 (1)	100 (1)	600 (1)	
						1200 (1)	200 (1)		168 (1)	150 (1)	2500 (1)	
						1327 (1)	300 (1)		300 (1)	222 (1)	3400 (1)	
						18600 (1)	400 (1)		1253 (1)	400 (1)	5700 (1)	
						22700 (1)	500 (1)		2800 (1)	600 (1)	28100 (1)	
							2800 (1)		10600 (1)	737 (1)	52600 (1)	
							73700 (1)			1060 (1)		
										2800 (1)		
										3100 (1)		
										52600 (1)		

Source: KRC - Health survey Data 2007

Appendix VI: Purchases and/or Repairs Made

Item	Facilities/Health facility	Purchased or received by no. of health facilities	Repaired by no. of health facilities
Cars	1	0	5 (20.8%)
Motor cycles	1	1 (4.2%)	4 (16.7%)
	2		1 (4.2%)
Bicycles	1		2 (8.3%)
	2		1 (4.2%)
Examination beds	1	2 (8.3%)	1 (4.2%)
Chairs	4	1 (4.2%)	
	9	1 (4.2%)	
Benches	5	1 (4.2%)	
Tables	1	1 (4.2%)	
Desks	3	1 (4.2%)	
Medicine cupboard/ store	1	1 (4.2%)	
	20	1 (4.2%)	
Sterilisation equipments	1		1 (4.2%)
Refrigerators	1		2 (8.3%)
Weighing scales	1	2 (8.3%)	1 (4.2%)
	2	1 (4.2%)	
Height measurement	1		1 (4.2%)
Blood pressure machine	1		1 (4.2%)
	3	1 (4.2%)	
Micro scopes	2	1 (4.2%)	

Appendix VII: Essential Items Possessed by Health facilities

Item	Opinion	No.	%age
Duty rosters for staff	Yes	17	73.9
	No	6	26.1
Duty roster for staff displayed	Yes	9	40.9
	No	13	59.1
Numbered waiting cards for patients	No	24	100
Seating arrangements in waiting room	Yes	21	91.3
	No	2	8.7
Suggestion box	Yes	5	21.7
	No	18	78.3
Name tags for staff	Yes	3	13.6
	No	19	86.4
Labels on the rooms	Yes	16	69.6
	No	7	30.4
Updated education to the community	Yes	9	50.0
	No	9	50.0
Specific training on client care	Yes	11	45.8
	No	13	54.2
Local Council leaders monitoring regularly	Yes	14	58.3
	No	10	41.7
Number of days per week the in-charge is present	0 days	2	8.3
	3 days	3	12.5
	4 days	3	12.5
	5 days	9	37.5
	7 days	7	29.2
Number of staff meetings held in last six months	0	1	4.2
	1	7	29.2
	2	8	33.3
	3	3	12.5
	5	3	12.5
	6	1	4.2
	7	1	4.2
Health facility have a HUMC	Yes	21	87.5
	No	3	12.5
HUMC monitor Regularly	Yes	16	80.0
	No	4	20.0
Number of HUMC meetings held in last 6 months	0	6	33.3
	1	6	33.3
	2	5	27.8
	3	1	5.6

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