STATE HOUSE
UGANDA

Health Monitoring Unit
Raising the bar in healthcare.

# ANNUAL REPORT
## FINANCIAL YEAR 2023/24

State House | Republic of Uganda

**STATE HOUSE**
**HEALTH MONITORING UNIT**

# ANNUAL REPORT

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# FOREWORD

*Esteemed Stakeholders,*

It is my great honour to present the Annual Report for the financial year 2023/24 — a critical year that reflects our continued resilience, innovation, and commitment to strengthening Uganda's healthcare systems. This period, being the penultimate year, marks a significant chapter in the implementation of the Health Monitoring Unit's (HMU) Strategic Plan 2020/21–2024/25, as we move steadily towards our goal of building a more accountable, responsive, and quality-driven health sector.

Over the past year, HMU has remained steadfast in its mission to elevate healthcare delivery standards, uphold integrity, and promote a culture of accountability. Our collective efforts have been directed at ensuring that health services meet the highest standards of quality, with a focus on empowering healthcare workers and enhancing community trust.

Anchored on our key thematic areas — Leadership and Governance, Human Resources for Health (HRH), Health Service Delivery, Essential Medicines and Health Supplies (EMHS), Infrastructure and Equipment, as well as Finance and Audit — we have continued to apply a results-based approach to our work. Through rigorous audits, spot checks at health facilities, monitoring of human resources, essential medicines, infrastructure investments, and financial management, we have ensured that the health sector remains aligned with national and international standards.

In a rapidly changing healthcare landscape, HMU has embraced adaptive strategies to detect, investigate, and respond to cases of mismanagement and health sector-related crimes. Our unwavering commitment to accountability — for funds, medical supplies, and infrastructural resources — remains a cornerstone of our work.

This report captures our key achievements, challenges encountered, lessons learned, and strategic recommendations during the fourth year of our Strategic Plan's implementation. It offers a detailed reflection on our contribution to the national Vision 2040 agenda, aiming for a future where every Ugandan has access to affordable, high-quality healthcare.

The insights drawn from the 2023/24 financial year reinforce our belief that progress is possible through strategic partnership, collaboration, vigilance, and innovation. I invite all stakeholders — from policymakers to community members — to engage with the findings and recommendations in this report as we collectively strive to transform Uganda's healthcare sector for the better.

*Together, let us continue to raise the bar in healthcare delivery.*

**Dr. Warren NAAMARA**

*Director, State House Health Monitoring Unit (HMU)*

# ACKNOWLEDGEMENT

I would like to extend our heartfelt gratitude to the dedicated Health Monitoring Unit (HMU) staff members who led teams into the field and tirelessly conducted monitoring activities across various health facilities and districts during the fiscal year 2023/24.

A special acknowledgment goes out to our partners, including the Ministry of Health (MoH), Uganda Police Force (UPF), Internal Security Organization (ISO), Directorate of Public Prosecution (DPP), Judiciary, National Medical Stores (NMS), National Drug Authority (NDA), Professional Regulatory bodies, and all District Local Governments. Your unwavering support has been instrumental, serving as a strong pillar to our work. It is through your support that we have been able to fulfil our mandate.

A special thanks goes to the State House Comptroller and entire administration for the support in day-to-day tasks, including the timely release of funds to implement activities.

Lastly, we extend our gratitude to His Excellency, the President, for his continued trust in HMU to carry out its mandate. With his support and confidence, we remain undaunted, approaching our mission with fearlessness and boldness, striving to make a meaningful impact in the health sector and improve health service delivery for the people of Uganda.

**Dr. Warren NAAMARA**

*Director, State House Health Monitoring Unit (HMU)*

# ACRONYMS USED

| Acronym | Full Meaning | Acronym | Full Meaning |
|---|---|---|---|
| ART | Anti-Retroviral Therapy | LC | Local Council |
| ANC | Antenatal Care | MCH | Maternal and Child Health |
| ADHO | Assistant District Health Officer | MJAP | Mildmay Uganda Joint AIDS Program |
| ANO | Assistant Nursing Officer | MNCH | Maternal Neonatal and Child Health |
| CAO | Chief Administrative Officer | MOH | Ministry of Health |
| CHO | City Health Officer | MOFPED | Ministry of Finance, Planning and Economic Development |
| CME | Continuing Medical Education | MOPS | Ministry of Public Service |
| CID | Criminal Investigations Directorate | MSB | Macerated Still Birth |
| DHO | District Health Officer | NDA | National Drug Authority |
| DHT | District Health Team | NMS | National Medical Stores |
| DLG | District Local Government | NRH | National Referral Hospital |
| DPP | Directorate of Public Prosecution | NICU | Neonatal Intensive Care Unit |
| ELMIS | Electronic Logistics Management Information System | NWSC | National Water and Sewerage Corporation |
| EMR | Electronic Medical Records | OPD | Outpatient Department |
| EMHS | Essential Medicines and Health Supplies | PHC | Primary Health Care |
| eHMIS | Electronic Health Management Information System | PHRO | Principal Human Resource Officer |
| EPI | Expanded Programme on Immunisation | PNFP | Private-Not-For-Profit |
| FSB | Fresh Still Birth | RBF | Results-Based Financing |
| GH | General Hospital | RDC | Resident District Commissioner |
| HCIV | Health Centre IV | RRH | Regional Referral Hospital |
| HCIII | Health Centre III | SMO | Senior Medical Officer |
| HCII | Health Centre II | SOP | Standard Operating Procedures |
| HCW | Health Care Worker | TBA | Traditional Birth Attendant |
| HMIS | Health Management Information System | UNICEF | United Nations Children's Fund |
| HMU | Health Monitoring Unit | UMDPC | Uganda Medical and Dental Practitioners Council |
| HRH | Human Resources for Health | UPF | Uganda Police Force |
| HUMC | Health Unit Management Committee | | |
| IPC | Infection Prevention and Control | | |
| IPD | Inpatient Department | | |
| ISO | Internal Security Organization | | |
| KOICA | Korean International Cooperation Agency | | |
| LAN | Local Area Network | | |

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# EXECUTIVE SUMMARY

## Background and Context

The State House Health Monitoring Unit (HMU) is a specialized department established by Presidential Instrument in 2009 with the mandate to monitor, audit, and strengthen Uganda's national healthcare system. Operating within the fourth year of its 2020/21–2024/25 Strategic Plan, HMU in FY 2023/24 intensified its monitoring activities across seventeen districts and one Regional Referral Hospital, deploying a comprehensive assessment framework covering human resources for health, leadership and governance, essential medicines, infrastructure, health services delivery, infection prevention, and health information systems.

The purpose of this Annual Report is to document HMU's monitoring findings, present evidence-based analysis, and provide actionable recommendations to all stakeholders responsible for improving Uganda's health outcomes. All findings are based on direct facility observations, staff interviews, document reviews, financial audits, and community engagements conducted by HMU field teams.

## Scope of Monitoring Activities

| 17 | 1 | 244 | 7.36 |
|---|---|---|---|
| Districts Monitored | Regional Referral Hospitals | Total Facilities Visited | UGX Queried (Billion) |

Comprehensive monitoring was conducted across Wakiso, Jinja, Iganga, Manafwa, Namutumba, Namayingo, Pader, Mukono, Sironko, Kitagwenda, Mpigi, Buyende, Nwoya, Gomba, Mityana, Kamwenge, and Kamuli districts. A total of 1 Regional Referral Hospital, 9 General Hospitals, 32 HCIVs, 162 HCIIIs, 28 HCIIs, and 13 PNFP facilities were assessed. For each district, HMU conducted entry meetings with district leadership, health facility visits, financial audits, on-the-spot capacity building, community dialogues, and dissemination meetings.

## Summary of Key Findings

### Human Resources for Health

Understaffing at 25–40% of approved positions was the single most pervasive challenge across all monitored districts. The government's ban on recruitment at local government level has critically constrained health workforce growth, while existing staff are further depleted through organized absenteeism, unsanctioned study leave, double employment, and neglect of duty. In Namutumba, only 32% of scheduled staff were found on duty on the day of the HMU visit. In Pader, only 4 of 13 facility in-charges were present. In Iganga, the Medical Officer in charge of surgery conducted zero procedures over six months due to absenteeism.

### Leadership and Governance

Governance failures were documented at every level of the health system. Long-standing DHO vacancies in Manafwa (since 2021), Pader (since 2013), Mukono (since 2021), and Iganga (since 2021) left districts without qualified technical leadership. Financial mismanagement was nearly universal — UGX 7.36 billion was queried across audited facilities for unaccounted funds, missing payment vouchers, and fraudulent procurement. PHC fund disclosures — a legal requirement — were displayed in fewer than 20% of monitored facilities.

### Essential Medicines and Health Supplies (EMHS)

NMS delivered only 2–4 of the 6 planned supply cycles to most districts in FY 2022/23, creating chronic stockouts of life-saving medicines including Artesunate, Ceftriaxone, HIV Determine kits, and Mama Kits. Active theft of medicines was confirmed in Iganga, Manafwa, Sironko, Namutumba, and Mpigi, with losses ranging from hundreds of thousands to over UGX 11 million per facility. No district was fully functional on electronic EMHS tracking systems.

### Infrastructure and Equipment

Dilapidated structures, non-functional equipment, absent mortuaries, and land encroachment were documented across all districts. Equipment sent to regional maintenance workshops was rarely returned functional. Beds and mattresses allocated by MoH through Members of Parliament were not delivered to facilities in at least two districts nearly two years after allocation. Fraudulent land titling on health facility land was documented in Jinja (Walukuba HCIV).

### Service Delivery

Despite resource constraints, MCH departments remained the most active and best-organised services at all levels. However, patient extortion was pervasive — particularly for C-sections and deliveries — at Mukono GH, Buwenge HCIV, Mpigi HCIV, Nindye HCIII, and others. Mukono GH registered 1,875 C-sections in six months (10/day), with financial motivation cited as the primary driver. Theatre underutilization at multiple HCIVs despite adequate equipment pointed to medical officer absenteeism and poor work ethics.

### Infection Prevention and Control (IPC)

IPC failures were universal. Blood-stained delivery beds, dirty labour suites, non-functional handwashing equipment, improper waste segregation, and absent IPC committees were found across all districts. Kamwenge recorded the most severe IPC violations, with midwives using unsterilized equipment to deliver mothers. Neonatal sepsis, linked to poor IPC and cultural practices in Kitagwenda, contributed to preventable neonatal deaths.

### HMIS and Digitalization

Electronic Health Management Information Systems, Electronic Logistics Management Information Systems (ELMIS/Rx-solution), and Electronic Medical Records were largely absent or non-functional. Key barriers included absent computers, unreliable internet, no LAN installations, and insufficient ICT training. ICT equipment donated to facilities like Entebbe RRH in 2020 remained redundant with no MoH utilization plan.

## Key HMU Interventions During FY 2023/24

- Financial audit queries raised totaling UGX 7,361,065,906 across all monitored districts.
- Criminal arrests and charges filed against health workers in Iganga, Manafwa, Sironko, Namutumba, Pader, and Mpigi.
- Community dialogues (Barazas) held in all monitored districts, collectively reaching tens of thousands of community members.
- Radio talk shows broadcast in all districts in local languages, disseminating findings to over 1 million listeners per district in some cases.
- On-the-spot capacity building in EMHS management, IPC, records management, and ELMIS training.
- Aide Memoires developed with facility staff and district health teams in all monitored districts.
- Facilitation of land titling, equipment repair, and infrastructure interventions in multiple facilities.
- Illegal private wing at Iganga General Hospital closed; illegal user fees abolished with immediate effect.

## Cross-Cutting Recommendations

- MoH and MoPS to lift or issue targeted waivers to the health sector recruitment ban for critical cadres (Medical Officers, Midwives, Anaesthetic Officers, and Pharmacists) as a matter of urgency.
- Recentralize recruitment of DHOs and Senior Medical Officers to MOH to improve supervision quality.

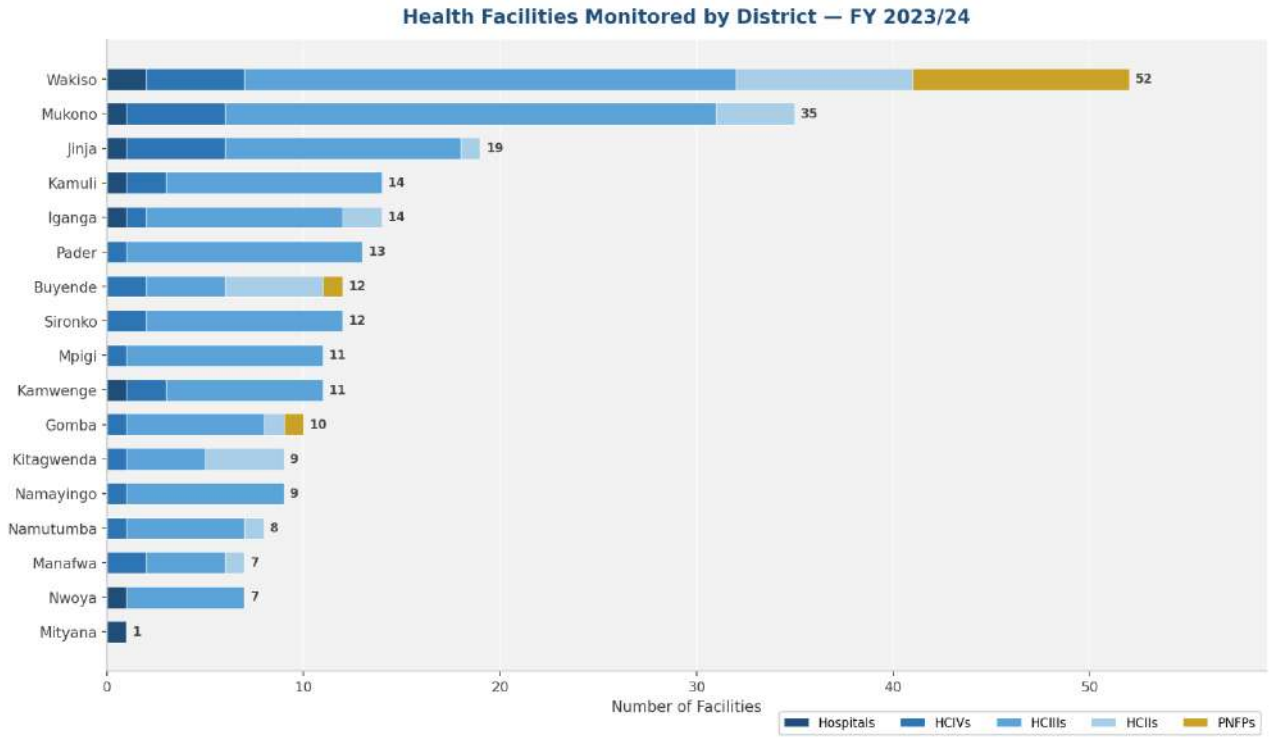
- Health Service Commission to fill all vacant substantive DHO positions in districts that have failed to attract.
- All districts must appoint substantive DHOs; acting arrangements should be capped at six months with full accountability requirements.
- The Office of the Auditor General (OAG) to conduct forensic audits in all facilities where HMU has filed queries exceeding UGX 100 million.
- NMS to strictly adhere to bimonthly delivery schedules and deliver only one cycle at a time per facility.
- MoH to fast-track the national rollout of ELMIS, eHMIS, and Electronic Medical Records across all General Hospitals and HCIVs.
- CAOs and DHTs to enforce zero tolerance for patient extortion, absenteeism, and EMHS theft.
- MoH and MoFPED to increase capital development budgets for health infrastructure, prioritizing high-volume facility upgrades.
- HUMCs must be fully constituted and operationalized at all health facilities, with quarterly accountability meetings open to the public.
- Community engagement mechanisms, including community barazas and radio talk shows, should be institutionalized as part of every district monitoring cycle.

# 1.0 BACKGROUND AND INTRODUCTION

The Health Monitoring Unit (HMU) is a department within the State House of Uganda, established in 2009 by Presidential Instrument to improve health service delivery. Its mission is to monitor and support an efficient and accountable national healthcare system that provides equitable and affordable quality health services to the Ugandan population. HMU uses a double-edged approach of both monitoring and health systems strengthening to achieve positive and sustainable health sector results.

The financial year 2023/24 marks the fourth year of the 5-year strategic period (2020/21 to 2024/25). This period represents a renewed commitment to "raising the bar in healthcare." HMU's work during this period has focused on: ensuring that availed resources are well accounted for; improving quality of health service delivery in public and private health facilities; establishing a functional, results-oriented partner coordination mechanism; and empowering the population to hold the healthcare system accountable.

This report provides a comprehensive account of activities and interventions carried out in FY 2023/24, covering outcomes at Regional Referral Hospitals, General Hospitals, and Lower Health Centres presented according to the regions and districts in which they fall.



# 2.0 HMU VISION, MISSION, GOALS AND STRATEGIC OBJECTIVES

## 2.1 Vision Statement

A healthy Ugandan population supported by an effective and responsive healthcare system.

## 2.2 Mission Statement

To monitor and strengthen the National Healthcare System to become more accessible, efficient, responsive, and accountable to the people of Uganda.

## 2.3 Strategic Goals and Objectives

### Pillar 1: Availed Resources are Well Accounted For

- Detect, investigate, and where necessary institute criminal proceedings for the purpose of prosecution.
- Build the capacity of government Ministries, Departments, Agencies, and Local Governments (MDALGs) and regulatory bodies.
- Strengthen capacity of HMU staff in audit and investigations.
- Strengthen accountability of the health sector by MDALGs.

### Pillar 2: Improved Quality Healthcare Service Delivery

- Improve utilization of maternal and perinatal death audit recommendations in HCIVs and above.
- Increase utilization of inpatient services in Health Centre IIIs and IVs.
- Improve functionality of operating theatres in HCIVs and General Hospitals.
- Improve access to diagnostic services in HCIIIs, HCIVs, and General Hospitals.

### Pillar 3: Functional, Results-Oriented Partner Engagement

- Strengthen partnerships with related government MDALGs and Parliament by 2026.
- Develop or revitalize partnerships with non-government partners.
- Revitalize partnerships with professional regulatory bodies including UMDPC, UNAMC, AHPC, and Pharmacy Council.

### Pillar 4: An Empowered Population that Holds the Healthcare System Accountable

- Empower citizens to exercise their rights and obligations in health service delivery.
- Improve responsiveness of the call centre to receive and address complaints.

# 3.0 METHODOLOGY OF MONITORING

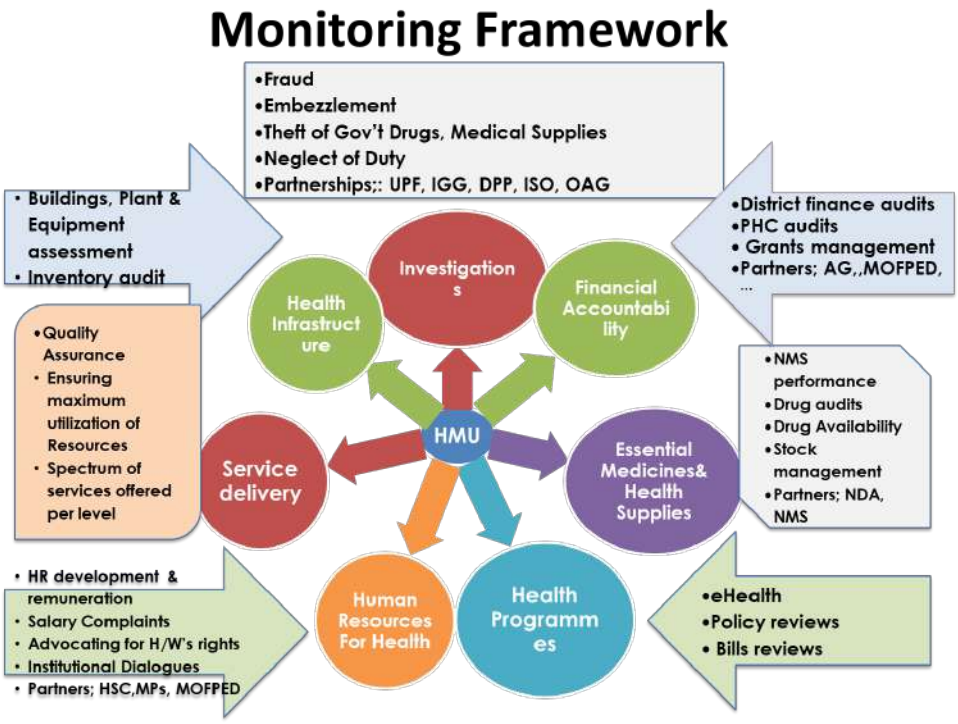



*Figure 1: HMU Monitoring Framework*

## 3.1 District Entry Meetings

HMU conducted entry meetings with every District Local Government (DLG) leader including the Chief Administrative Officer (CAO), Resident District Commissioner (RDC), District Chairperson (LC5), and District Health Team (DHT) to discuss reports, complaints, and service delivery gaps. Financial audits were conducted at the district level.

## 3.2 Health Facility Assessment

During health facility visits, HMU assessed the major building blocks of the healthcare system in each facility, covering Human Resources for Health; Leadership and Governance; Infrastructure and Equipment; Essential Medicines and Health Supplies; Health Service Delivery; Infection Prevention and Control; HMIS and Digitalization; and Finance.

Where capacity gaps were identified, on-the-spot training was provided covering Continuing Medical Education (CME), medicines management, records management, IPC, and sterilization practices.

## 3.3 Data Collection, Action, and Documentation

The assessment process employed approved data collection tools and observation checklists. Teams discussed findings with health workers, provided on-job training, took immediate action on actionable gaps, and conducted debrief meetings. HMU facilitated development of Aide Memoires — action plans agreed upon with health workers — as a basis for monitoring progress in subsequent follow-up visits by district leadership.

## 3.4 Community Engagement and Dissemination

Monitoring findings were disseminated to facilities, DLGs, and communities through facility feedback meetings, district dissemination meetings with key stakeholders, radio talk shows broadcast in local languages, community dialogues (Barazas), and newspaper articles. This participatory approach ensured community ownership of health system accountability.

# 4.0 FINDINGS

## 4.1 Summary of Health Facilities Monitored

In FY 2023/24, comprehensive monitoring was carried out at Entebbe Regional Referral Hospital and in seventeen districts. The table below summarizes all health facilities visited per district.

| District | Hospital | HCIV | HCIII | HCII | PNFP | Total |
|---|---|---|---|---|---|---|
| Wakiso | 2 | 5 | 25 | 9 | 11 | 52 |
| Iganga | 1 | 1 | 10 | 2 | - | 14 |
| Manafwa | | 2 | 4 | 1 | - | 7 |
| Jinja | 1 | 5 | 12 | 1 | - | 19 |
| Namutumba | - | 1 | 6 | 1 | | 8 |
| Namayingo | - | 1 | 8 | - | - | 9 |
| Pader | - | 1 | 12 | - | - | 13 |
| Mukono | 1 | 5 | 25 | 4 | 0 | 35 |
| Sironko | | 2 | 10 | - | - | 12 |
| Kitagwenda | | 1 | 4 | 4 | - | 9 |
| Mpigi | - | 1 | 10 | - | - | 11 |
| Buyende | - | 2 | 4 | 5 | 1 | 12 |
| Nwoya | 1 | - | 6 | - | - | 7 |
| Gomba | - | 1 | 7 | 1 | 1 | 10 |
| Mityana | 1 | - | - | - | - | 1 |
| Kamwenge | 1 | 2 | 8 | - | - | 11 |
| Kamuli | 1 | 2 | 11 | - | - | 14 |
| **TOTAL** | **9** | **32** | **162** | **28** | **13** | **244** |

### 4.2.1 Wakiso District

A total of 52 facilities were visited comprising 1 Regional Referral Hospital (Entebbe RRH), 11 PNFP facilities, 5 HCIVs, 25 HCIIIs, and 9 HCIIs across sub-counties and Health Sub-Districts of Busiro North, Busiro East, Busiro South, Busiro HSD, Kyadondo North, Kyadondo East, and Kira Municipality.

| Best Practices — Wakiso |
|---|
| • The Laboratory at Wakiso HCIV and Namayumba HCIV are well managed. |
| • Maternity and ART departments were the most organised and highest-output departments across all visited facilities. |

#### Leadership and Governance

- Facility managers were not oriented into duty; no handover reports from outgoing facility managers.
- Lack of purposeful, action-oriented supervision with no follow-up to address identified gaps.

- Alleged misuse of non-wage PHC funds by facility in-charges and their supervisors for personal benefit.
- Lack of financial accountability by most facility in-charges.

## Human Resources for Health

- Understaffing in all listed public health facilities, exacerbated by a ban on recruitment.
- High scheduled and actual absenteeism in lower health facilities, leading to self-referrals to higher-level facilities.
- Installed faulty biometric machines and put to proper use.

Table: Staffing levels, attendance to duty, salary complaints and supervision of Health facilities in Wakiso District Local Government

| Facility | Appr. \| Filled \| Vacant \| On Duty \| Days I/C |
|---|---|
| **BUSIRO NORTH HSD** | |
| Namayumba HCIV | 130 \| 40 \| 90 \| 1 (E/N) \| 33 — Salary: Anaesthetic assistant unpaid |
| Luwunga Barracks HCIII | 19 \| 16 \| 3 \| 13 \| 48 |
| Namayumba Epi-centre HCIII | 19 \| 13 \| 6 \| 6 \| 30 |
| Nabitokolo HCIII | 19 \| 11 \| 8 \| 2 \| — |
| Kiziba HCIII | 19 \| 29 \| 0 (overstaffed) \| 5 \| 24 |
| Busawamanze HCIII | 19 \| 14 \| 5 \| 1 \| 15 — Salary: Askari (4 months) |
| Kakiri HCIII | 19 \| 21 \| 0 (overstaffed) \| 9 \| 17 |
| **BUSIRO EAST HSD** | |
| Wakiso HCIV | 130 \| 45 \| 85 \| 15 \| 0 — Salary: Health Inspector (scale not upgraded) |
| Mende HCIII | 55 \| 14 \| 41 \| 4 \| 32 |
| Bulondo HCIII | 55 \| 18 \| 37 \| 3 \| 0 |
| Wakiso Epi-centre HCIII | 55 \| 19 \| 36 \| 3 \| 28 |
| Kyengera HCIII | 55 \| 17 \| 38 \| 8 \| 14 |
| Nsangi HCIII | 55 \| 23 \| 32 \| 9 \| 10 |
| Sentema HCII | 11 \| 7 \| 4 \| 2 \| 36 |
| **BUSIRO SOUTH HSD** | |
| Kajansi HCIV | 130 \| 27 \| 103 \| 14 \| 26 |
| Kigungu HCIII | 55 \| 15 \| 40 \| 11 \| 20 |
| Katabi HCIII | 55 \| 17 \| 38 \| 7 \| 45 |
| Bussi HCII | 55 \| 26 \| 29 \| 15 \| 18 |
| Nakawuka HCIII | 55 \| 19 \| 36 \| 8 \| 17 |
| Nsagu HCII | 11 \| 9 \| 2 \| 1 \| 16 |

| | |
|---|---|
| **BUSIRO HSD (SECURITY/SPECIAL)** | |
| Katabi Military HCIII | 55 \| 85 \| 0 (overstaffed) \| 75 \| 45 |
| State House HCIV | 130 \| 45 \| 85 \| 40 \| 55 |
| Katabi Air Force HCIII | 55 \| 19 \| 36 \| 18 \| 55 |
| Kitara Prisons HCIII | 55 \| 19 \| 36 \| 17 \| 55 |
| Kitara HCII | 19 \| 11 \| 8 \| 3 \| 10 |
| **KYADONDO NORTH HSD** | |
| Buwambo HCIV | 130 \| 35 \| 85 \| 30 \| 16 |
| Namulonge HCIII | 55 \| 15 \| 40 \| 3 \| 14 |
| Kasozi HCIII | 55 \| 9 \| 46 \| 3 \| 23 |
| Nabweru HCIII | 55 \| 11 \| 44 \| 9 \| 14 |
| Kawanda HCIII | 55 \| 15 \| 40 \| 12 \| 18 |
| **KYADONDO EAST HSD** | |
| Kasangati HCIV | 130 \| 45 \| 85 \| 37 \| 34 |
| Watuba HCIII | 55 \| 7 \| 48 \| 5 \| 18 |
| **KIRA MUNICIPALITY** | |
| Bweyogerere HCIII | 55 \| 14 \| 41 \| 12 \| 17 |
| Kira HCIII | 55 \| 15 \| 40 \| 14 \| 28 |

## Infrastructure and Equipment

- Procurement of essential equipment was not done due to corruption — prices were inflated by the district procurement department.
- Equipment taken for repair to Wabigalo Regional Workshop was not returned or was returned in a worse state.
- Dilapidated beds and torn mattresses stained with blood and body fluids found across multiple facilities.
- MoH gave beds and mattresses to Members of Parliament who had not delivered them to facilities at the time of HMU's visit.
- Subsistence farming on facility premises: pigs at Busawamanze and Kiziba HCIIIs; goats at Namayumba HCIV.
- Several facilities on Buganda Land cannot be issued land titles or undergo infrastructure upgrades.
- In Kasozi HCIII the facility land was donated to government by Mr. Musoke. Out of 138 acres of land donated, the district processed a land title of only 11 acres and the rest had already been stolen.
- In Watuba HCIII the facility land was donated by the Royal family of Nalinya. Currently a chunk of the donated land is being reclaimed back by the family and the estate administrators are helpless.

Dilapidated beds and torn mattresses in Wakiso HCIV maternity ward

Bulondo HCIII Motor Bike is kept in the laboratory

Sulking gutters in Wakiso HCIV.

Water logged Veranda of the OPD Wakiso HCIV

A dirty compound at Kaziba HCIII

Non-functional pit latrine at Busawamanze HCII

*A goat house at Namayumba HCIV*

## Essential Medicines and Health Supplies

- Inadequate funding for EMHS in all health facilities visited especially at HCIV level (Kajjansi, Wakiso, Buwambo and Namayumba HCIVs).
- The process of inter-district and inter-facility redistribution of medicines is not streamlined.
- Some facilities; (Namayumba Epi-center HCIII (2014), Sentema HCII (1998),) *are not yet enrolled on NMS grid*.
- Kyengera HCIII continues to receive EMHS deliveries at the HCII level despite its official upgrade to HCIII.

- Facilities that fill in and send discrepancy forms after NMS deliveries do not get the missed items and their accounts are not reconciled with the value for the missed item. It is worse for non-credit line items.
- Poor record-keeping in EMHS LMIS tools. Records are incomplete, inaccurate, inconsistent, and untimely.
- Inadequate planning for EMHS due to incorrect consumption data, as most facilities do not utilize the dispensing/consumption log.
- Pilferage of EMHS in the visited public health facilities.
- The Namayumba HCIV medicines store needed partitioning; the ceiling in the Wakiso HCIV store was deteriorating.
- In Namayumba and Wakiso HCIVs the EMHS stores were used for storage of expired medicines, HMIS tools, computers and other equipment.

## Health Service Delivery

- Pseudo-classification: Infrastructure, EMHS, and staffing do not correspond to the care level offered by most facilities. Most facilities Despite being classified as HCIIIs on both MoH and NMS inventory offer health service care of a HCII (ANC and outpatient); Kajansi, Wakiso and Buwambo HCIV receive EMHS for a lower-level facility.
  - Health facility deliveries were 20% of ANC attendances, indicating a significant gap in facility-based delivery.
  - Bweyogerere HCIII registered the highest number — 5 maternal deaths in Wakiso.
  - Understaffing and stockouts drive self-referrals to Entebbe RRH and Traditional Birth Attendants (TBAs).
  - Referral system delays between calls and ambulance availability resulted in maternal and perinatal deaths.

### OPD & IP Functionality

| Facility | OPD Attendance \| Admissions \| OPD Deaths \| Ward Deaths (Feb 2023) |
|---|---|
| **BUSIRO NORTH HSD** | |
| Namayumba HCIV | 1,557 \| 52 \| 0 \| 0 |
| Luwunga Barracks HCIII | 978 \| 45 \| 0 \| 0 |
| Kiziba HCIII | 817 \| 40 \| 0 \| 0 |
| Nabitokolo HCIII | 524 \| 84 \| 0 \| 0 |
| Kakiri HCIII | 1,178 \| 0 \| 0 \| 0 |
| Namayumba Epi-centre / Busawamanze HCIII | Data unavailable — inventory officer absent |
| **BUSIRO EAST HSD** | |
| Wakiso HCIV | 8,665 \| 496 \| 0 \| 1 |
| Nsangi HCIII | 7,025 \| 0 \| 0 \| 0 |
| Kyengera HCIII | 488 \| 0 \| 0 \| 0 |
| Wakiso Epi-centre HCIII | 496 \| 0 \| 0 \| 0 |
| Mende HCIII | 622 \| 24 \| 0 \| 0 |

| | |
|---|---|
| Bulondo HCIII | Data unavailable — inventory officer absent |
| **BUSIRO SOUTH HSD** | |
| Kajansi HCIV | 3,158 \| 150 \| 0 \| 0 |
| Kigungu HCIII | 514 \| 0 \| 0 \| 0 |
| Katabi HCIII | 1,165 \| 0 \| 0 \| 0 |
| Bussi HCIII | 684 \| 56 \| 0 \| 0 |
| Kasanje HCIII | 1,022 \| 9 \| 0 \| 0 |
| Nsagu HCII | Data unavailable — inventory officer absent |
| **BUSIRO HSD (SPECIAL FACILITIES)** | |
| Entebbe RRH | 10,879 \| 3,534 \| 3 \| 5 [Highest volume; receives most self-referrals] |
| Katabi Military HCIII | 2,231 \| 266 \| 0 \| 2 |
| State House HCIV | 3,197 \| 467 \| 0 \| 0 |
| Katabi Air Force HCIII | 2,049 \| 187 \| 0 \| 0 |
| Kitara Prisons HCIII | 2,118 \| 129 \| 0 \| 0 |
| **KYADONDO NORTH HSD** | |
| Buwambo HCIV | 2,101 \| 346 \| 0 \| 0 |
| Namulonge HCIII | 1,715 \| 12 \| 0 \| 0 |
| Kasozi HCIII | 1,063 \| 77 \| 0 \| 0 |
| Nabweru HCIII | 1,473 \| 7 \| 0 \| 0 |
| Kawanda HCIII | 3,066 \| 17 \| 0 \| 0 |
| **KYADONDO EAST HSD** | |
| Kasangati HCIV | 2,973 \| 32 \| 1 \| 0 |
| Watuba HCIII | 1,347 \| 0 \| 0 \| 0 |
| **KIRA MUNICIPALITY** | |
| Bweyogerere HCIII | 1,642 \| 76 \| 0 \| 0 |
| Kira HCIII | 2,492 \| 18 \| 0 \| 0 |

- Most facilities listed above have no dedicated inpatient wards.
- The inpatient figures reflect emergency cases stabilized and quickly referred, using side beds in improvised spaces.

Laboratory Services

- Wakiso HCIV and Namayumba HCIV had adequate laboratory space
- Many facilities improvise laboratory space; Buwambo HCIV represents the most critical case.

Maternal and Child Health (MCH) Services.

- The MCH department was the most outstanding in all visited facilities despite several challenges.

- Health facility deliveries were 20% of ANC attendances.
- Despite being the most utilized department, maternity services were compromised by midwife understaffing, absenteeism, poor management, EMHS stockouts, inadequate space, and insufficient staff accommodation.
- Self-referrals to higher-level facilities including Entebbe RRH or TBAs due to the aforementioned challenges.
- This creates additional workload and EMHS stockouts at Entebbe RRH.

| Facility | ANC (three months) \| Deliveries (three months) \| Maternal Deaths |
|---|---|
| **BUSIRO NORTH HSD** | |
| Namayumba HCIV | 2,582 \| 570 \| 0 |
| Kiziba HCIII | 507 \| 106 \| 0 |
| Kakiri HCIII | 512 \| 115 \| 0 |
| **BUSIRO EAST HSD** | |
| Wakiso HCIV | 4,602 \| 994 \| 0 |
| Wakiso Epi-centre HCIII | 553 \| 141 \| 0 |
| Mende HCIII | 299 \| 90 \| 0 |
| Nsangi HCIII | 2,426 \| 499 \| 0 |
| Kyengera HCIII | 1,225 \| 72 \| 0 |
| **BUSIRO SOUTH HSD** | |
| Kajansi HCIV | 2,672 \| 438 \| 0 |
| Kigungu HCIII | 236 \| 95 \| 0 |
| Katabi HCIII | 634 \| 125 \| 0 |
| Kasanje HCIII | 654 \| 108 \| 0 |
| Nakawuka HCIII | 418 \| 124 \| 0 |
| **BUSIRO HSD (SPECIAL FACILITIES)** | |
| Entebbe RRH | 952 \| 1,265 \| 3 [Referral-in burden elevates mortality risk] |
| Katabi Military HCIII | 200 \| 45 \| 0 |
| State House HCIV | 1,096 \| 180 \| 0 |
| Katabi Air Force HCIII | 549 \| 342 \| 0 |
| Kitara Prisons HCIII | 234 \| 132 \| 0 |
| Kitara HCII | 134 \| 28 \| 0 |
| **KYADONDO NORTH HSD** | |
| Buwambo HCIV | 1,648 \| 339 \| 0 |
| Namulonge HCIII | 789 \| 150 \| 0 |

| | |
|---|---|
| Kasozi HCIII | 426 \| 248 \| 0 |
| Nabweru HCIII | 447 \| 236 \| 0 |
| Kawanda HCIII | 2,563 \| 350 \| 0 |
| **KYADONDO EAST HSD** | |
| Kasangati HCIV | 199 \| 998 \| 0 |
| Watuba HCIII | 1,196 \| 332 \| 0 |
| **KIRA MUNICIPALITY** | |
| Bweyogerere HCIII | 374 \| 619 \| 5 ⚠ Highest maternal deaths in Wakiso |
| Kira HCIII | 567 \| 241 \| 0 |

Referral System

- Delays between calls and ambulance availability have, in some instances, resulted in maternal and perinatal deaths.
- In some cases, staff use their own vehicles to refer patients (e.g., Nakawuka HCIII).
- Most preventable referrals are caused by:
  i) Poor governance and leadership at all levels; District Leadership, DHOs office, Facility In charges and HUMC
  ii) Absent critical staff in emergency care; Medical Doctors and Anaesthetic Officers
  iii) TBAs that keep mothers and delay referral to Health facilities
  iv) Inadequate EMHS
- Wakiso District, despite its large population, has no public General Hospital.
- Self-referrals to national referral hospitals are high, partly driven by proximity to Kampala.

## HMIS and Digitalization

- Facilities not supplied with computers; internet is inconsistent and extremely slow — averaging 5–10 minutes to process a single patient record.
- LAN not installed in most facilities; no operationalisation of Electronic Medical Records System (EMRS).

## HMU Interventions — Wakiso

- Intervened to advance land title acquisition for Busawamanze, Nakawuka, Bussi, Kigungu, and Nsagu facilities.
- Alerted NDA pharmacovigilance team regarding a deteriorated drug being administered at Busawamanze HCIII.
- Capacity building conducted in EMHS supply chain management.
- Instituted investigations into the whereabouts of beds and mattresses given to MPs for facility distribution.

## Recommendations — Wakiso

- CAO to sanction absent health workers and process salary recovery per Public Standing Orders.
- NMS to enroll Namayumba Epi-Centre HCIII and Sentema HCII on the NMS grid immediately.
- Upgrade high-volume HCIIIs to HCIVs and HCIVs to General Hospitals where warranted.
- DHO and ADHO MCH to urgently investigate the cause of high maternal deaths at Bweyogerere HCIII.
- MoH to supply ICT equipment and connectivity to all facilities to support EMRS operationalisation.

### 4.2.2 Iganga District

A total of 14 health facilities were monitored: Iganga General Hospital, Bugono HCIV, 10 HCIIIs (Namungalwe, Busowobi, Bunyiiro, Nambale, Bulamagi, Kasambika, Nawandala, Nabidongha, and Iganga Municipal Health Centre), and 2 HCIIs (Nakalama EPI Centre, Nawansinge).

#### Leadership and Governance — Iganga Hospital

- DHO position vacant since December 2021 following retirement of the substantive DHO.
- Medical Officer of Health Services and Principal Health Inspector positions at Iganga Municipal Council vacant for over 11 years (since the creation of the Council) attributed to lack of wage.
- Top hospital management abused their offices and mismanaged hospital funds, working in isolation with the accountant.
- Hospital PHC quarterly releases and their utilization were unknown to hospital staff, representing a total breakdown in transparency.
- Last general staff meeting held September 5, 2023; no CPDs on Client Charter ever conducted.
- Interdicted staff sneaking into former offices at night: Dr. Mugoya K. Dauda (former Ag MS), Mugolofa Ramathan (SHA), and Isabirye Michael (Senior Accounts Assistant).

*HMU Officers and Iganga Hospital departmental heads meeting to address identified gaps*

#### Human Resources for Health — Iganga Hospital

- Staffing level of the hospital is 58.2% (178/343)
- Positions with 0% staffing include: Executive Consultant, Senior Anaesthetic Officers, Anaesthetic Officers, Biostatistician, Consultants (Internal medicine, Paediatrics, Obstetrics & Gynaecology, Surgery), Medical Officer Special Grade Internal Medicine, Assistant Engineering Officers (Electrician and Biomedical), Nursing Officers-Midwifery and Nursing, Senior Laboratory Technicians, Pharmacy attendants and imaging Technologist.
- **Absenteeism and Abandonment of Duty:** Dr. John Mulidho (SMO attached to Iganga Hospital) worked only 46 days from July 2023 to May 2024. Consequently, theatre performance was low, with only 18 caesarean sections conducted between November 2023 and April 2024. He was temporarily suspended from the payroll.
- **Facility in charges' attendance to duty:** DR. MUGOYA K. DAUDA the then Ag MS was not signing the attendance book.

**Criminal Trespass and public nuisance;**

- Interdicted staff sneaking into their former offices at night; DR. MUGOYA K. DAUDA (SMO and former Ag MS), MUGOLOFA RAMATHAN (SHA) and ISABIRYE MICHEAL (Senior Accounts Assistant).

*Hospital staff (not on duty) and non-hospital employees found loitering around causality unit with intent to traffic patients/ extort from them.*

**Action Points:**

- The CAO to engage Ministry of Finance Planning and Economic Development (MoFPED) to provide wage for recruitment of staff to fill the critical vacant positions.
- The CAO, PHRO and Rewards and Sanctions Committee to award appropriate sanctions for the errant personnel and rewards for the hard-working personnel in line with the public service standing orders.
- The CAO, PHRO to recover wage paid to the absentee officers.

## Health Services Delivery — Iganga Hospital

Service delivery in the hospital was assessed for a period of 6 months between December 2023 to May 2024.

**Out Patients Department:**

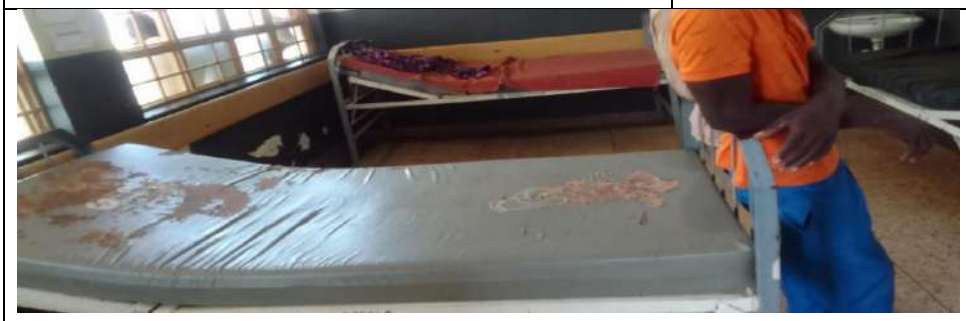
- The hospital registered 45,865 patients against a set target of 19,386 for a period of 6 months which was 287% — nearly three times the expected patient numbers.
- This suggests that either the targets were set too low, or the hospital is serving a population beyond its catchment area.
- There was no emergency tray and trolley in OPD.

**Infection Control at OPD:** IPC equipment, protocol and supplies were in place at OPD except Hand sanitizer, Respirators which were lacking and the OPD being a closed space.

**Action Points**

- Review target setting and adjust according to the demographic profile
- Expand the hospital infrastructure, recruit more staff and avail more EMHS to attend to the high patient numbers.

**Casualty/Emergency Department:**

*Iganga General Hospital Casualty with no resuscitation equipment, torn mattresses and dirty waste bins*

- There was gross understaffing of the department; 1 Medical Officer, 1 clinical Officer, 4 ANOs, 1 EN and 2 NAs. There are 2 interns assigned to the unit.
- There is inadequate oxygen, blood and blood products, emergency drugs including adrenaline and hydrocortisone in the hospital.
- The hospital has two ambulances; only one is fuelled (by MoH/KOICA). The second is unfuelled, so attendants pay drivers out of pocket for ambulance use.
- There is overcrowding of redundant people and health workers at casualty and extortion is rife. Despite the Hospital management making several warnings to staff to stop being idle and disorderly at casualty, some staff have been found of extorting.

**Equipment and IPC:** The equipment available were functional and in proper use except 2 Oxygen Cylinder heads being faulty, 3 non-functional oxygen concentrators, Non-functional Air Conditioner in the Doctor's Consultation room, lack of Nebulizer, lack of wheel chair, lack of mobile X-ray and Ultrasound Scan. There were no color-coded waste bins, inadequate bin liners, lack of safety boxes and cleaning detergents due to inadequate supply by NMS.

**In Patient Department:** The registered total hospital inpatient admissions were 4,488 in six months. The Medical and surgical wards registered 61 and 13 deaths respectively in the six months period which is on average 10 and 2 deaths per month, respectively.

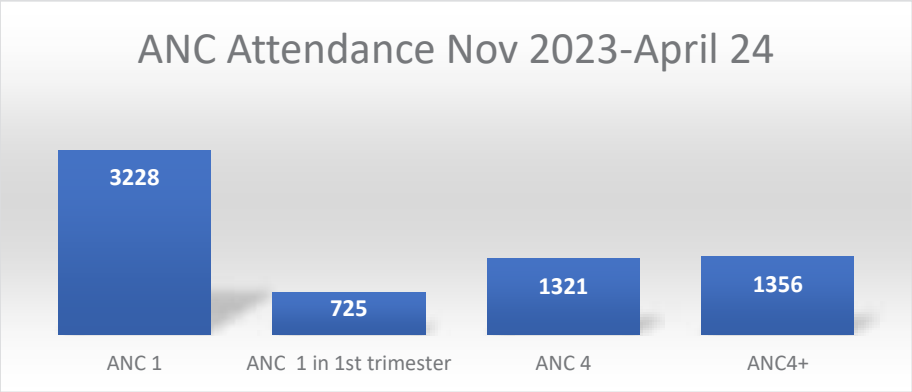
**Action Points**

- Conduct death audits for every inpatient death and encourage attendants of the deceased to conduct post-mortems in order to find out cause of deaths.
- Specialists to attend to duty as required by the Public Standing Orders

**MATERNITY**

**ANC**

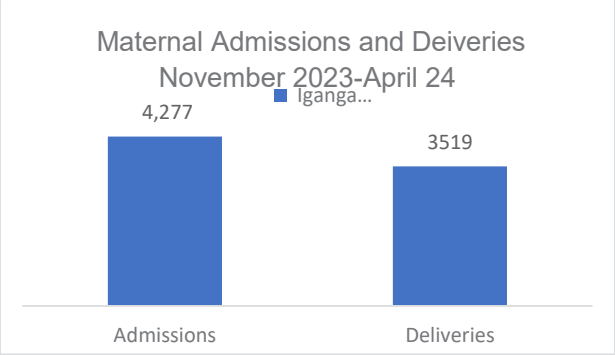
- The bar graph below shows that few pregnant mothers (22%) who go for the 1st ANC visit are in their 1st trimester and fewer mothers complete ANC 4 (only one-third of ANC1 attendees).
- Interventions towards getting more mothers in 1st trimester go for ANC are critical for better pregnancy outcomes.

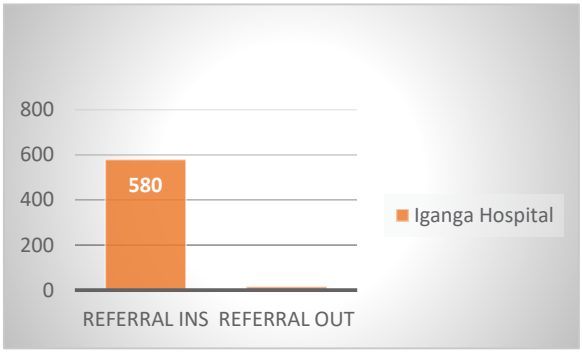



**Recommendations**

- Education of the community on the importance of early diagnosis of pregnancy and ANC attendance.
- Early detection of pregnancy in health facilities

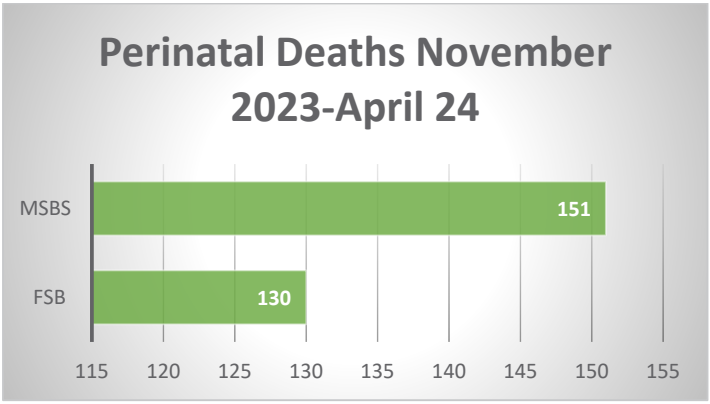
**Admissions and Deliveries in Maternity:**




The chart shows that Majority (82%) of admissions in Maternity deliver in the hospital and that a negligible proportion of admissions (0.4%/15 mothers) are referred out.

**Prenatal Deaths**




- The high number of FSBs can be attributed to delay in attending to mothers in the hospital because of inadequate number of critical staff to offer Emergency Maternal Obstetric and Neonatal Care (EMONC) and absence of the Head of Department who is often conducting IP supported field activities.

- Currently, the hospital employs only two Anaesthetic Officers and four Medical Officers to cover all hospital departments.
- Additionally, the Medical Officer Special Grade Obstetrics & Gynaecology is rarely in the hospital as evidenced by the operating theatre records; the number of midwives is also inadequate
- The Hospital registered 20 maternal deaths 2023/24.
- The hospital conducted 20 maternal death audits and 298 out of 308 (97%) perinatal death audits.
- It was found that 5 mothers were referred from 5 private facilities including a TBA, 8 mothers were referred from public health facilities 4 of which belong to Iganga district and 3 were not indicated.

**Action Points**

- The ADHO MCH and MOSG Iganga to inspect the standard and capacity of the referring private health facilities to manage pregnant mothers and take appropriate action that will halt preventable maternal deaths.
- The ADHO MCH and MOSG Iganga to conduct support supervision of referring public health facilities within the district to address gaps associated with the maternal deaths.
- The DHO Iganga to inform the DHO/s of the public referring facilities outside Iganga district to conduct support supervision in the latter facilities in order to address gaps associated with the maternal deaths.
- The MOSG to prioritize work in the hospital over the support supervision activities by IPs especially since there is gross understaffing in the department and the indicators of perinatal deaths and Maternal Deaths are high.
- The CAO to recruit more doctors, Anaesthetic Officers and midwives

**Obstetrics and Gynae and General Surgery Theatres:**

- The Hospital has 4 theatres; 1 in casualty, 1 in eye clinic and 2 for obstetrics and gynaecology and general surgery.
- The hospital has two Anaesthetic Officers and no theatre attendants or assistants.
- There is one non-functional anesthetic machine.
- Inadequate number of scrubs, drapes, gumboots, aprons and linen. No curtains to separate theatre beds

On the Left and below: Sub-optimally utilized theatre due to lack of Anaesthetic machines. Also, with broken drip stands and old suction machine that is difficult to clean.

Functional 2nd theatre

**Theatre Equipment in Obstetrics and Surgery Theatres:** there were no complete sets for Caesarean section, Laparotomy and STS kits. The theatre beds were 3 but not adjustable. Operating lamps were 3 with only one functional, suction machine had dirty tubes, no oxygen cylinders, the three trolleys all had no wheels, non-functional autoclave.

**IPC in theatre**

- No running water in the scrubbing basin due to a broken tap.
- Sharps disposal containers, sanitizer, and some color-coded bins out of stock
- Theatre walls are cracked and the floor is old.

**Type of Anaesthesia Given for Major Surgeries:** General Anaesthesia 111 and Local / Spinal Anaesthesia 630. Majority (85%) of anesthesia for major operations is Spinal due to a faulty Anaesthetic machine

**Performance of Doctors in Obstetrics in Theatre Caesarean sections (C/S) for Six Months Period Nov 2023 to April 2024**

| Doctor | Cadre | Emergency C/S | Elective C/S | Total |
|---|---|---|---|---|
| Nsubuga Hamis | MO | 151 | 16 | 167 |
| Mulidho John | MO | 15 | 1 | 16 ⚠ Absenteeism noted |
| Mudondo Eunice | MO | 6 | 0 | 6 |
| Kiwanuka Pontiano | MOSG | 8 | 1 | 9 ⚠ Low output; frequently off-site |
| Sekatawa Wickliffe | MO | 21 | 2 | 23 |
| Isabirye Isa | MO | 5 | 0 | 5 |
| TOTAL | — | 206 | 20 | 226 |

*Source: Theatre Book Iganga Hospital*

- As shown in the table above majority of Emergency Caesarean sections are conducted by Dr. Hamis Nsubuga who awaits a promotion to the position of Medical Officer in the district.
- Of note is that the MOSG conducted only 8 emergency caesarean sections over a six-month period, which indicates absenteeism from the department.
- During the monitoring exercise the MOSG was often in the field conducting support supervision with implementing partners. There was no duty allocation on the rota for all MOSG which made it impossible to account for the tasks the Officers conducted in the hospital. Of note is that the hospital trains interns.

**Action Points**

- All MOSG; Obstetrics and gynaecology, surgery, Medicine and Paediatrics to have duty roster with duty allocation displayed in their departments.
- The MOSG to prioritize work in the hospital over the support supervision activities by IPs especially since there is gross understaffing in the department and the indicators of perinatal deaths and Maternal Deaths are high.
- The MOSG should prioritize hospital presence to supervise and train interns
- The duty roster should include support supervision activities so that MOSGs can account for time spent off-site

**Performance of the surgery department in theatre**

| Doctor | Cadre | Total Surgeries (Dec–May) |
|---|---|---|
| Mubeezi | MOSG | 78 — Highest performer; consistent 13/month |
| Isabirye | MO | 48 |
| Mudega Noah | MO | 36 |
| Wakabi | MO | 24 |
| Babitunga | MO | 18 |
| Mulidho John | MO | 0 — Zero surgeries; absent entire period |
| Mwesigwa / Angellah B. | MO | 0 — Zero surgeries |
| TOTAL | — | 204 |

*Source: Operating Theatre book Iganga General Hospital*

- The table above shows that Dr. Mubeezi the MOSG surgery conducted the highest number of surgeries.
- Dr. Mulidho a Medical Officer conducted none because he was absent from duty in this period.
- Of note, Dr. Mulidho was transferred from Bugono HCIV

- Action Points
- The CAO to sanction Dr. Mulidho in line with the Public Service Standing Orders
- Dr. Mulidho to be forwarded to the Rewards and Sanctions Committee and sanctioned in line with the Uganda Public Service Rewards and Sanctions Framework.
- Recruit two additional Medical Officers for the Surgical Ward.

**Neonatal Care Unit (NCU)**


L-R: Iganga Hospital congested Neonatal Care Unit.

- It operates as a Level 2 Special Care Unit (similar to Jinja RRH), lacking ventilators, intubation equipment, and surfactant
- Inadequate space to accommodate the neonates.
- Inadequate oxygen and blood.

**Performance indicators for Neonatal Intensive Care Unit (NICU) December 2023–May 2024**
A total of 690 admissions of which 581 were born at the facility and 109 born before arrival. Referrals to NICU were 87, while referral out were 06. Total Neonatal deaths were 64 with majority (50/64) being hospital born deaths. Preterms were 41/64 of the deaths. All the 64 deaths had mortality audits conducted.

- In the registered period 9% (64/690) of admitted neonates died in care and 655 neonates were discharged.
- It was observed that;
- The paediatrician Dr. Mutumba was the most present MOSG in the hospital and most of the time in the paediatric department and NCU during working hours. His presence and work are evidenced by the low death rate in NCU despite the inadequate infrastructure, equipment and EMHS.
- Neonatal Death audits conducted for all neonatal deaths with the full participation of the paediatrician.

### Infrastructure and Equipment Management

Facility Compound; Iganga Hospital compound was fairly kempt. The dustbins were open and the waste exposed to the public and stray animals**.** The OPD was clean, Hospital was fenced. The Hospital had water from NWSC, rain harvesting and bore hole. Source of Power: UMEME, Generator and Solar

Availability of Imaging services: 02 non-functional X ray machines and three non-functional ultra sound machines. The facility has a land title and the land has been encroached on by Muslims who want to construct a mosque on Hospital Land.

Iganga Hospital: Entrance to the inpatient bathrooms.

Iganga General Hospital: Inpatient bathrooms very dirty

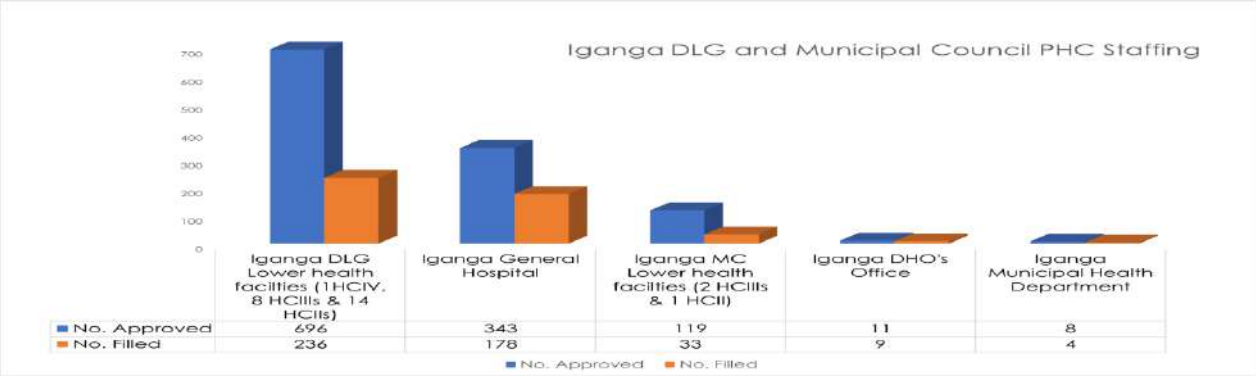
## Findings In Lower-Level Health Facilities (HCIVs, HCIIIs, and HCIIs)

## Leadership and Governance

- **General Staff Meetings:** All facilities held monthly meetings except Nawandala HCIII.
- **General Staff CPDs on Client Charter:** No CPDs on Client charter has ever been conducted in any facility.
- **Public Display of PHC received and expenditures:** Only Namungalwe, Nambale and Kasambika HCIIIs had released funding displayed for public viewing.
- Only Namungalwe and Kasambika HCIIIs had financial accountabilities (expenditures) displayed for public viewing.

- HUMC:
  - All facilities held HUMC meetings once every quarter.
  - However, the HUMC meetings did not have an item of reviewing the past meetings to follow on action plans. There was no action plan and most of the minutes were not signed by the Chairman and secretary which casts doubt on their authenticity.

## Human Resources for Health

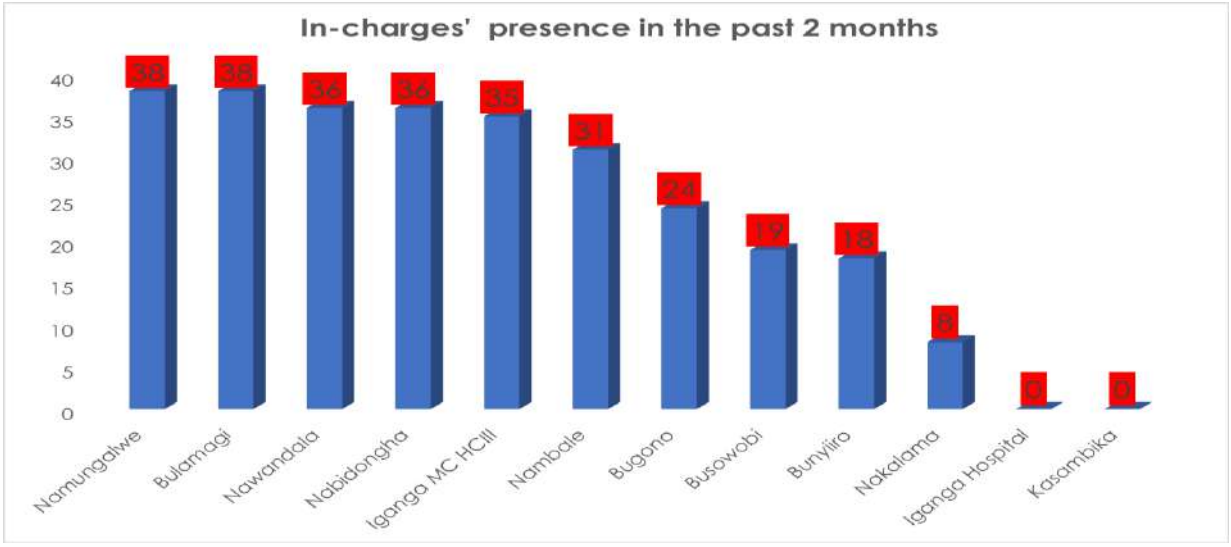



General staffing for both Iganga DLG and Municipal Council is 39% (460/1177) with a staffing gap of 61% (717/1177). Most affected cadres are Nurses and Anaesthetic officer.

**Iganga Municipal Council:** A total of 50 staffing gaps registered with Medical Officer of Health Services and Principal Health Inspectors completely absent and additional critical positions lacking.

- **Iganga DLG - Lower facilities:** A total of 16 posts requiring a total of 31 personnel are completely unfilled
- **Absenteeism and Abandonment of Duty** Luwale Ali (porter attached to Bugono HCIV) - abandoned their post since January 2024 and was temporarily suspended from the payroll.

**Facility in charges' attendance to duty**

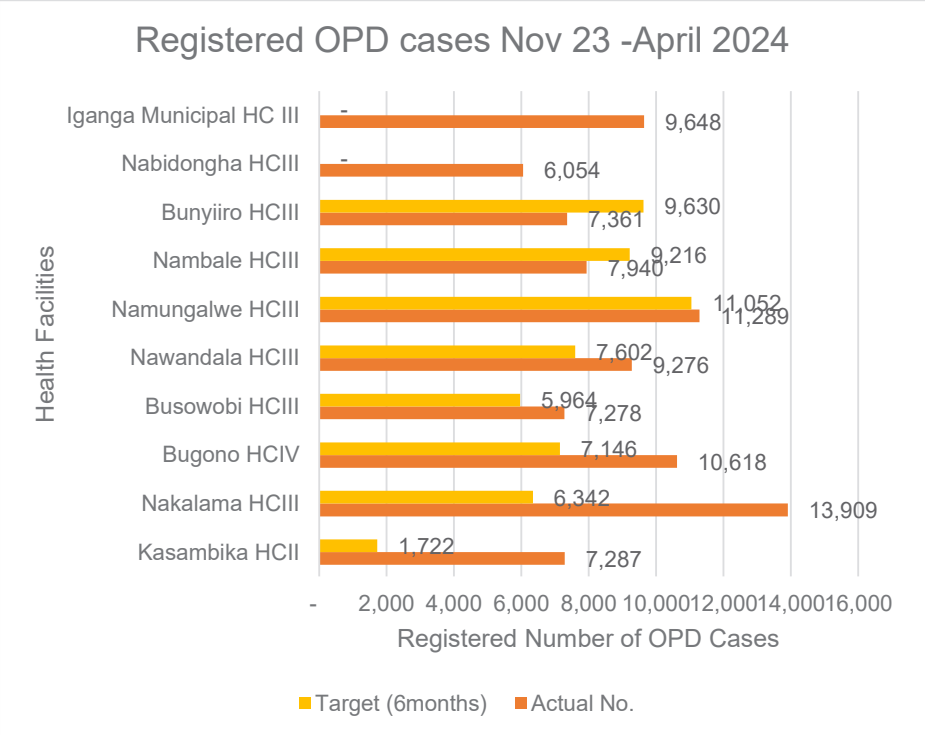



*Source; arrival and attendance books. Expected in two months is 36 working days.*

- All in charges found present apart from Nabidongah who was on sick leave

- In charges of Namungalwe and Bulamagi HCIIIs had the highest number of days attended (38 days) while Iganga hospital and Kasambika had the least number of days.
- In charge Bunyiiro HCIII was on annual leave while Kasambika I/C had just been posted there on May 09, 2024
- Absentee In charge; MADAMBILE SUDI (Clinical Officer Nakalama HCIII)

## Health Service Delivery at Lower Health Facilities

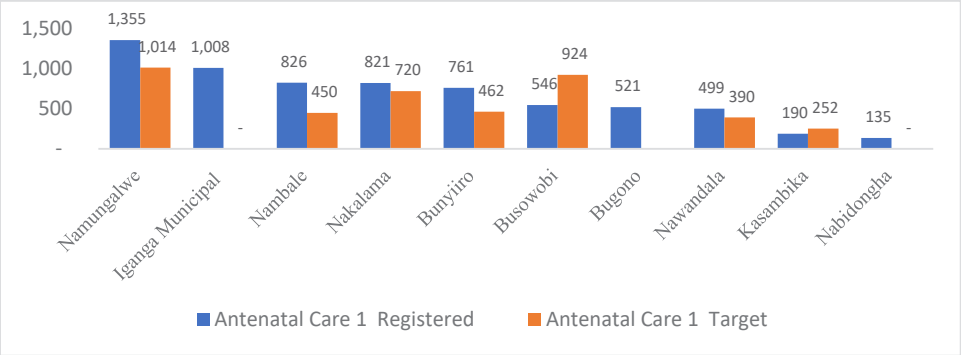



Nakalama HCIII, Namungalwe HCIII and Bugono HCIV registered the highest OPD attendances
Iganga Municipal and Nabidongha HCIIIs did not have set targets
6 out of 8 health facilities exceeded their targets with Kasambika exceeding by 423%.

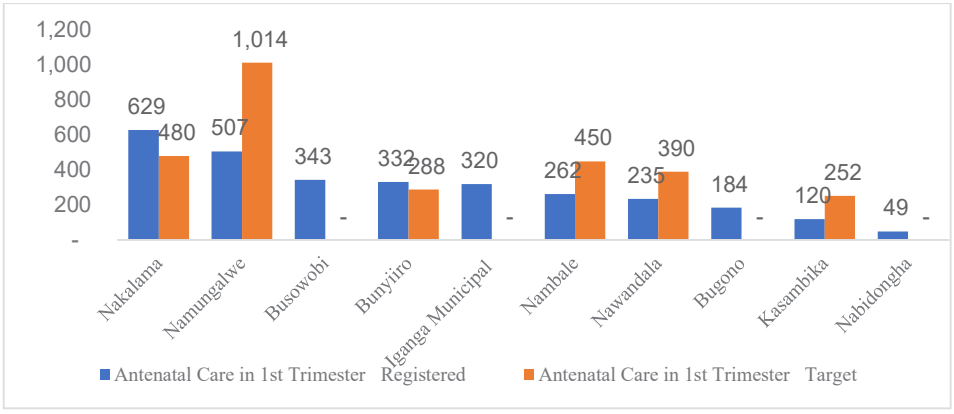
| Does the OPD have the following. | YES | NO | HMU Intervention/ Remarks |
|---|---|---|---|
| Adequate Space | Bunyiiro and Nambale | Bugono HCIV, Namungalwe, Busowobi, Nakalama, Kasambika, Nawandala, Nabidongha, Iganga Municipal | MOH to budget for expansion of the facilities |
| Emergency Tray | Bugono HCIV, Bunyiiro, Kasambika, Nawandala, Iganga Municipal | Namungalwe, Busowobi, Nakalama, Nambale, Nabidongha. | Emergency trays prepared for Namungalwe, Busowobi, Nakalama, Nambale, Nabidongha |
| Stretcher | Bunyiiro, Nambale | Bugono HCIV, Namungalwe, Busowobi, Nakalama, Kasambika, Nawandala, Nabidongha, Iganga Municipal Health Centre | Plan to procure from the district Equipment budget |
| Wheel Chair | Bunyiiro, Nabidongha, Nakalama (4 in store), Nawandala (1 in store) | Bugono HCIV, Namungalwe, Busowobi, Nambale, Kasambika, Iganga Municipal Health Centre | Wheel Chairs removed from store and put to use at Nakalama and Nawandala HCIIIs |

## MATERNITY

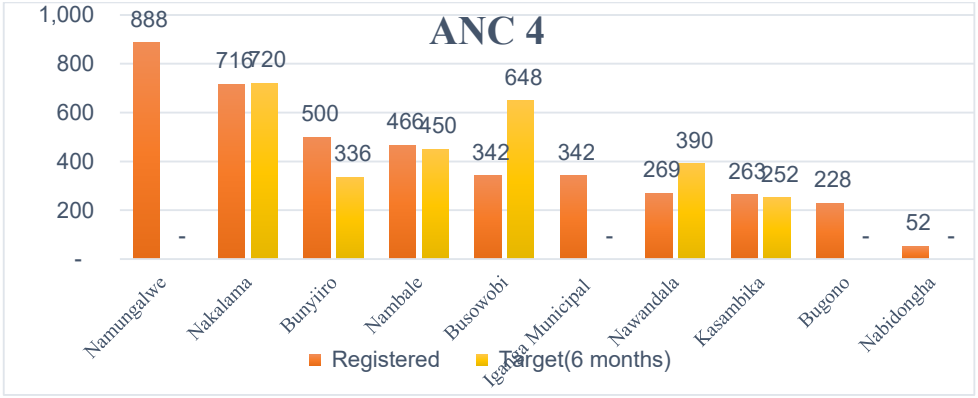
Graph 1: ANC1 November 2023–April 2024



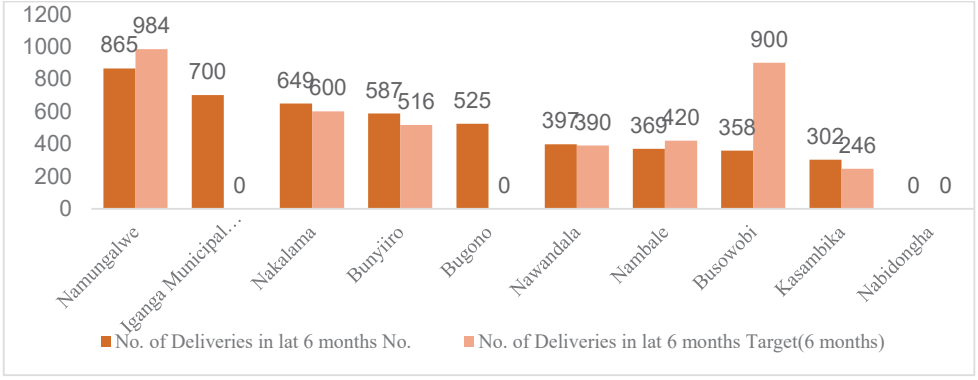

Graph 2: ANC1 attendance in 1st trimester November 2023–April 2024




Graph 3: ANC 4 November 2023–April 2024




Graph 4: Deliveries November 2023–April 2024




ANC 1

Namungalwe, Nambale, Nakalama, Bunyiiro and Nawandala performed above target for ANC1 attendances. Iganga Municipal, Bugono HCIV and Nabidongha did not set targets for the indicator.

ANC1 in 1st trimester

Nakalama and Bunyiiro performed above target in registering ANC1 attendance in 1st trimester
Busowobi, Iganga Municipal, Bugono HCIV and Nabidongha did not set targets.

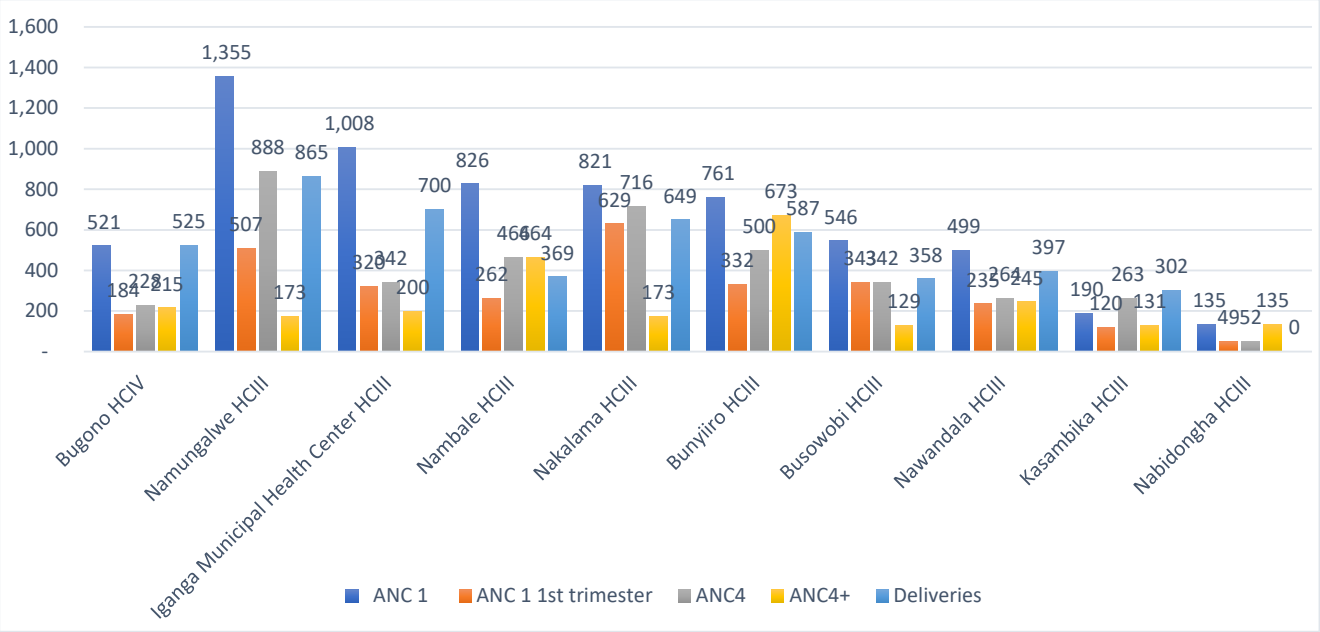
ANC 4

Namungalwe and Nakalama registered the highest number of ANC4 attendance Namungalwe, Iganga Municipal, Bugono HCIV and Nabidongha did not set targets.

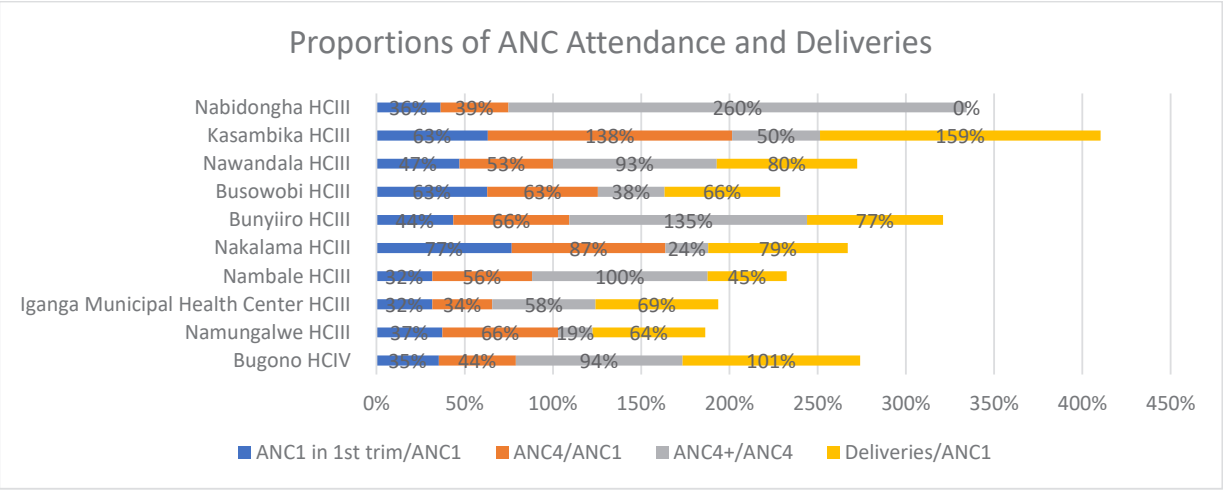
Deliveries

Nakalama, Bunyiro, Nawandala and Kasambika performed above target Iganga Municipal and Bugono HCIV did not set targets.

**Graph 5: Registered ANC attendances and Deliveries in a HCIV and HCIIIs for November 2023–April 2024**




**Graph 6: Proportions of ANC attendances and Deliveries**

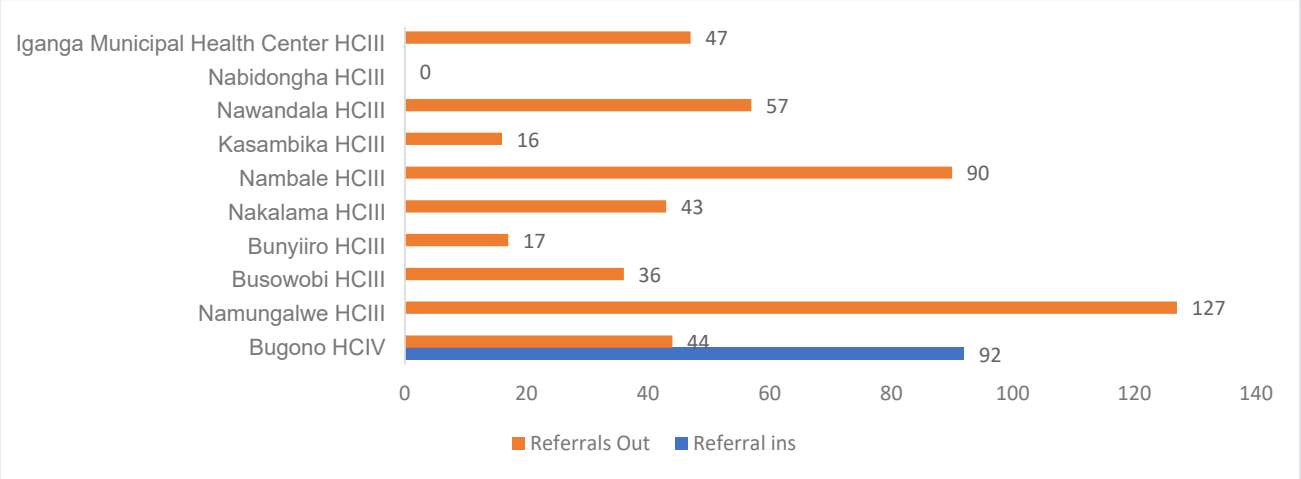



The two graphs above show that:

- Nakalama HCIII was the best performing health facility in MCH services followed by Namungalwe and Bunyiiro.
- Namungalwe, Iganga Municipal and Nambale registered the highest while Nabidongha and Kasambika registered the lowest ANC1 attendances.
- Although ANC1 attendance in the 1st trimester was relatively lower than the total ANC1 attendances, Nakalama, Kasambika and Busowobi registered 77% and 63% mothers who attended ANC1 in the 1st trimester. However, Namungalwe, Nabidongha, Bugono HCIV, Iganga Municipal and Nambale registered less than 40% of mothers who attended ANC1 in the 1st trimester.
- Namungalwe and Nakalama registered the highest number of ANC 4 among all the facilities.
- ANC4 and 4+ were relatively lower than ANC1 attendances in the facilities except in Kasambika which registered 138% ANC4 of ANC1 attendances.
- Nakalama, Bunyiiro and Namungalwe registered 87% and 66% ANC4 of ANC1 attendances.

- Nabidongha and Bunyiiro registered more ANC4+ than ANC4 attendances by 260% and 135%. Nambale, Bugono and Nawandala registered 100%, 94% and 93% ANC4+ of ANC4 attendances respectively.
- Namungalwe and Iganga Municipal registered more than 1,000 deliveries followed by Nakalama and Bunyiiro who registered more than 700 deliveries
- All facilities registered deliveries less than ANC1 attendances except Kasambika (159%) and Bugono HCIV (101%). Nawandala, Nakalama and Bunyiiro registered 89%, 79% and 77% deliveries of ANC1 attendances respectively.
- Of note is that Nabidongha did not have a labour suit due to lack of equipment.

**MNCH Referrals in and Out November 2023 - April 2024**




- The graph above shows that;
- Bugono HCIV registered the highest number of referrals in from maternity while Kasambika and Bunyiiro had the least referrals out.
- Namungalwe registered the highest number of referrals out from maternity followed by Nambale. This can be attributed to Namungalwe registering the highest numbers of ANC attendances and deliveries and requiring referrals for patients that require services available at HCIV and above
- ***Bugono HCIV referred 48% from maternity despite being a HCIV with a fully functional theatre and 2 Medical Officers.***

**Action Points**

- Reward and recognize Nakalama and Namungalwe for commendable performance.
- ADHO MCH to equip Nabidongha with labour suit equipment to improve MCH services at the facility.
- Namungalwe and Iganga Municipal HCIIIs to be upgraded to HCIVs due to the registered high numbers of ANC and Deliveries.
- Nakalama HCIII to investigate the reasons for a relatively high number of mothers attending ANC1 in 1st trimester and share good practices and lessons learnt
- All health facilities to investigate reasons for low numbers of mothers attending ANC1 in 1st trimester and ANC4 and design both facility and community interventions to improve the indicator.
- Investigate why Kasambika registered more ANC4 attendances and deliveries than ANC1 attendances and design appropriate interventions that will increase mothers attending ANC1.
- Bugono HCIV and Iganga Municipal to set targets for all MNCH performance indicators
- **Medical Officers in Bugono HCIV to improve performance of the facility by attending to duty as expected and fully operationalizing the theatre.**
- **Investigate why Nambale and Nawandala are registering relatively high number of referrals**
- ADHO to support Kasambika HCIII improve on MNCH services in general

**Performance of Neonatal Care Unit in Bugono HCIV for December 2023–May 2024:** Total admissions 52, born at facility 43, Neonatal deaths 03, in referral to NICU 06, referral out is 11, totals discharged 38.

### Labour Suit Equipment:

All facilities had emergency trays. The facilities that lacked Functional Foetal Doppler were Namungalwe, Bunyiiro, Nambale, Nabidongha. The Delivery sets were available in all facilities except Nabidongha. Delivery lamp in Labour Suite were available in all facilities except Busowobi, Bunyiiro, Nakalama, Nabidongha HCIIIs.

### Infection Prevention and Control in Labour Suit

Handwashing equipment and liquid soap were lacking in Namungalwe, Nakalama, Iganga Municipal Health Centre, Namungalwe, Bunyiiro, Nawandala Health Centres.

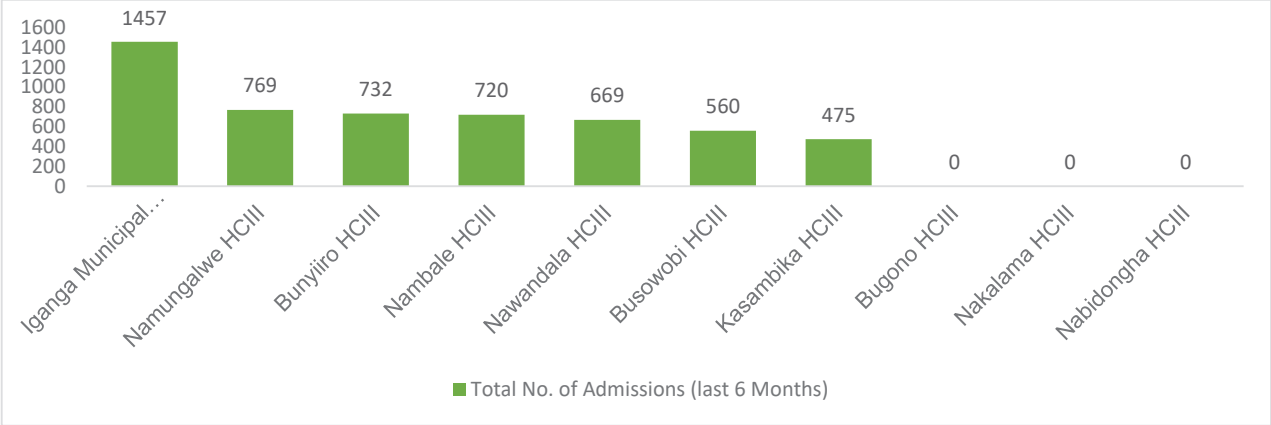
Above: HMU Director, Dr. Warren NAAMARA takes a tour of the maternity ward at Nakalama HCIII

L-Nambale HCIII Maternity: Well Kempt Labour suite R- Kasambika HCIII: Un solicited medical equipment kept in the maternity ward

L- Nambale HCIII Maternity: Sterilized equipment kept in buckets due to lack of Storage drums

| R- ADHO - Maternity delivers a brand-new delivery bed to Nakalama HCIII from another facility where it was lying idle | |
|---|---|
|  |  |
| Namungalwe HCIII Maternity Ward: blankets in the Postnatal ward leading to poor infection prevention and control. | Namungalwe HCIII Postnatal Ward: Blankets removed after HMU's intervention. |

**Patient Admissions November 2023–May 2024**




- Bugono HCIV and all HCIIIs were offering inpatient services except Nabidongha which did not have adequate infrastructure and equipment. Iganga Municipal registered the highest number of inpatients followed by Namungalwe, Bunyiiro and Nambale.
- Nakalama was not admitting patients despite having 2 available rooms which were converted to storing new beds and other un used items.
- Records at Bugono HCIV were inaccessible.
- The inpatient ward of Bugono was small and dilapidated

**HMU Intervention**

- The ward and another room in Nakalama were restored to purpose of admitting ANC mothers and other inpatients respectively

**Action Points**

- Expand and renovate inpatient wards in all the lower health facilities.
- Upgrade Iganga Municipal and Namungalwe HCIIIs to HCIV.

## Infrastructure and Equipment Management: Lower Facilities

Facility Compound: All facilities were well kept except Bunyiiro, Bulamagi, Nawandala

Nambale HCIII: Well-maintained Compound

Namungalwe HCIII: Well-maintained facility

Busowobi HCIII: incomplete Ceiling covered with cobwebs.

Bugono HCIV: Grass growing on the rooftop.

**OPD cleanness:** All the facilities had clean OPD except Busowobi, Bunyiiro, Bulamagi

Availability of General and Maternity Wards: All had except Busowobi, Bunyiiro, Nakalama, Kasambika, Nawandala, Nabidongha, Kasambika

Facility Fencing: The facilities with no fence were Bunyiiro, Nakalama, Bulamagi, Kasambika, Nawandala

**Source of Water:** The facilities lacking water were Busowobi, Bunyiiro, Nakalama, Bulamagi, Kasambika, Nawandala. Those without rain water were Namungalwe, Nabidongha and those without borehole were; Bugono, Busowobi, Bunyiiro, Nakalama, Nabidongha, Iganga Municipal Health Centres

**Source of Power**: The facilities without electricity were Busowobi, Nakalama, Kasambika. Those without generators were; Busowobi, Bunyiiro, Nakalama, Nambale, Bulamagi, Kasambika, Nabidongha, Iganga Municipal Health Centre. All except Nabidongha had solar power

Availability of Imaging services: Bugono HCIV has 1 functional Ultrasound Scan machine.

**Facility Land titling:** Iganga Hospital, Bunyiiro, Nambale, Kasambika, Nabidongha have titles. While Nambale and Nawandala's land is encroached on.

**Infrastructure and equipment in pictures:**

Above and Below: Bugono HCIV un sorted medical equipment lying idle in the Doctor's Quarters for over 10 years.

## Essential Medicines & Health Supplies in Iganga District Local Government

Team conducted one-year comprehensive audits for selected medicines & commodities in all monitored facilities. Below are the findings;

- Iganga Hospital has a budget of UGX 553,410,860 every financial year.
- The HCIV has a budget of UGX 114,958,030 per year.
- HCIIIs (9) have a budget of UGX 28,909,862 each per year
- HCIIs (16) have a budget of UGX 6,442,552 each per year.
- Generally, medicines &commodities are managed well at most facility stores (apart from Nakalama HCIII, Kasambika HCIII &Bugono HCIV) but pilferage happens at departmental level.
- There is a breakdown of medicine accountability systems in the district. Stock cards, IRVs, Dispensing logs are available but poorly utilized.
- Breakdown of inter-facility transfer of medicine & commodities as some facilities e.g. Nawandala HCIII have excesses of certain commodities and yet others don't have the same commodities i.e. Iganga district.
- The district has a good system for managing expiries as medicine expiries had been collected from the facilities prior to HMU monitoring.
- HMU noted the urgent need to initiate store managers trainings as a way of improving medicine management in the district since most store managers are Health Information Assistants.

- Lack of proper stewardship & governance in the pharmaceutical sector as the only pharmacist in the district is based at Iganga hospital and is not involved in medicine management in other facilities.
- NMS no longer adheres to its delivery schedule.
- Long stockout durations at facilities especially the medicine store at Iganga Hospital
- HMU also recognized the Best Performing store managers at Namungalwe HCIII & Iganga Hospital. HMU also noted the Worst Performing Store in charges at Kasambika HCIII, Nakalama HCIII and Bugono HCIV.
- Use of dispensing logs at departmental level. No calculators in all facilities
- Health Information Assistants are the store managers in almost all facilities. Student was the in charge in Nakalama
- The use of discrepancy forms has been abandoned in almost all facilities.
- Government policy on how Essential medicines should be received in facilities is not respected.
- There is a general problem of storage space in the whole district
- Issue & Req vouchers not signed by other stakeholders in most facilities especially Nawandala HCIII
- Need for more HMIS books in the entire district
- Accountability for sundries at dispensing points is poor or entirely absent
- Iganga Hospital Audit of selected items (Mama Kits, HIV Determine, IV Artesunate, Gauze, Surgical Gloves and Cotton) in the medicine store revealed no variances signifying good practices
- Medicine management & accountability in the main store was very impressive as there was no single loss to government in the items selected for audit.
- HMU recognized the store in-charge as one of the best-performing in the district.
- The district was encouraged to use her to cascade training to lower facilities.

**Audit of selected items in different departments in Iganga hospital**

*Table showing loss to government after an audit in different departments in Iganga Hospital*

| # | Item | From Store | Utilized | Balance | Variance | Loss to Govt (UGX) |
|---|---|---|---|---|---|---|
| 1 | Mama Kits | 2,354 | 2,281 | 50 | 23 | 40,000 |
| 2 | HIV Determine (boxes) | 11,100 | 6,997 | 4,103 + 100 extra | 41 boxes | 8,000,000 |
| 3 | IV Artesunate (vials) | 13,980 | 1,300 | 50 | 930 | 5,580,000 |
| 4 | Surgical Gloves | 899 | No record | — | — | — |
| 5 | Gauze | 154 | No record | — | — | — |
| 6 | Cotton | 204 | No record | — | — | — |
| TOTAL | — | — | — | — | — | 13,620,000 |

HMU noted the following;

- There was no single dispensing log for sundries in the hospital.
- The lab staff claimed that they had a separate record for tests conducted outside the facility which they were still looking for during the period of audit.
- Artesunate accountability was wanting in the Inpatient pharmacy. The claim was that record keeping was poor.
- HMU noticed that the day-to-day execution of duties had been outsourced to interns.

### Audit of selected items in different lower health units in Iganga

An audit of six selected items (Mama Kits, HIV determine, IV Artesunate, Surgical Gloves and Cotton) in seven Facilities; Nawandala, Kasambika, Nambale, Namungalwe, Nabidongha, Iganga HCIIIs and Bugono HCIV revealed losses worth UGX 46,453,282.

### Nakalama HCIII — A Case in Point

- HMU unearthed a lot of medicine mismanagement in this facility with medicines worth UGX 11,979,870 unaccounted for.
- Security measures were compromised as the store was managed by a student instead of a government employee, drugs were issued without proper authorization, the store manager lacked inventory management training.
- The unaccounted drugs, specifically the Determine test kits, were found to be empty boxes. The in-charge and the storekeeper claimed that the six empty boxes were delivered by NMS. However, they did not provide a discrepancy form to show that the items were delivered empty by NMS and could not explain why the discrepancy form was not filled out.

**HMU Intervention:** HMU working with Uganda Police conducted arrests at Nakalama, Kasambika and Bugono.

### Assessment of NMS Performance in Facilities (June 2022–July 2023)

- In April 2023, the National Medical Stores (NMS) delivered three cycles of supplies simultaneously to various health facilities. This approach led to several issues:
- **Overstocking**: The bulk deliveries resulted in the overstocking of items.
- **Increased Theft**: Overstocking became a major contributing factor to drug theft, as storekeepers took advantage of the excess stock.
- The budget performances were; Iganga Hospital (66.70%), Bunyiiro HCIII (75.40%) and Nakalama HCIII (77.60%). These discrepancies amounted to over UGX 201,162,211 worth of medicines and supplies undelivered.
- **Non-adherence to Delivery Schedule**: NMS did not follow the delivery schedule in various facilities, leading to significant stockouts, particularly during the last quarter of 2023.
- **Procurement Planning:** HMU reviewed the procurement plan of the district to understand how funds at National Medical stores are utilized by the district.

**Stockouts of Essential Drugs and Commodities.**

Table showing the state of stockout by quantity of drugs and commodities from 1 July 2023 to 7th June 2024

| Drug / Commodity | Iganga Hospital (days) | Bulamagi HCIII (days) | Bunyiiro HCIII (days) | Nakalama HCIII (days) |
|---|---|---|---|---|
| ACT – Artemether/Lumefantrine | 0 | 0 | 30 | 34 |
| Artesunate 60mg Inj | 165 | 20 | 0 | 30 |
| TLD (Tenofovir/Lamivudine/Dolutegravir) | 0 | 0 | 0 | 0 |
| HIV Determine Test Kits | 34 | 0 | 0 | 0 |
| Malaria RDT (25-test pack) | 48 | 0 | 0 | 72 |
| Mama Kits | 23 | 0 | 0 | 0 |
| Ceftriaxone 250mg Inj | 123 | 15 | N/A | 180 |

### Stockouts of Essential Drugs and Commodities

- The stockouts were primarily attributed to the National Medical Stores (NMS) not adhering to the bimonthly delivery schedule. These disruptions highlight the need for improved supply chain management, strategic stockpiling, regular monitoring, and inter-facility coordination to ensure reliable access to essential healthcare supplies.

**HMIS tools**

- During the facility visits, it was observed that Electronic Health Information Management Systems (HIMS) tools, essential for drug management, were entirely absent.
- Additionally, in Iganga where computers were available, they were not utilized at the departmental levels to monitor stock status effectively.

**Storage Management:**

- **Standard Operating Procedures (SOPs):** Some facilities have SOPs in place.
- **Inventory of Expired Medications:** All facilities maintain inventories of expired medications.
- **Store Security:** All facilities secure their stores with locks.
- **Storage for Damaged/Expired Drugs:** All facilities have designated separate spaces for damaged or expired drugs.
- **Storage Methods:** All facilities employ appropriate storage methods.
- **Temperature Monitoring:** None of the facilities currently monitor storage temperatures, indicating an area for improvement to ensure drug efficacy and safety.

**General recommendations**

- **Supply Chain Management:** NMS should ensure adherence to delivery schedules to prevent stockouts and maintain optimal inventory levels in various facilities.
- **Budget Utilization:** Health facilities should regularly follow up with NMS to ensure their budgets are current and claim any unspent funds, thereby improving efficiency and resource management.
- **Training and Capacity Building:** DHO and district pharmacist should conduct regular training sessions for store managers on inventory management and adherence to budget allocations. DHO and Pharmacist should ensure all personnel handling medicines are trained in proper procedures to prevent unauthorized issuance and enhance accountability.
- **Enhanced Security Measures:** DHO should strictly enforce protocols for storing and issuing medicines, including proper authorization for all transactions and inter-facility transfers. Improve monitoring and accountability for high-value items like HIV test kits to prevent losses due to mishandling or theft.
- **Electronic Health Information Systems (HMIS/eLMIS):** DHO to implement electronic HMIS tools where absent, to improve real-time monitoring of stock levels and facilitate timely replenishment orders.
- **Storage Management Practices:** DHO and pharmacist to regularly review and update SOPs for storing and managing to ensure compliance and safety standards.
- Others include;
- Need for store managers training
- Embossment of sundries and Laboratory Kits
- Stop receiving supplies beyond 6pm.

## Medicine management in Photos

| | | | | | |
|---|---|---|---|---|---|
|  |  |  |  |  |  |
| Mama kit accountability at Nawandala HCIII | Medicine accountability at Nambale HCIII | Evidence of poor record keeping in Nambale HCIII | Aidah, a best performer at Namungalwe HCIII | Mamakit audit at Namungalwe HCIII | Disorganized store at Nambale HCIII |
|  |  |  |  |  |  |
| Audit exercise in Iganga Hospital | HMU doing an audit in Inpatient pharmacy in Iganga Hospital | An empty Store at Iganga Hospital | Physical count at namungalwe HCIII | Determine audit in Namungalwe HCIII | An Empty Store at Nabigodwa HCIII |

## Community Engagement — Iganga

- In raising the bar in health care, HMU mainstreams the *improvement of citizen ownership of health services in Uganda"* HMU's strategic direction dictates that citizen/public engagement is inevitable in the transformation of the Health Sector.
- HMU held a community dialogue (Baraza) at the Iganga Primary School Grounds in Iganga Municipality where the public aired out their grievances. HMU also held a Radio Talk show on Eye FM to disseminate field findings and enable the public to air out their grievances.

**Radio Talk Show**: This was conducted on Eye FM in Luganda & Lusoga. It was attended by the Deputy RDC, Vice chair-LC5 and HMU members. The radio station has a catchment area of over 1 million people.
**Thematic Areas covered on the Talk show include;**

### Human Resources for Health

- Organized absenteeism in the facilities
- Poor attitude after salary enhancement
- Allegations of bribery by District Service Commission during recruitment, promotions

### Dissemination meeting in Photos

National Medical stores (NMS) representative addressing the Gathering

Director HMU, LC5 Chairman & DRCDC at the dissemination

The Director, HMU addresses members of the Press

Participants gather for the meeting

### HMU Interventions on the Talk Show

- HMU articulated government policy on charging user fees on the public wing (Mortuary, Lab, Radiology)
- HMU shared a preliminary audit report on medicine accountability in the hospital
- HMU shared preliminary audit findings.
- HMU shared a preliminary report on organized absenteeism in the hospital
- HMU took note of structural issues to address to MOH, NMS etc.
- HMU committed to address non-Health issues in the district to the Anti-Corruption Unit.

**Photos of HMU officials & DHO on the Talk show**


HMU officials & DHO on the Radio Talk show

**Community Dialogue (Baraza):** HMU held a Baraza at Iganga Primary School grounds which was attended by over 2000 community members. These vehemently aired out their grievances for HMU and District officials to listen to and address. One after another, the community members took to the microphone to speak out and air their issues. The public was visibly ecstatic.
The HMU team ensured that everybody including the DHO, CAO, RDC, Ag Ms-Iganga Hospital, Facility in charges stood up and accounted to the public.

**Photos from the Community Dialogue**



Community Members at the Baraza



Community Members asking questions

**HMU Interventions During the Community Dialogue**

- HMU ensured that all facility in charges, Medical Superintendent, District officials stood up and accounted to the public by answering their questions.
- HMU clarified that public funds should be displayed once they are received like the way it's done at Namungalwe HCIII.
- HMU articulated government policy on private wing services and informed the public that the establishment of the private wing at Iganga Hospital was illegal and had been closed with immediate effect.
- HMU articulated government policy on charging user fees on the public wing (Mortuary, Lab, Radiology). The public was informed that it is illegal.
- HMU told the public to engage in the fight against criminality by calling HMU toll free numbers to whistle blow.

- HMU decried corruption tendencies in the district service commission and encouraged affected persons to come with evidence.
- HMU took note of structural issues to address to MOH, NMS etc.
- HMU ensured that NMS was available to answer all the medicine supply related issues and concerns about imaging services. NMS committed to supplying Imaging materials by end of August.
- HMU shared government policy on extortion and informed the public that unscrupulous individuals had been arrested in OPD of Iganga Hospital trying to lure patients into private facilities.
- HMU talked about its interventions in terms of arrests, administrative action etc.
- HMU recognized best performers and pledged to reward them with certificates of award.

### HMU Interventions — Iganga

- Arrests made at Nakalama, Kasambika, and Bugono HCIV for medicine theft in collaboration with Uganda Police.
- Illegal private wing at Iganga General Hospital closed with immediate effect.
- Illegal user fees on public OPD, Lab, Mortuary, and Radiology declared abolished; public informed of their rights.
- NMS committed to resolving supply issues and delivering imaging materials by end of August.

### Recommendations — Iganga

- Health Service Commission to urgently recruit a substantive DHO for Iganga district.
- CAO to sanction Dr. Mulidho and other absent staff in line with the Public Service Standing Orders.
- ADHO MCH and MOSG Iganga to urgently inspect and address referring private facilities and TBAs.
- MOSG to prioritize presence in the hospital, given gross understaffing and high maternal and perinatal death rates.
- NMS to adhere to delivery schedules and avoid simultaneous multi-cycle deliveries.
- DHO to train store managers on inventory management and implement monthly EMHS audits.

## 4.2.3 Jinja City and District

A total of 19 health facilities were visited across Jinja City (Walukuba, Bugembe, Mpumudde, Budondo HCIVs; Wakitala, Kisima, Lukolo, Muwumba, Jinja Central HCIIIs; Masese HCII) and Jinja District (Buwenge General Hospital, Buwenge HCIV; Magamaga, Butagaya, Budima, Kakira, Mpambwa, Busede, Kakaire HCIIIs).

### Leadership and Governance

- Most district leaders had not signed the support supervision book at visited health centres.
- Funds accountabilities publicly displayed only at Budondo HCIV and Bugembe HCIV — all others were non-compliant.
- Concern about allocation of health facility land for other purposes by leaders in Jinja City.

### Finance and Administration

**Fund Accountability and Planning:**

- Most health facilities do not publicly display their fund accountabilities. Displays were only observed at Budondo HCIV and Bugembe HCIV.
- Kisima HCIII, Wakitaka HCIII, and Muwumba HCIII showed no evidence of displaying received finances and accountability for public viewing.

**Financial Audit Brief (Jinja City and District):**

- **Receipts (Jinja City):** Health Centre IVs (HCIVs) and Health Centre IIIs (HCIIIs) receive funds from Government (Primary Health Care - PHC), Capital Development, and the Results-Based Funding (RBF) Project. Total receipts audited across several facilities for FY 2022/23 and Q1-3 of FY 2023/24 amounted to UGX 1,144,441,902.

| **Jinja City Releases for Health Facilities Audited** | | | | | |
|---|---|---|---|---|---|
| **HEALTH UNIT** | **FIN YEAR** | **PHC** | **RBF** | **CAPITAL DEVT** | **TOTAL** |
| Budondo HCIV | 2022/23 | 86,618,848 | 18,603,350 | 58,301,268 | 163,523,466 |
| | 2023/24 Qtr 1 to 3 | 45,703,670 | 23,358,678 | | 69,062,348 |
| Bugembe HCIV | 2022/23 | 131,003,538 | 148,604,870 | | 279,608,408 |
| | 2023/24 Qtr 1 to 3 | 45,703,670 | 37,448,349 | | 83,152,019 |
| Mpumudde HCIV | 2022/23 | 86,465,239 | 21,443,000 | | 107,908,239 |
| | 2023/24 Qtr 1 to 3 | 45,703,670 | 26,636,271 | | 72,339,941 |
| Walukuba HCIV | 2022/23 | 161,258,616 | 16,552,870 | 59,389,116 | 237,200,602 |
| | 2023/24 Qtr 1 to 3 | 45,703,670 | 22,163,808 | | 67,867,478 |
| Kissima HCIII | 2022/23 | 5,073,288 | | | 5,073,288 |
| | 2023/24 Qtr 1 to 3 | 11,987,492 | 2,299,216 | 22,120,000 | 36,406,708 |
| Muwumba HCIII | 2022/23 | 9,945,186 | | | 9,945,186 |
| | 2023/24 Qtr 1 to 3 | 9,140,619 | 3,213,600 | | 12,354,219 |
| **TOTAL** | | **684,307,506** | **320,324,012** | **139,810,384** | **1,144,441,902** |

- **Receipts (Jinja District):** The Jinja District Health Office (DHO) receives funds from Government (PHC), RBF, Capital Development, Family Planning, ICHDS, COVID Catch Up, WHO, UNICEF, Measles Rubella, Global Funds, and Ebola Funds.

| Fund Source | FY 2022/23 (UGX) | FY 2023/24 Q1–Q3 (UGX) | Total (UGX) |
|---|---|---|---|
| PHC – DHO Office | 69,258,842 | 51,213,018 | 120,471,860 |
| RBF – DHO | 15,858,000 | 8,195,046 | 24,053,046 |
| PHC – Health Facilities | 1,069,017,354 | 863,168,151 | 1,932,185,505 |
| RBF – Govt Facilities | — | 108,026,292 | 108,026,292 |
| Family Planning | 39,990,250 | 77,155,992 | 117,146,242 |
| Capital Development | 785,209,357 | 186,722,608 | 971,931,965 |
| ICHDS | — | 64,092,715 | 64,092,715 |
| COVID Catch-Up | 18,394,667 | — | 18,394,667 |
| WHO Funds | 51,462,000 | — | 51,462,000 |

| | | | |
|---|---|---|---|
| UNICEF Funds | 52,400,200 | — | 52,400,200 |
| Measles Rubella Campaign | 72,617,340 | — | 72,617,340 |
| Global Fund | 58,028,405 | — | 58,028,405 |
| Ebola Funds | 300,770,000 | — | 300,770,000 |
| TOTAL | 2,533,006,415 | 1,358,573,822 | 3,891,580,237 |

- **Missing and Incomplete Accountabilities (Jinja City):** A review revealed UGX 803,040,270 in missing payment vouchers and incomplete accountabilities across audited city facilities. This contravenes Public Finance Management Regulations 2016, sections 29(1) and 36(5). This non-compliance could indicate withheld vouchers, improperly documented payments, potential fraud, and may lead to negative consequences like reduced funding or penalties for the Accounting Officer. Verification that funds were used as intended was not possible, raising concerns about potential fund diversion.

| **JINJA CITY HEALTH OFFICE SUMMARY OF ISSUES (FIN YEARS 22/23 AND 22/24)** | | | |
|---|---|---|---|
| **HEALTH UNIT** | **RECEIPTS** | **ISSUE** | **AMOUNT** |
| Budondo HCIV | 232,585,814 | Unaccounted for funds | 52,720,831 |
| | | Missing Vouchers | 25,258,422 |
| | | | |
| Bugembe HCIV | 362,760,427 | Unaccounted for funds | 109,926,941 |
| | | Missing Vouchers | 143,567,281 |
| | | | |
| Mpumudde HCIV | 180,248,180 | Unaccounted for funds | 122,498,512 |
| | | Missing Vouchers | 10,380,000 |
| | | | |
| Walukuba HCIV | 305,068,080 | Unaccounted for funds | 173,610,290 |
| | | Missing Vouchers | 106,293,493 |
| Kisima HCIII | 41,479,996 | Unaccounted for funds | 41,070,000 |
| Muwumba HCIII | 22,299,405 | Unaccounted for funds | 17,714,500 |
| **TOTAL** | **1,144,441,902** | **-** | **803,040,270** |

- **Unaccounted for Funds (Jinja District):** An amount of UGX 1,083,117,210 remained unaccounted for or insufficiently accounted for across the DHO's office, Buwenge General Hospital, and Buwenge HCIV for the reviewed period. This also contravenes section 36(5) of the Public Finance Management Regulation 2016 and carries similar risks of non-compliance. Independent verification of fund usage was not possible, suggesting potential diversion.

| Health Unit | Total Receipts (UGX) | Audit Issue | Amount Queried (UGX) |
|---|---|---|---|
| DHO’s Office | 3,891,580,237 | Unaccounted funds | 772,982,879 |
| Buwenge General Hospital | 623,977,089 | Unaccounted / Missing vouchers | 186,565,306 / 55,853,987 |
| Buwenge HCIV | 165,886,850 | Unaccounted / Missing vouchers | 50,639,338 / 17,075,700 |
| TOTAL | 4,681,444,176 | — | 1,083,117,210 |

- **Good Practices:** Evidence of a solid internal audit department was noted, with documents reviewed and well-filed.

- **Conclusion:** Queries were raised, and the DHO and health centre management teams were given two weeks to respond. Full accountability for funds is required; failure may lead to prosecution.

## Human Resources for Health

- Gross understaffing across all Jinja City HCIVs — 19–32% of approved positions filled.
- Buwenge General Hospital staffed at only 25% under the new approved structure.
- In-charge of Buwenge General Hospital absent during HMU visit; signed attendance registers only 10 times in two months.
- Staff in multiple facilities wore uniforms for higher positions without formal re-designation — irregular and illegal.

- **Staffing Norms:**
  - Analysis based on the Ministry of Health (MoH) structure revealed gross understaffing across all cadres (clinical and non-clinical) in Jinja city health facilities.

**Jinja City Facilities:** *The percentages of filled positions compared to MoH approval*

| Facility | Approved \| Filled \| % Filled |
|---|---|
| Walukuba HCIV | 130 \| 34 \| 26.2% |
| Bugembe HCIV | 130 \| 41 \| 31.5% |
| Mpumudde HCIV | 130 \| 25 \| 19.2% |
| Budondo HCIV | 130 \| 36 \| 27.7% |
| Wakitaka HCIII | 55 \| 17 \| 31% |
| Muwumba HCIII | 55 \| 12 \| 21.8% |
| Kisima HCIII | 55 \| 6 \| 11% |

  - Buwenge General Hospital is grossly understaffed at only 25% based on the new structure. It has only 11 enrolled midwives instead of the approved 20, and only 13 out of 32 approved Assistant Nursing Officer positions are filled.
  - Conversely, Buwenge General Hospital has overstaffing in two positions: Enrolled Nurse (28 filled vs. 20 approved) and Porter (7 filled vs. 5 approved).

- **Staff Attendance:**
  - **Jinja City:** The percentage of staff physically present compared to the duty roster was generally over 75% in visited facilities, sometimes exceeding 100%.

| Facility | On Roster \| Present \| % Attendance \| Remarks |
|---|---|
| Walukuba HCIV | 16 \| 20 \| 125% — Some staff not on rota but found present |
| Bugembe HCIV | 26 \| 21 \| 80.7% |
| Mpumudde HCIV | 17 \| 13 \| 76% |
| Budondo HCIV | 24 \| 27 \| 112.5% — Three off-duty staff (incl. in-charge) were working |
| Wakitaka HCIII | 7 \| 6 \| 85% |
| Muwumba HCIII | 9 \| 7 \| 77.8% |
| Kisima HCIII | 6 \| 6 \| 100% |

- **Jinja District Facilities:** the percentage of approved staff positions filled across all facilities is very low, ranging from 25% to 34% as illustrated in the table below:

| Facility | Approved \| Filled \| % \| Note |
|---|---|
| Buwenge Hospital | 343 \| 86 \| 25% \| Grossly understaffed |
| Buwenge HCIV | 130 \| 39 \| 30% |
| Mpambwa HCIII | 55 \| 19 \| 34.5% |
| Busede HCIII | 55 \| 19 \| 34.5% |
| Magamaga HCIII | 55 \| 18 \| 32.7% |
| Butagaya HCIII | 55 \| 17 \| 30.9% |
| Budima HCIII | 55 \| 18 \| 32.7% |
| Kakira HCIII | 55 \| 15 \| 27.3% |

- Certain cadres at Buwenge General Hospital (e.g., Stenographer Secretary, Driver, HR Officer, Medical Records Assistant, Askari, Medical Officer, Nutritionist, Radiographer) do not appear on any duty roster, making attendance monitoring difficult. A general/consolidated duty roster is suggested.

**In-Charge Attendance:**

- **Jinja City:** Attendance varied, with the lowest being 13 days (Muwumba HCIII In-charge, post-stroke). Walukuba HCIV and Bugembe HCIV showed 34 and 46 days present respectively.
- **Jinja District:** Attendance over the preceding two months varied significantly

| Facility | Present? \| Days Attended \| Remarks |
|---|---|
| Buwenge General Hospital | NO \| 10 \| Absent during HMU visit |
| Buwenge HCIV | YES \| 15 (one month) \| On leave late-March to mid-May 2024 |
| Mpambwa HCIII | NO \| 8 (May 2024) \| Recently transferred 19/04/24; away at district meeting |
| Busede HCIII | NO \| 18 (Mar–Apr) \| On annual leave; 14 days workshop documented |
| Magamaga HCIII | NO \| 37 \| In-charge arrived late on visit day |
| Butagaya HCIII | NO \| 12 (May 2024) \| Transferred from Kakira, April 2024 |
| Budima HCIII | YES \| 30 \| Good teamwork observed |
| Kakira HCIII | YES \| 14 (May 2024) \| Recently transferred, April 2024 |

- **Uniforms:** Staff in several facilities (Bugembe HCIV, Walukuba HCIV, Budondo HCIV, Mpumudde HCIV, Kisima HCIII, Muwumba HCIII) were found in incomplete uniforms.
- **Staff Conduct & Issues:**

- Some staff who attained higher qualifications through further studies wear uniforms for higher positions and perform duties not aligned with their substantive appointments without formal re-designation, which is irregular and illegal.
- Salary issues were reported by staff from Buwenge General Hospital, Butagaya HCIII, Budima HCIII, and Busede HCIII.
- Absenteeism is an issue; for instance, the In-charge of Buwenge General Hospital was absent during the visit and had only signed the attendance register 10 times in two months.

- Poor work attitudes were reported as a challenge.

- **Overall Challenges:** Low staffing, absenteeism, and poor staff attitudes are key challenges. Staff managing medicine stores often lack adequate training.

## Essential Medicines and Health Supplies (EMHS)

- A discrepancy at Butagaya HCIII: IRV showed 224 tins of TLD taken by MJAP, but stock card indicated 2,476 tins removed — a difference of 2,252 tins, suggesting possible theft.
- EMHS redistributed to PNFPs without Memoranda of Understanding, raising accountability concerns.
- All facilities lacked refrigerators for cold chain management.
- Rx-solution ELMIS installed but not effectively used; store managers lack training.

- **Records Management:**
  - Gaps in records management make assessing National Medical Stores (NMS) budget management and performance difficult.
  - Laboratory and theatre items often lack stock card usage. Buwenge General Hospital has abandoned stock cards, and the Rx-solution system is not effectively utilized for stock-taking.
  - Despite installation, the Rx-solution system is often not updated promptly. Assistant Inventory Managers lack skills in using the system.
  - HMIS tools (stock cards, Issue and Requisition Voucher - IRV books, dispensing logs) show improvements but have gaps like incompleteness (lack of signatures), issuing items on unauthorized vouchers, issuers/recipients not signing, leaving vouchers open, issuing items without capturing quantities, and failure to separate triplicate copies.
  - HMIS tools are not updated instantly, leading to incorrect or omitted information.
- **Requisition and Ordering:**
  - Most HCIII In-charges and designated store staff do not know how to use the NMS Client Self Service Portal (CSSP) and cannot generate orders independently.
  - Among HCIVs, only Walukuba and Mpumudde had staff capable of using CSSP.
- **NMS Deliveries:**
  - NMS sometimes delivers un-requisitioned items or quantities far exceeding requests. Example: Buwenge Hospital received a year's supply of Artesunate Inj. 60mg and TLD (90T and 30T), risking expiry or theft.
  - NMS delivers large consignments for two cycles, but facilities lack adequate storage infrastructure.
- **Storage:**

Inadequate EMHS storage space exists at all visited facilities except Buwenge General Hospital. Facilities improvise multiple storage areas. Part of Buwenge General Hospital's store serves EMHS and medical equipment.

*Part of Buwenge General Hospital store that served as storage for EMHS and medical equipment*


- All visited facilities lacked refrigerators for cold chain management.

- **Staffing and Capacity:**
  - Staff designated to manage stores are often seconded by the Ministry of Finance and lack medical knowledge for EMHS management, or nurses are verbally delegated without proper capacity building.
  - In-charges often lack knowledge of EMHS supply chain management.
  - Staff delegated to stores are not trained in EMHS management, ELMIS, or HMIS tools, struggling with item names.
- **Intra-facility Distribution:**
  - Staff often do not follow supply chain SOPs when requisitioning/receiving items.
  - Most in-charges do not authorize or adequately supervise EMHS store activities and transactions, often due to knowledge gaps.
  - Practices like inconsistent pack sizes on stock cards, one staff member handling requisitioning, authorizing, and receiving, and stamping unauthorized/unsigned vouchers were observed.
  - Poor documentation makes it hard to track issued items, recipients, and dispatchers, creating opportunities for misuse.
- **Inter-facility Redistribution:**
  - Redistribution has been delegated to Mildmay Uganda Joint AIDS Program (MJAP) without sufficient City/District staff supervision.
  - District health teams lack full ownership of medicines monitoring, heavily relying on partner support (MJAP). Planning for potential IP withdrawal is needed.
  - A discrepancy was noted at Butagaya HCIII where an IRV showed 224 tins of TLD taken by MJAP, but the stock card indicated 2476 tins removed, a difference of 2252 tins, suggesting possible theft.
  - EMHS are redistributed to Private Not-For-Profit (PNFP) facilities without clear Memoranda of Understanding (MoUs), raising concerns as these items might be sold or incur service fees.
- **Accountability and Use:**
  - There is little concerted effort to ensure accountability at all levels of EMHS access within facilities. Many items could not be accounted for.
- **Expired Medicines:**
  - Expired medicines had generally been withdrawn to the DHO's office.
  - In Jinja City, expired medicines were aggregated at Bugembe HCIV awaiting NMS collection for disposal.


*1. Expired medicines from Jinja City health facilities, aggregated at Bugembe HCIV*

- **Challenges:**
  - Knowledge gaps in supply chain management.
  - Lack of training for delegated stores staff.
  - Recent staff transfers hindered pinpointing responsibility for unaccounted medicines.
  - District/City monitoring teams do not conduct sufficient onsite capacity building for stores staff.
- **Overall:** Inadequate supply, poor accountability, theft, and poor storage are key challenges.

## Health Services Delivery

- **Outpatient Services (OPD):**
  - All visited facilities had functional OPDs.
  - Quality of services needs significant improvement.
  - Poor staff attendance to duty affects services.
  - Record-taking and keeping are poor, requiring support for all staff, including clinicians.
  - Patient extortion is rampant; better record-keeping might help mitigate this.
  - **OPD Attendance (Nov 2023 - Apr 2024):** Buwenge General Hospital had the highest average monthly attendance (2760). Among HCIIIs, Kisima HCIII had the lowest average (291), attributed to its island location. Butagaya HCIII had the lowest mainland HCIII average monthly attendance (547), performing worse than Magamaga HCIII (570) despite Magamaga's proximity to larger facilities and poorer infrastructure.

| Facility | Nov–Apr Total OPD \| Monthly Avg. \| Note |
|---|---|
| Buwenge General Hospital | 16,557 \| avg 2,760/month — Highest volume in Jinja District |
| Buwenge HCIV | 7,993 \| avg 1,332/month |
| Budondo HCIV | 8,005 \| avg 1,334/month |
| Butagaya HCIII | 3,281 \| avg 547/month — Lowest among mainland HCIIIs |
| Budima HCIII | 5,356 \| avg 893/month |
| Kakaire HCIII | 4,443 \| avg 741/month |
| Magamaga HCIII | 3,417 \| avg 570/month |
| Busede HCIII | 4,573 \| avg 762/month |
| Kakira HCIII | 4,334 \| avg 722/month |
| Wakitaka HCIII | 4,861 \| avg 810/month |
| Kisima HCIII | 1,745 \| avg 291/month — Island location limits access |

- **Inpatient Services:**
  - Admission capacity exists mainly at Buwenge General Hospital and some HCIVs/HCIIIs.
  - Kisiima HCIII does not admit patients despite having a new, well-equipped ward; no reason was provided.
  - The general ward at Magamaga HCIII was converted into a store.
  - Most facilities lacked patient files for clinical notes. Buwenge General Hospital had run out of patient files during the visit. Budima HCIII had made efforts to create files.
- **Maternity Care and Child Care (MCH) Services:**
  - Services (Antenatal, Delivery, Postnatal, Immunization, EMTCT) are offered at all visited facilities.
  - Comprehensive Emergency Obstetric Care (CEmOC), including C-sections, is available at HCIVs and the general hospital.

- **Findings/Challenges:**
  - Limited space and inadequate equipment in facilities like Magamaga, Busede, Budima, Wakitaka, and Kakira hinder service delivery.
  - Buwenge General Hospital offers MCH services in improvised OPD spaces and has a congested labour suite compromising waste management and infection control.
  - Extortion by healthcare workers reported at Buwenge HCIV. Patients reported being charged for C-sections.
  - A new, incomplete maternity block at Buwenge HCIV has design flaws regarding infection control.
  - Walukuba HCIV has a heavily congested maternity wing run by a small team of midwives and faces urgent infrastructural needs despite having a separate MCH campus.
  - A new post-natal block under construction at Walukuba HCIV (main campus) is considered too small for proposed functions, including a Neonatal Care Unit (NICU).
  - Delivery numbers over 6 months varied:

| Facility | Deliveries (6 months) \| C-Sections \| Maternal Deaths \| FSBs |
|---|---|
| Buwenge General Hospital | 772 \| — \| — \| — |
| Buwenge HCIV | 436 \| — \| — \| — |
| Butagaya HCIII | 203 \| N/A \| — \| — |
| Budima HCIII | 22 \| N/A \| — \| — |
| Kakaire HCIII | 133 \| N/A \| — \| — |
| Mpambwa HCIII | 256 \| N/A \| — \| — |
| Magamaga HCIII | 125 \| N/A \| — \| — |
| Busede HCIII | N/A \| N/A \| — \| — |
| Kakira HCIII | 118 \| N/A \| — \| — |
| Wakitaka HCIII | 184 \| N/A \| — \| — |
| Kisima HCIII | 0 \| N/A \| — \| 0 — Not offering deliveries despite equipped ward |

- **Operating Theatres and Surgical Services:**
  - The General Hospital and all visited HCIVs had operating theatres, though Buwenge HCIV and Mpumudde HCIV faced challenges.
  - Mpumudde HCIV's theatre design deviates from MoH plans, causing patient flow and infection control issues.
  - Buwenge HCIV's theatre is improvised in a squeezed space (intended radiology department) with poor infection control infrastructure.
- **Referral and Ambulance Services:**
  - Services exist but are underutilized.
  - Referrals are mostly for obstetric and sometimes pediatric cases, mainly to HCIVs, Buwenge GH, Jinja RRH, and Mulago NRH.

- A boat ambulance serves Lake Victoria Island populations


*The boat ambulance linking nearby Lake Victoria Island populations to medical services within Jinja city.*

- Inadequate patient review before referral occurs. Referrals should ideally be made by senior staff.
- Documentation (pre-referral notes, reasons, post-referral follow-up) is inadequate.
- Concerns were raised about unnecessary referrals from Buwenge HCIV, potentially to private clinics. The government ambulance's availability was questioned.

- **Mortuary Services:**
  - There is a significant lack of mortuary infrastructure in the district.
  - Buwenge HCIV has an old structure without refrigeration; a decomposing body was present during the visit.
  - Buwenge General Hospital and Jinja City HCIVs lack mortuaries.

## Infrastructure and Equipment — Jinja

- Walukuba HCIV: Fraudulent land titles acquired on facility land, obstructing construction. Incinerator on contested land allegedly destroyed.
- Masese HCIII: City authorities gave away part of the facility's over-4-hectare land, leaving less than 2 hectares.
- Buwenge HCIV: Improvised theatre in a squeezed space with poor infection control design.
- No mortuaries at Buwenge GH or Jinja City HCIVs. Buwenge HCIV mortuary is an old structure without refrigeration; a decomposing body was present during the visit.

*Staff house at Walukuba HCIV maternity wing targeted by land grabbers*


*Incinerator at Walukuba HCIV — on contested land, allegedly destroyed by land grabbers*

At Masese HCIII, city authorities had given away part of the over four-hectare land, leaving less than two hectares. Following interaction with the City Physical Planner, it was agreed to preserve the entire designated land (at least four hectares), open adjacent roads, and process a title for the facility to accommodate planned expansion.

- **Facility Conditions:**
  - Poor infrastructural conditions affect service delivery in Magamaga, Busede, Budima, Wakitaka, and Kakira HCIIIs.
  - Buwenge General Hospital has inadequate MCH space and a congested labour suite. It also reportedly has only one toilet/bathroom for patients and attendants and poor lighting at the gate.
  - Buwenge HCIV has an improvised theatre and a new maternity block with infection control design flaws. The facility was reported as often dirty and bushy.
  - Walukuba HCIV has a congested maternity wing and urgent MCH infrastructure needs. A new postnatal block is deemed too small.
  - Lack of adequate EMHS storage infrastructure is widespread.
  - All visited facilities lacked refrigerators for cold chain items.
  - Lack of an ultrasound scan at Buwenge General Hospital was questioned.
  - Mortuary infrastructure is largely absent.
- **Equipment:** Inadequate equipment hinders MCH services in several facilities.

## Community Engagement — Jinja

### Radio Talk Show

On **Busoga One FM 90.6**, the Resident District Commissioner of Jinja, Mr. Gulume Richard, and the Assistant District Health Officer for Maternal and Child Health, Mr. Mugambo Joash, were joined by Dr. Elijah Ssemaganda, the Assistant Director of the Health Monitoring Unit. The trio discussed the findings from the monitoring activities conducted in health facilities across Jinja City and Jinja District.

### Community Dialogue

- A community dialogue (Baraza) was held at Buwenge HCIV, attended by District Health Team members, and Town Council leaders.
- **Community Concerns Raised:**
  - Poor service delivery and work attitudes at Buwenge HCIV leading to low patient attendance.
  - Frequent stockouts of medicines at Buwenge HCIV (often only Panadol available).
  - Need for a government health facility in Kasaliza zone.
  - Patients being sent to private pharmacies to buy medicines by HCWs at Jinja RRH and Buwenge GH.
  - Charges for C-sections and general extortion at Buwenge HCIV.
  - Poor staff attitudes, unnecessary referrals (sometimes to private clinics) at Buwenge HCIV.
  - Buwenge HCIV often being dirty and bushy.
  - Allegations of HCWs registering 'ghost' patients to account for medicines.
  - Limited operating hours of health centres, especially difficulty accessing care at night.
  - VHTs not receiving full allowances or invitations to facility meetings.
  - Lack of ultrasound scan at Buwenge General Hospital.
  - Inadequate sanitation facilities (one toilet/bathroom) at Buwenge GH.
  - Poor lighting at Buwenge GH gate, posing risks when sent to buy medicines at night.
  - Questions about the availability and operation of the government ambulance.
  - Elderly patients not being prioritized for care.

### Dissemination Meeting

A dissemination meeting was held with City and District leaders at the City Hall on 5 July 2024. The Health Monitoring Unit team discussed the findings in the areas of health service delivery, essential medicines and health services, finance, infrastructure and equipment. Both the Resident District Commissioner and Resident City Commissioner were present, among other District and City leaders.

**HMU INTERVENTIONS**

- Agreement that all unaccounted-for EMHS must be accounted for.
- Instructions given to all in-charges of visited facilities to:
  - Supervise and participate in EMHS management.
  - Build capacity of staff delegated to manage EMHS stores.
  - Deploy delegated stores staff with an internal MEMO.
  - Ensure completeness of HMIS tools.
  - Operationalize committees for receiving EMHS deliveries.
  - Learn Rx-solution for stock management and CSSP for ordering.
  - Designate storage areas for Class A drugs.
  - Source refrigerators for cold chain storage.
- Capacity building on EMHS supply chain management conducted in all visited facilities.
- Assistant inventory management officers linked to the MoH Rx-solution group for guidance.
- Recommended targeted monitoring, supervision, and onsite capacity building by DHT.
- Findings regarding lost medicines shared, ensuring awareness of potential consequences if unaccounted for.
- Ensured committees for receiving NMS deliveries were constituted.
- Recommended activation and operationalization of Medicines Therapeutic Committees in HCIVs and the General Hospital.
- Stopped redistribution of EMHS to PNFPs without clear guidelines/MoUs.
- Cautioned DHO and City Health Officer against fully relinquishing redistribution powers to Implementing Partners without DHT involvement.
- Advised sourcing consumption data from Dispensing Logs.
- Advised the district to hold Continuing Medical Education (CME) for all staff involved in medicines/supplies management.

### Recommendations — Jinja

- Cancel fraudulent land titles at Walukuba HCIV and fence the entire facility land.
- Construct mortuaries with solar-powered refrigerators at General Hospital and all HCIVs.
- Train all staff on EMHS supply chain, ELMIS, and HMIS tools.
- Recruit pharmacists for General Hospital and all HCIVs; pharmacy technicians for HCIIIs.
- Streamline EMHS redistribution and cease redistribution to PNFPs without signed MoUs.
- Submit all missing accountabilities; future failures to lead to prosecution.

## 4.2.4 Manafwa District

Five health facilities were visited: HCIVs (Bugobero and Bubulo) and HCIIIs (Bukewa, Butiru, and Bukimanayi).

| Best Practices — Manafwa |
|---|
| • Well maintained facilities: Bugobero HCIV, Bukewa and Butiru HCIIIs. |
| • Well equipped, clean and spacious theatre at Bugobero HCIV. |
| • Spacious, well equipped, and organised laboratories at Bugobero and Bubulo HCIVs. |
| • Well organised, lit and aerated stores with fully updated stock cards at Bugobero and Bubulo HCIVs. |

### Leadership and Governance

- Substantive DHO vacancy since March 2021 — multiple advertisements have failed to attract qualified candidates.
- Inadequate quality support supervision from all expected levels.
- Financial accountability records only visible at Bukewa HCIII; no public display of PHC funding at any facility.

## Human Resources for Health

- District-wide staffing at 140% of approved positions (269/192) — significant overstaffing overall.
- 12% of government staff (32/269) illegally deployed to 3 PNFP facilities — recalled following HMU intervention.
- Dr. Wenani Daniel (MO) irregularly promoted to SMO and conducting duties beyond his grade — appointment rescinded.
- PHC payroll had 75 excess staff compared to approved 192; non-existent cost centers created on payroll to accommodate them.
- Three staff abandoned duties: Musila Isaac (EN), Masaba Samson (Driver), and Dr. Mutoo Paul (double-employed at Baylor Uganda).

*Staffing Norms by facility*

| Facility | Ownership \| Approved \| Filled \| % Filled |
|---|---|
| Bubulo HCIV | Govt \| 48 \| 57 \| 119% (overstaffed) |
| Bugobero HCIV | Govt \| 48 \| 54 \| 113% (overstaffed) |
| Butiru HCIII | Govt \| 19 \| 31 \| 163% (overstaffed) |
| Lwanjusi HCIII | Govt \| 19 \| 26 \| 137% (overstaffed) |
| Bukewa HCIII | Govt \| 19 \| 21 \| 111% (overstaffed) |
| Bukimanayi HCIII | Govt \| 19 \| 21 \| 111% (overstaffed) |
| Ikaali HCII | Govt \| 9 \| 14 \| 156% (overstaffed) |
| Manafwa DHO's Office | Govt \| 11 \| 13 \| 118% (overstaffed) |
| DISTRICT TOTAL | Govt \| 192 approved; 269 on payroll (PHC) — 75 excess staff |

- **Payroll Anomalies:**
  - Based on the Ministry of Health Budgeting Guidelines for FY 2022-23, the Primary Health Care (PHC) payroll as of June 30, 2023, had an excess of 75 staff (267 staff compared to the approved 192).
  - To accommodate these extra staff, the district created non-existent cost centers/institutions on the payroll under the PHC category.
  - **Unaccounted Staff:** One Theatre Assistant assigned to Bubulo HCIV (Ms. Haboya Faith) appeared on the staff list but could not be physically traced at the facility nor found on the payroll.
- **Staff Welfare and Housing:**
  - Most health facilities had limited or no staff housing. Consequently, all visited facility in-charges were non-resident.
  - The in-charges of Bubulo HCIV and Bugobero HCIV resided in Mbale town, despite having designated accommodation at their facilities.
  - At Bubulo HCIV, the doctors' house had never been occupied due to a lack of water and power, leading to its deterioration over time. Renovation was reportedly ongoing but slow.
  - At Bugobero HCIV, the doctors' house was undergoing renovation at the time of the visit.
  - Most staff at the visited facilities were found dressed in uniforms.
- **Staff Salary Issues:** Four (04) staff reported salary-related problems, including underpayments, arrears, and non-payment since deployment.
- **Attendance to Duty:**

- Attendance by health facility in-charges was below the public service recommended minimum of 15 days per month. Attendance over the past three months was recorded as:
  - Bubulo HCIV: 38 days
  - Butiru HCIII: 37 days
  - Bugobero HCIV: 19 days
  - Bukimanayi HCIII: 7 days
- Attendance data for the Bukewa HCIII in-charge was unavailable as the biometric machine had recently broken down, and a new manual register had just been started.
- Faulty biometric machines led to the use of manual attendance registers/books; a system found to be abused through staff signing in for absent colleagues.

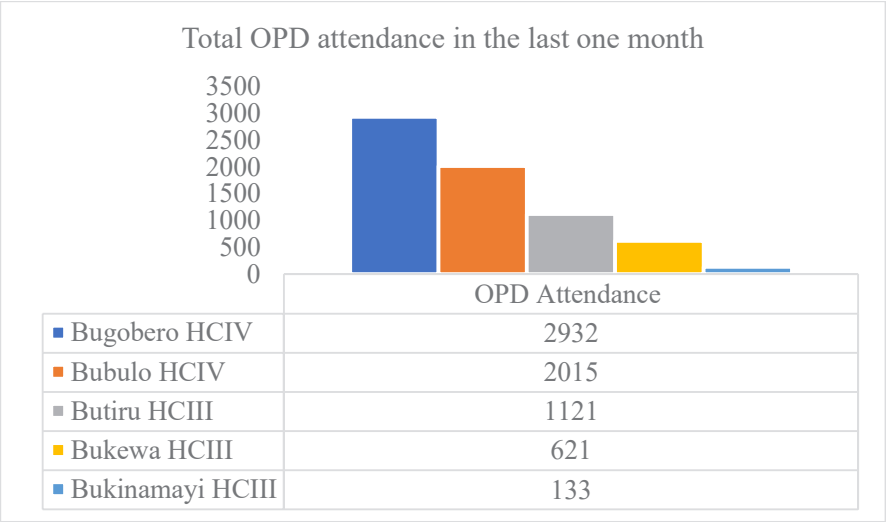
- **Study Leave:**
  - Fifteen (15) staff were reported to be on sanctioned/approved study leave.
  - Three (03) staff were specifically noted on unsanctioned study leave: 2 from Bubulo HCIV and 1 from Bukewa HCIII.
  - Two (02) staff were identified as being on *unsanctioned* study leave: Khaukha Emmanuel M.A (Dispenser) and Katami Miriam Khalayi (Asst. Nursing Officer Midwifery).
- **Errant Staff and Neglect of Duty:**
  - Three (03) staff were identified as having abandoned or neglected their duties:
    - Musila Isaac (Enrolled Nurse), transferred to Bugobero HCIV in February 2023, had not reported for duty for the last 4 months (since March 2023) but had arranged for a volunteer nurse to sign the attendance register for him.
    - Masaba Samson (Driver) had not reported for duty for the past six months (since January 2023). (Note: Both Musila Isaac and Masaba Samson were arrested, charged, and detained at Manafwa CPS over neglect of duty).
    - Dr. Mutoo Paul Bukhota (Senior Medical Clinical Officer) was found to be double-employed by Manafwa DLG (deployed at Bubulo HCIV) and Baylor Uganda-Mbale Branch. He attended duty at Bubulo HCIV for only 16 days between March and June 2023, reportedly preferring to spend time at the Mbale regional Emergency Operations Centre (EOC) supporting surveillance activities.
- **Staff with Additional Duties:** The monitoring team noted concern that staff assigned extra duties at district or regional levels often concentrated on these assignments while neglecting their primary roles at their designated health facilities. For example, Khaukha Emmanuel M.A attended duty for only 9 days at Bubulo HCIV between March and June 2023 while focusing on his assignment as the District Drug Inspector.

## EMHS — Manafwa

- All facilities, especially HCIIIs, reported massive stockouts — NMS had not delivered for three consecutive months.
- Medicines worth UGX 1,059,500 unaccounted for at Bugobero HCIV (2,928 HIV Determine strips; 1,310 Ceftriaxone vials).
- Store personnel at Bugobero HCIV (Yahaya Songoni) stole 200 vials of Artesunate injection and activated charcoal — partially recovered by HMU.
- Neither Bubulo nor Bugobero HCIVs utilized ELMIS; neither had dedicated refrigerators for medicines.

## HEALTH SERVICE DELIVERY

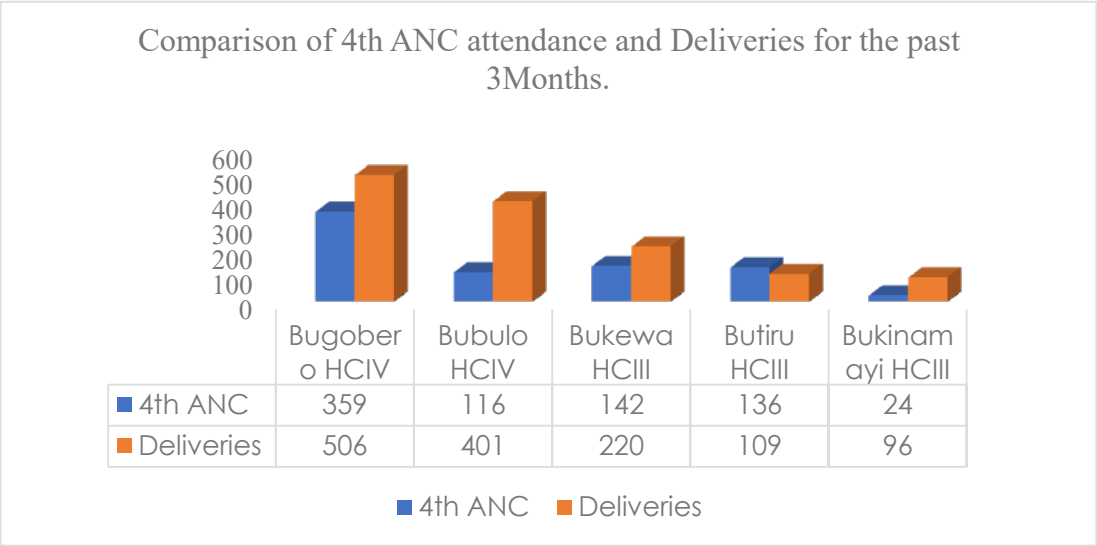
- **Outpatient Department (OPD):**
  - OPD services were generally busy across all visited facilities.
  - The overall OPD attendance for the last month was 6,822.
  - Attendance breakdown: Bugobero HCIV (2932, 43%), Bubulo HCIV (2015, 30%), Butiru HCIII (1121, 16.4%), Bukewa HCIII (621, 9.1%), Bukimanayi HCIII (133, 2%).




| | OPD Attendance |
|---|---|
| Bugobero HCIV | 2932 |
| Bubulo HCIV | 2015 |
| Butiru HCIII | 1121 |
| Bukewa HCIII | 621 |
| Bukinamayi HCIII | 133 |

  - No OPD deaths were reported in the last month at any visited facility.
- **Inpatient Department (IPD):**
  - The HCIVs (Bugobero and Bubulo) had general admission wards; the HCIIIs did not.
  - Inpatient numbers over the last month were significantly higher at Bugobero HCIV (369) compared to Bubulo HCIV (99), suggesting underutilization of inpatient services at Bubulo HCIV.
  - No inpatient deaths were reported in the general admission wards during the last month.

- **Maternity and Antenatal Care (ANC) Services:**
  - Overall, the number of deliveries (1332 total) was higher than the ANC4 attendances (777 total) across most facilities, except Butiru HCIII.
  - ANC4 attendances: Highest at Bugobero HCIV (359/777, 46.2%), lowest at Bukimanayi HCIII (24/777, 3.1%).
  - Hospital deliveries: Highest at Bugobero HCIV (506/1332, 40%), lowest at Bukimanayi HCIII (96/1332, 7.2%).
  - No maternal deaths were reported in the past three months at any facility.
  - Bubulo HCIV reported six infant deaths, with malaria in pregnancy cited as the major cause. This could be linked to mothers not attending ANC, not taking IPT for malaria prophylaxis, and potentially exacerbated by medicine stockouts.
  - Reasons for higher deliveries than ANC4 attendance may include mothers missing ANC4 but choosing facility delivery. Conversely, higher ANC than deliveries might indicate client satisfaction gaps, lack of motivation for facility delivery, or use of private facilities/Traditional Birth Attendants.
- **Caesarean sections:** Of all deliveries in the past three months, 180/907 (19%) were via caesarean section. Bugobero HCIV conducted more C-sections (129) than Bubulo HCIV (51).




- **Blood Transfusion Services:**
  - The HCIVs (Bugobero and Bubulo) had functional blood transfusion services with available records.
  - However, the blood bank refrigerator at Bugobero HCIV was non-functional. Blood for transfusion was temporarily stored in the vaccine fridge awaiting repair by the regional maintenance workshop.

## Infrastructure and Equipment

- **General Facility Condition:** Most facilities were generally well-kept, with the notable exception of Bubulo HCIV. The in-charge attributed this to a reduction in PHC funds (Q4 FY 2022/23), though Bugobero HCIV maintained good upkeep despite last receiving PHC funds in February 2023.
- **Staff Housing:** Staff housing was generally inadequate across facilities but mostly in good condition, except at Bubulo HCIV where the unoccupied doctor's house had deteriorated.

*Bugobero HCIV Compound*

*Well Kempt*

*Bugobero HCIV OPD*

*Well maintained Butiru HCIII*

*Well maintained Bukewa HCIII*

*Bubulo HCIV: Unkempt Compound*

*Bubulo HCIV: Dilapidated staff house for Demolition*

*Bubulo HCIV: Unkempt Staff quarters*

*Bubulo HCIV: Dilapidated water tank for demolition*

- **Construction Projects:**
  - *DHO's office:* Renovation works on a district medicines store were initially shoddy and stalled (reportedly paid at 70%), with the contractor found using child labour and substandard materials. (Note: The building was later completed following HMU intervention).

*DHO's office: Stalled District Medicines Store*

*HMU team attending a stakeholder's crisis meeting chaired by the RDC to address the issue of the stalled construction of the District Medicines Store*

*Completed District Medicines Store after HMU's Intervention*

  - *Bubulo HCIV:* Renovation of the doctor's house was ongoing but slow. This house has never been occupied due to lack of water and power.
  - *Bukewa HCIII:* A three-apartment staff house block was under construction (funded by DDEG PHC FY 2022/23). Staff expressed willingness to occupy it before painting due to housing inadequacy.
  - *Bukimanayi HCIII:* A Maternity block and a staff house were being constructed under the UGIFT project.

- **Motor Vehicle Management:**
  - **Ambulances:** The district had only two functional ambulances: UG7287M (from MoH) and one sponsored by the area MP (Bubulo Constituency). Both were stationed at Bubulo HCIV, despite Bugobero HCIV having a higher patient volume.
  - A grounded and vandalized ambulance, previously donated by the Kizito Foundation to Bugobero HCIV, remained non-operational.
  - **Other Vehicles:** Motor vehicle UG4606M, designated for the health department, was being used by the district LCV chairperson. An agreement was made for its return to the health department within one week, to be subsequently handed over to Bugobero HCIV for outreach services.

- **Land and Security:**
  - **Fencing:** Three facilities (Bugobero HCIV, Bubulo HCIV, Bukewa HCIII) were fenced; two (Bukimanayi HCIII, Butiru HCIII) were not, compromising security.
  - **Land Titles:** Four facilities (Bugobero HCIV, Bubulo HCIV, Bukewa HCIII, Butiru HCIII) had land titles. Bukimanayi HCIII did not have a title, though it was reportedly being processed.
  - **Encroachment:** Land encroachment was reported at Bukimanayi HCIII and Butiru HCIII, with no action taken.
- **Equipment Management:** All visited facilities had updated Equipment Inventory Books. However, not all equipment was engraved, leaving it vulnerable to theft.
- **Utilities:**
  - **Power:** All facilities were connected to the Umeme grid and had functional solar power systems in their maternity sections.
  - **Water:** Two facilities (Bugobero HCIV and Butiru HCIII) had access to piped gravitational water. Three facilities (Bubulo HCIV, Bukewa HCIII, Bukimanayi HCIII) relied solely on harvested rainwater.
- **Mortuary Services:** None of the visited health facilities had a functional mortuary.
- **Laboratory, Infection & Vector Control:**
  - **Laboratories:** Bugobero and Bubulo HCIVs had fairly spacious laboratories. Laboratories at Bukewa HCIII, Bukimanayi HCIII, and Butiru HCIII had inadequate space and were congested.
  - **Waste Management:** All facilities had rubbish pits, rubbish bins, and placenta pits.
  - **Vector Control:** Bugobero HCIV was infested with bats in some sections, despite fumigation having been done within the last year.

**Aide Memoire**

- The HMU provided technical support for an Aide Memoire development session on September 21, 2023, held in the district council hall.
- Attendees included the DHO’s office and health worker representatives from all health facilities.
- During the meeting, identified gaps were shared, and an action plan to address them was agreed upon.
- Health workers (doctors and nurses) present renewed their professional oath to better serve the residents of Manafwa district.

**Public Engagement and Dissemination**

- **Radio Talk Shows:** The HMU team, together with the RDC and DHO’s office, conducted radio talk shows on Step Radio (July 06, 2023) and Elgon FM (September 14, 2023). These broadcasts, in local languages, disseminated findings and discussed health service delivery challenges in the district.
- **Community Dialogue (Baraza):** As part of public engagement, the HMU conducted a community baraza at Bugobero Town Council grounds on September 20, 2023.
- **Accountability:** To foster accountability, the HMU invited the RDC, CAO's office, and DHO's office to directly respond to public questions during the community Baraza and radio programs.
- **Dissemination Plan:** Findings of the monitoring visit were planned to be disseminated through a district dissemination meeting, community barazas, and sharing activity reports with all stakeholders.

### HMU Interventions — Manafwa

- Police opened case files against errant officers; Dr. Mutoo Paul, Musila Isaac and Masaba Samson arrested and charged.
- Irregular appointment of Dr. Wenani Daniel as SMO rescinded by the CAO on November 23, 2023.
- Health workers deployed in PNFP facilities recalled and redeployed to government health centres.
- Stolen medicines at Bugobero HCIV partially recovered and returned to store.
- Stalled renovation of the DHO's medicines store completed following HMU intervention.

### Recommendations — Manafwa

- CAO to engage PS-MoH and MoPS to fast-track recruitment of a substantive DHO.
- CAO to sanction errant health workers and pay outstanding salary arrears.
- DHT to ensure adequate support supervision and accountability across all lower health facilities.
- In-charges of Bugobero and Bubulo HCIVs to reside in designated staff houses at their facilities.
- MOH to provide adequate infrastructure, staff houses, and laboratory equipment.

## 4.2.5 Namutumba District

Eight health facilities visited: HCIV (Nsinze), HCIIIs (Magada, Bulange, Ivukula, Namutumba, Nabisoigi, Kagulu), and HCII (Nangonde).

### Key Findings

- Overall staffing at 30% using new MoH structure (137/460 positions filled).
- Overall staff attendance on day of HMU visit was 32% (50/156 scheduled staff found on duty) — the lowest attendance rate observed across all monitored districts.
- Highest absence rates: Magada (8/13 absent), Kagulu (4/9 absent), Ivukula (4/6 absent), Bulange (3/9 absent).
- Mr. Kyaterakera Paul (SMCO, Magada HCIII): arrested for negligence — worked only 24 days over 9 months. Mr. Balikowa Robert (CO, Magada) went on unsanctioned study leave and left with the facility bank account.
- Ms. Wamwendeire Florence (SMCO, Namutumba HCIII): arrested for negligence — worked only 27 days over 4 months.
- NMS did not deliver an average 15.5% of EMHS budget to HCIIIs and 5.2% to Nsinze HCIV in FY 2022/23.
- Pharmacy stores in all facilities generally dirty; 5/7 lacked SOPs; stock cards poorly maintained.

## Leadership and Governance

- **Supervision:** The support supervision book in most facilities indicated inadequate or no supervision by the district technical, political, and civic leadership. It was noted that some leaders only sign the visitor's book, ignoring or being unaware of the existence and use of the red support supervision book. This concern was voiced during the dissemination meeting, where some individuals claimed ignorance about the book but committed to using it moving forward.
- **Meetings:**
  - All facilities held regular general staff meetings, which are important governance tools for monitoring performance and resolving emerging issues.

- However, Health Unit Management Committee (HUMC) meetings were held irregularly in some facilities.
- Meeting frequency at the facility level (July – December 2023) was noted as follows:
  - *General Staff Meetings:* Three facilities met 4 times, two met 5 times, and two met 6 times within the six months.
  - *HUMC Meetings:* Two facilities did not meet, two met twice, one met three times, and one met five times.

- **Financial Accountability:** All health facilities were not publicly displaying their accountabilities for primary health care (PHC) funds, which is a legal requirement.

## Human Resources for Health

- **Staffing Levels:**
  - The district's health facilities were critically understaffed. Based on the *old* Ministry of Health staffing structure; only 67% of positions were filled.
  - However, using the *new* MoH approved staffing structure (which the district has not yet implemented but was used for monitoring), the situation is worse, with only 137 out of 460 positions filled (30% staffing level).

| NO. | FACILITY | Approved staffing | Filled positions | Percentage |
|---|---|---|---|---|
| 1 | Nsinze HCIV | 130 | 39 | 30% |
| 2 | Magada HCIII | 55 | 19 | 35% |
| 3 | Kagulu HCIII | 55 | 14 | 25% |
| 4 | Nabisoigi HCIII | 55 | 16 | 29% |
| 5 | Namutumba HCIII | 55 | 19 | 35% |
| 6 | Ivukula HCIII | 55 | 14 | 25% |
| 7 | Bulange HCIII | 55 | 16 | 29% |

*Staffing norms by Facility*

**Staff Diligence:**

- Special appreciation was noted for Ms. Aliganyira Prossy (Enrolled Nurse at Ivukula HCIII) for her wonderful work attitude, multi-tasking to attend to all patients, and professionalism in executing her duties.

**Absenteeism and Time Management:**

- There was rampant absenteeism by staff in all facilities. Overall staff attendance on the day of the HMU visit was 32% (50 actual staff found present out of 156 scheduled for duty).
- High absenteeism numbers were recorded at Magada (08/13), Kagulu (04/09), Ivukula (04/06), and Bulange (03/09) HCIIIs on the day of the visit. At Ivukula HCIII specifically, only four payroll staff (including Porter Bonny, E/N Aliganyira, and E/M Tabisa) were found on duty on 25th January 2024. Another absentee mentioned was a clinical officer named Namulinda C.
- Staff attendance on the day of monitoring per facility was recorded as follows:

| Facility | Scheduled \| Found Present \| Remarks |
|---|---|
| Nsinze HCIV | 9 \| 11 \| All present; 2 additional off-duty staff also found working |
| Magada HCIII | 13 \| 5 \| 8 absent |
| Kagulu HCIII | 9 \| 5 \| 4 absent |
| Nabisoigi HCIII | 9 \| 9 \| All present |
| Namutumba HCIII | 11 \| 12 \| All present + 1 off-duty askari |
| Ivukula HCIII | 6 \| 4 \| 2 absent |
| Bulange HCIII | 9 \| 6 \| 3 absent |
| TOTAL | 156 \| 50 \| 32% overall — Lowest across all monitored districts |

- Time management remains a significant challenge. Most Health Centre IIIs (HCIIIs) use manual attendance registers, which are subject to abuse (late arrivals registering earlier times, colleagues signing for absent staff). This was observed at Namutumba HCIII on 30/01/2024, where the HMU team arrived at 9:30 am to find most departments locked, with staff, including the in-charge, arriving after 10:00 am.
- Nsinze HCIV uses both a manual register and a biometric machine, resulting in greatly improved attendance; 100% of staff rostered for day duty were present on the monitoring day.

**Specific Cases of Misconduct/Negligence:**

- Staff assigned additional district-level responsibilities often neglect their primary facility duties. Mr. Kyaterakera Paul (Senior Medical Clinical Officer, Magada HCIII) was found to be perpetually absent, having worked only 24 days between January and September 2023. His file showed previous cautions. He was arrested and charged with negligence of duty.
- Ms. Wamwendeire Florence (Senior Medical Clinical Officer, Namutumba HCIII) was similarly arrested and charged with negligence of duty, having worked only 27 days between September 2023 and January 2024.
- Mr. Balikowa Robert (Clinical Officer and In-charge, Magada HCIII) went on study leave (potentially unsanctioned) but refused to hand over the office and left with the facility bank account.

**Staff Uniforms:** Attending duty without uniforms is a major problem for both clinicians and some nurses, making it difficult to identify staff members.

**Salary Issues:**

- While the majority of healthcare workers reported timely and correct salary payments, a few (less than 5 reported) faced challenges, including underpayments and arrears carried across financial years.
- Specific staff with salary problems were noted:

| Staff Name & Title | Facility | Issue |
|---|---|---|
| Marida Akello – Laboratory Assistant | Magada HCIII | Salary arrears: April, May, June 2021. UGX 2,100,000 owed |
| Waikya Amosi – Porter | Nsinze HCIV | Underpayment: paid UGX 200,000/month instead of UGX 380,000 |
| Wabulembo Warren – SMCO | Nabisoigi HCIII | Underpayment: UGX 3,600,000 claimed in arrears |

The Principal Human Resource Officer (PHRO) acknowledged these cases during the dissemination meeting, attributed delays to procedural technicalities in paying arrears, and assured that the issues were being processed and would eventually be resolved.

**Staff Accommodation:** Inadequate staff accommodation contributes to absenteeism, particularly for clinicians, many of whom reportedly reside in Iganga town while working in Namutumba district.

## ESSENTIAL MEDICINES AND HEALTH SUPPLIES (EMHS)

### NMS Deliveries and Stock Levels:

- In FY 2022/23, the National Medical Stores (NMS) did not deliver, on average, 15.5% of the allocated EMHS budget to the HCIIIs and 5.2% to Nsinze HCIV in Namutumba district.
- In the current financial year (as of the report date), only one delivery was made (November 2023), with the next expected in March 2024. This resulted in intense stockouts, hampering service delivery.
- Namutumba HCIII, due to its location and high patient load, experiences rapid consumption of medicines and supplies (e.g., mama kits), contributing to stockouts.
- The quantity of certain essential medicines, like Ceftriaxone, delivered to facilities is low compared to consumption, requiring prioritization by the district health team.
- NMS sometimes delivered medicines not ordered for (e.g., morphine solution), which subsequently expired unused.

### Storage Conditions:

- Pharmacy stores in all facilities visited were generally dirty. Staff were warned and instructed to maintain cleanliness.
- Five out of seven facilities monitored either lacked Standard Operating Procedures (SOPs) or did not have them displayed in the store.
- Namutumba HCIII's store door, made of iron bars, allowed dirt ingress and increased vulnerability to theft.

### Medicines Management and Accountability:

- Management of medicine stores fell below expected standards: stock cards were often not updated, actual monthly physical counts were not regularly done (balances just filled in), and expired medicines lacked secure, separate storage areas.
- A district-wide mentorship in medicines stores management was needed.
- Audits revealed discrepancies:
    - At Nsinze HCIV: Items without stock cards (some donations), excesses of drugs due to donations not being entered, unknown items (some expired), high stocks of certain medicines needing consumption promotion (e.g., IV Ampicillin, IV Ampiclox), and non-updated ELMIS (RX Solution). Solutions were discussed with store personnel.
    - At Namutumba HCIII: Medicines were issued without proper/complete HMIS documentation. In-charges were found singly filling issue/requisition vouchers and taking medicines. Staff were cautioned.
    - Across facilities: Ward/department store audits found discrepancies which were reconciled. Health workers were encouraged to improve documentation for dispensed items.

### Expired Medicines:

- There were plenty of uncollected expired medicines in all visited facilities except Kagulu HCIII, occupying inadequate storage space.
- Four out of seven facilities monitored (Nabisoigi, Namutumba, Ivukula HCIIIs, and Kagulu HCII) lacked expired drugs registers.

- Three facilities (Nabisoigi, Ivukula, and Kagulu) did not have designated storage areas for expired medicines.
- The District Health Officer's (DHO) office was informed and promised immediate collection.

**Reporting and Information Systems:**

- All health facilities regularly submitted their HMIS 105 section 6 reports and SPARS tool reports.
- All HCIIIs and the HCIV are equipped with computers for ELMIS systems (RX Solution), supported by Management Sciences for Health (MSH). The system is synchronized with the Ministry of Health's Pharmaceutical Information Portal (PIP). Capacity building was provided where needed.

## HEALTH SERVICE DELIVERY

- **Maternity and Maternal Child Health (MCH) Services:**
  - All health facilities offer MCH services, including antenatal, delivery, postnatal, family planning, and EMTCT of HIV.
  - Most deliveries were conducted at Nsinze HCIV (average 118 monthly), being the district's highest-level referral facility. HCIIIs averaged 59 deliveries monthly.

The number of deliveries conducted over the last six months (July to December 2023) were summarized:

| Facility | Jul \| Aug \| Sep \| Oct \| Nov \| Dec \| Total \| Monthly Avg. |
|---|---|
| Nsinze HCIV | 89 \| 78 \| 109 \| 149 \| 132 \| 149 \| 706 \| 118 |
| Magada HCIII | 47 \| 55 \| 53 \| 56 \| 64 \| 79 \| 354 \| 59 |
| Bulange HCIII | 58 \| 66 \| 47 \| 45 \| 52 \| 41 \| 309 \| 52 |
| Ivukula HCIII | 47 \| 49 \| 41 \| 39 \| 46 \| 40 \| 262 \| 44 |

- Emergency obstetric care, including surgical operations, is offered only at Nsinze HCIV.

**Challenges in Maternity and Obstetric Care:**

- **Nsinze HCIV Specific Challenges*:*** Poor infection control, limited space for maternity ward sub-functions, and inter-district obstetric referrals were noted. Addressing these would improve service quality.
- **General Obstetric Challenges*:***
  - Inadequacy of Space*:* This was particularly acute at Ivukula HCIII, and Namutumba HCIII
  - Sterilization of Equipment*:* This was a major issue. at Magada HCIII, Bulange, Ivukula, and Nsinze HCIV Using unsterilized equipment exposes mothers and newborns to infection risks.
  - Cleanliness*:* Many maternity wards were not cleaned regularly or thoroughly. Porters reportedly did not report to duty regularly.
- Nsinze HCIV Operating Theatre*:* The theatre was fairly active (average 24 caesarean sections monthly, plus other surgeries) with a commendable anaesthesia team using various modes. Challenges included poor lighting, poor ventilation, a non-functional suction machine, and insufficient IV fluids, antibiotics, and disinfectants from NMS. Support from the organization 'Bulamu' in these areas was commended.
- Blood Supply: Blood supply at Nsinze HCIV was irregular; no blood was available at the time of the HMU visit.

- **Neonatal Intensive Care Unit (NICU) Services (Nsinze HCIV):**
  - The NICU space was improvised within the maternity ward (in a former consultation room).
  - There were no functional baby incubators (only baby cots).
  - Babies were rarely admitted, although registers showed 62 admissions between July and December 2023.
  - There were no properly trained NICU staff and no designated medicines for the unit.
- **Inpatient Services:**
  - Inpatient services at HCIIIs were not prioritized. Admission spaces were often re-purposed (e.g., storage for construction materials at Magada, ART clinic at Namutumba, general store/ART clinic at Kagulu) or simply neglected (e.g., Namutumba HCIII), discouraging patient utilization.
  - At Nsinze HCIV, inpatients were mainly seen by nurses, occasionally by clinical officers, and medical officers only reviewed upon request. Nurses often performed roles meant for clinicians.
  - Clinicians (clinical officers and medical officers) generally did not diligently attend to inpatients across facilities. Midwives and nurses often covered this gap, performing duties across multiple cadres (clinician, nurse, records assistant, dispenser, administration). This contributed to unchecked absenteeism, indiscipline, and weak leadership.
  - Poor documentation hampered inpatient care quality. Well-kept inpatient records were inadequate or lacking, with no inpatient files found, especially in HCIIIs. No dispensing logs or duty rosters were found in the inpatient wards.
- **Community Feedback:** Members of the community, via a dialogue, decried chronic absenteeism by healthcare workers, rudeness, extortion, and inconsistent availability of essential medicines.

## INFRASTRUCTURE AND EQUIPMENT MANAGEMENT

- **Buildings and Infrastructure:**
  - ***Commendable Work:*** The UPDF engineering brigade has done commendable work improving health infrastructure.
  - ***Ongoing Construction:*** Works include two staff quarters units and a latrine at Magada HCIII (UPDF), maternity ward expansion at Namutumba HCIII, a new operating theatre at Nsinze HCIV, and a new maternity block and staff houses at Nangonde HCII.
  - ***Needed Infrastructure:*** There is a need for an OPD block at Kagulu HCIII, a maternity ward at Ivukula HCIII, and general wards at Ivukula, Bulange, and Nabisoigi HCIIIs.
  - ***General Wards Status:*** Availability varies. Bulange and Ivukula HCIIIs lack admission space; Namutumba and Nabisoigi HCIIIs have very small spaces. Kagulu and Magada have fairly adequate space but repurposing is common (Magada: construction materials storage; Namutumba: HIV clinic; Kagulu: general store/HIV clinic). The former maternity ward at Bulange could potentially be renovated into a general ward (needs ceiling repair, bat control, paint).


*Figure 1: Magada HCIII used as a store*


*Figure 2: Kagulu HCIII female ward used as a store*

- ***OPD Condition:*** OPDs were generally congested with small operational areas, worst in Ivukula HCIII and Nangonde HCII. Kagulu HCIII lacks an OPD block altogether. Some facilities' OPDs were notably dirty (e.g., Namutumba HCIII), while most were average.
- *Maternity Wards:* Present in all HCIIIs. Ivukula's is the smallest and most congested. Namutumba's is small but expanding. Cleanliness is a major issue.
- ***Staff Housing:*** Insufficient housing units contribute to absenteeism. Where houses exist (e.g., Ivukula HCIII), compounds were often not well maintained, though Nsinze HCIV staff house compounds were fairly well looked after.
- ***Destructive Practices:*** The practice of driving nails into walls needs to stop immediately (observed in Kagulu ward).

- **Compounds and Sanitation:**
  - ***Cleanliness/Maintenance:*** Most facility compounds were not slashed at the time of visit (e.g., Magada, Ivukula, Bulange HCIIIs).
  - ***Fencing:*** Most facilities had good chain-link fences (except Nangonde HCII). Namutumba HCIII's fence along the highway needs repairs.
  - ***Drainage:*** No clear run-off water drainage systems were in place, predisposing facilities to flooding and poor sanitation.
  - ***Latrines:*** Most facilities have pit latrines in good condition, except Namutumba HCIII (available latrine not clean, shared).
  - ***Bathrooms:*** Almost all were found in a good state.

- **Equipment:**
  - *Autoclaves and Sterilization:* All health facilities visited (except Nsinze HCIV) lacked functional autoclaves and sterilization equipment. The three autoclaves at Magada HCIII were faulty and long out of use.
  - *Hospital Beds:* Available hospital beds were insufficient for patient numbers.
  - *Nsinze HCIV Theatre Equipment:* Challenges included poor lighting, poor ventilation, and a non-functional suction machine.

NMS deliveries audit to HCIIIs and HCIIs for FY22/23:

| Health Facility | Total Budget (UGX) | Delivered (UGX) | Shortfall (UGX) | % Shortfall |
|---|---|---|---|---|
| Nabisoigi HCIII | 28,909,860 | 24,436,883 | 4,472,977 | 15% |
| Namutumba HCIII | 28,909,860 | 24,036,839 | 4,873,021 | 17% |
| Ivukula HCIII | Not captured | — | — | — |
| Kagulu HCII | 28,909,860 | 24,436,783 | 4,473,077 | 15% |
| Nangonde HCII | Not captured | — | — | — |
| Bulange HCIII | 28,909,860 | 24,436,883 | 4,472,977 | 15% |
| TOTAL | 115,639,440 | 97,347,388 | 18,292,052 | 15.5% |

**Aide Memoire**

- A remedial workplan was developed during the district feedback/dissemination meeting, which was used to create the Aide Memoire. This will facilitate future follow-up on the implementation of agreed-upon interventions.

## PUBLIC ENGAGEMENT AND DISSEMINATION

- **District Dissemination:** The HMU conducted a district feedback/dissemination meeting involving political and technical leaders and the District Health Team (DHT).
- **Community Dialogue (Baraza):** The HMU conducted a community dialogue on 30th January 2024 within Namutumba town council. This allowed community members to provide feedback to district and health facility leaders regarding the health services they receive.

## HMU INTERVENTIONS

- The HMU conducted capacity building for health workers and medicines management personnel on proper documentation and medicines accountability.
- The police opened case files against the errant officers (Kyaterakera Paul and Wamwendeire Florence). These cases are currently with the Director of Public Prosecutions (DPP) for guidance.

## RECOMMENDATIONS

- **Leadership and Governance**
    - The district internal auditor should conduct financial audits into the utilization of PHC funds for the first two quarters of the financial year.

- **Human Resources:**
    - The CAO to reward Ms. Aliganyira Prossy and other diligent and committed staff for their good example.
    - The CAO to sanction all errant health workers according to Public Service Standing Orders, including Mr. Balikowa Robert, Mr. Kyaterekera Paul, Ms. Wamwendeire Florence, and all habitually absentee staff.
    - Mr. Balikowa Robert should explain in writing why he did not hand over the office; if his study leave was unsanctioned, he should be struck off the payroll and face other administrative sanctions. He must hand over the Magada HCIII office and bank account immediately.
    - Mr. Kyaterekera Paul should be subjected to the sanctions committee as per the Public Service Standing Orders.
    - All absentee staff (including specifically those absent from Ivukula HCIII on 25/01/2024, except the three noted as present) must explain in writing to the CAO why punitive measures should not be taken against them.
    - Porters should report to work daily and clean the health facilities.
- **Infrastructure and Equipment:**
    - The DHO to ensure all faulty autoclaves and sterilizers are repaired immediately in all health facilities. Where electric autoclaves are unusable due to power issues (like Nsinze) or unavailability, alternatives like gas-operated or charcoal stoves should be considered (e.g., Kagulu HCIII).

    - The Ministry of Health (MoH) / Namutumba District Local Government (DLG) to construct an OPD block at Kagulu HCIII.
    - The MoH / Namutumba DLG to construct general wards at Ivukula and Nabisoigi HCIIIs.
    - HCIIIs should be provided with general stores to prevent the conversion of wards into storage space.
    - The DHO to relocate the district vaccine store from the ward of Namutumba HCIII to free up space for inpatient services.
    - At Bulange HCIII, leadership should utilize Public Procurement and Disposal of Public Assets (PPDA) processes to dispose of construction materials stored in the former maternity ward, freeing the space for use as a general ward after minor repairs.
    - The practice of driving nails into walls (e.g., Kagulu ward) must stop immediately to prevent damage to buildings.

### Recommendations — Namutumba

- Implement stricter absenteeism enforcement; establish functional Rewards and Sanctions mechanisms.
- Conduct comprehensive financial audit for all facilities.
- MOH to expedite implementation of EMR and ELMIS.
- NMS to improve delivery schedules and communicate proactively on delays.

## 4.2.6 Namayingo District

**Nine (9) Health Facilities Visited: HCIV:** Buyinja, **HCIIIs**: Banda, Bumooli, Isinde, Shanyonga, Mutumba, Sigulu, Buganga, Lolwe

**FINDINGS**

## Leadership and Governance

The assessment highlighted significant challenges in leadership and governance within the Namayingo district health sector. A notable leadership vacuum exists due to the District Health Officer (DHO) being largely indisposed due to illness. Consequently, overall leadership and stewardship have fallen to an Assistant District Health Officer who reportedly operates under the influence of political leadership.

This situation has led to political interference in health service delivery. The LC5 chairperson has been implicated in politicizing services, making public statements such as, "I know the trouble I go through to get the vote," suggesting political considerations influence resource allocation or management. Efforts to enforce accountability have reportedly met with negative sentiment, allegedly stirred up by the LC5 chairperson who mobilized health workers to strike against Health Monitoring Unit (HMU) interventions, using baseless allegations to attract media attention. The strike was subsequently quelled. Furthermore, nepotism in job allocation was identified, with reports indicating that a number of positions have gone to relatives of the LC5 chairperson.

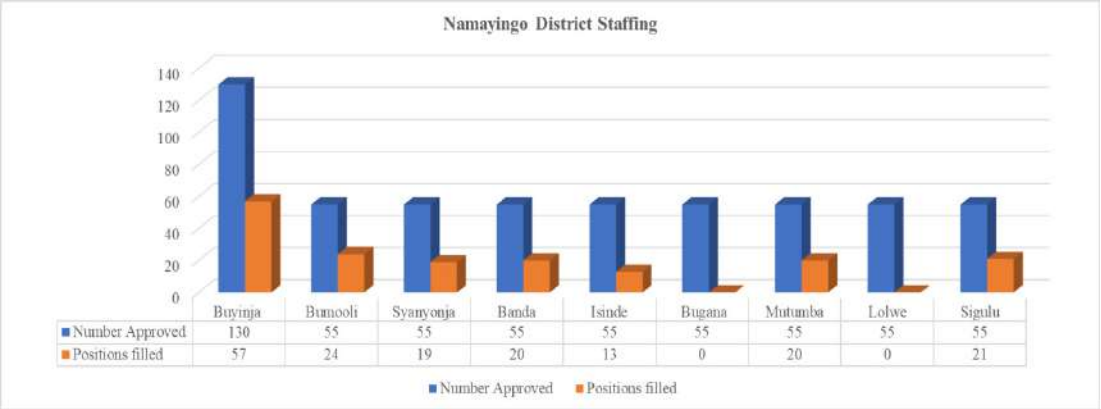
Financial administration issues were also noted across visited health facilities:

- There was no evidence of qualitative supervision or detailed reports from health sub-district in-charges, despite receiving funds (from RBF) for this purpose.
- A lack of prioritization was observed in budgeting and resource utilization, with most funds reportedly spent on airtime and coordination allowances.
- Accountabilities appeared questionable or forged, lacking evidence of corresponding activities on the ground.
- Primary Health Care (PHC) funds were not displayed on notice boards as required.

## Human Resources for Health

Human resources are critical for health service delivery, and the assessment revealed several systemic challenges in Namayingo district.

- **Staffing Levels:** There is a significant disparity between approved and filled positions based on the new structure. Only 213 out of 570 approved positions are filled, representing a staffing level of 37.4%. (Based on the old structure, the staffing level was 85%). The district has two doctors at Buyinja HCIV, the highest level of care, but one is currently on study leave. There is also a noted imbalance in staffing composition, with more askaris and porters than technical staff.




- **Absenteeism:** Widespread absenteeism among health workers, particularly in-charges and critical cadres like Records Officers and maternity in-charges, remains a major issue despite salary enhancements. Salary enhancement has not improved the availability or attitude disorientation of health workers.
    - An audit of attendance records over two months showed high absenteeism among in-charges. The best performer was the in-charge of Lolwe HCIII (attended 56 days), while the worst was the in-charge of Sigulu HCIII (attended 10 days).
    - Many in-charges reportedly have private clinics in Busia and Iganga.
    - Organized absenteeism occurs through duty rotas, for example, at Buyinja HCIV's IPD, where only two out of eight staff work on any given day (one per shift).
    - The district cold chain technician closed the store and has been away for a long period.
- **Salaries and Compensation:**
    - Salary payments are frequently delayed, often paid every two months, reportedly due to strain on the wage bill from a bloated payroll.
    - There is a lack of functional Rewards and Sanctions mechanisms for staff performance. No individuals were reported as being sent to the Rewards & Sanctions committee.
- **Staff Welfare and Conduct:**
    - Some staff lack uniforms, though a good number were found wearing them.
    - Concerns exist regarding the vetting of qualifications by the District Service Commission, with reports of unqualified staff being employed.
- **Payroll Integrity:** No ghost facilities were identified on the payroll.
- **Staff Morale:** Despite challenges, staff expressed visible excitement and optimism regarding the proposed new functional structure, particularly pharmacy technicians.

## Essential Medicines and Health Supplies (EMHS)

Essential medicines and health supplies (EMHS) are vital government assets procured with public funds. Health workers involved in their management are legally accountable and can face charges like theft, forgery, or illegal possession of government stores if they fail to account for these assets.

- **Funding System:** Since FY 2009/10, EMHS financing operates under a centralized credit line system, Vote 116, managed by the National Medical Store (NMS). Annually, the Government of Uganda allocates UGX 257,170,896 for Namayingo district. Specific allocations are:
    - HCIV: UGX 115,800,000 per FY
    - HCIIIs: UGX 28,904,238 per FY each
    - HCIIs: UGX 6,438,486 per FY each
- **Medicine Audit:** A comprehensive one-year audit of selected items (sundries like PGA, Nylon; surgical gloves; HIV tests; gauze; mama kits; Artesunate) was conducted due to public concerns about availability. The audit aimed to quantify losses, investigate government losses, and provide mentorship on medicine management.
- **Key Management Issues:**

- Accountability documents (Issue & Requisition vouchers) were often unauthorized or authorized significantly late.
- Improper storage practices were noted, e.g., the Maternity In-charge at Bumooli HCIII reportedly stored the mama kit stock card and kits at her home, supplying herself. No mama kit dispensing log was found there.
- Accountability at the department level is weak, with dispensing logs often not utilized. No department provided accountability for consumables like Gloves and Gauze.
- The store management at Isinde HCIII was particularly disorganized. Only Buyinja HCIV had a substantive Store Manager (who also serves as the district stores manager); in other facilities, Records Assistants often doubled as store managers, indicating improvised positions.
- Mothers complained about receiving incomplete mama kits. (Mama kits contain plastic sheeting, razor blades, cotton wool/gauze, soap, gloves, cord ties, child health card, and instructions, sealed for sterility).

- **Audit Findings (Quantified Losses):** Significant discrepancies were found between recorded stock and actual consumption/remaining stock, indicating poor management and potential loss. Lack of proper records was identified as a major driver of these variances.
  - **Bumooli HCIII:**
    - Medicine Store: Unaccounted mama kits worth UGX 379,470. Artesunate and Surgical Glove accountability was satisfactory.
    - Maternity Department: Over 150 mama kits (value UGX 3,794,700) could not be accounted for.
  - **Banda HCIII:**
    - Medicine Store: Failed to account for 41 mama kits (value UGX 1,036,398).
    - Maternity Department: Could not account for 440 issued mama kits (value UGX 11,122,320).
  - **Isinde HCIII:**
    - OPD: Failed to account for 600 vials of Artesunate Injection (value UGX 746,000).
    - Maternity Department: Could not account for mama kits worth UGX 11,147,598.
  - **Sigulu HCIII:**
    - Medicine Store: Could not account for mama kits worth UGX 12,386,220 and Artesunate worth UGX 2,009,000.
  - **Shanyonga HCIII & Mutumba HCIII:** No glaring gaps were noted in the medicine stores.

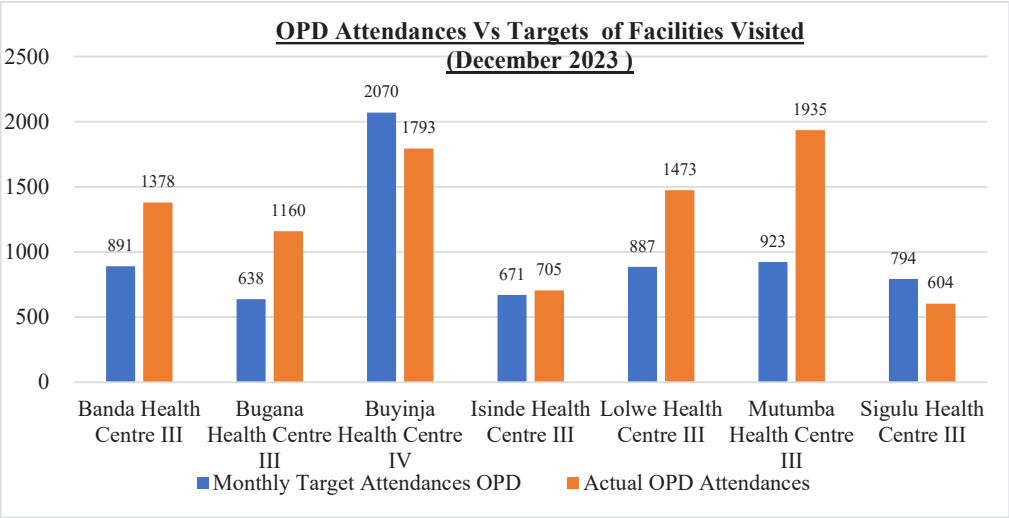
- **Expired Medicines:** An audit of the expired drugs store revealed shocking anomalies. The total value of expired commodities collected from facilities in the District Store was around UGX 300,000,000, primarily consisting of ARVs and family planning commodities. Attributed causes include:
  - Breakdown in inter-facility transfer of medicine.
  - Poor performance/low utilization in some health units.
  - Changes in HIV and TB treatment regimens.
  - Push of short-dated stock by the central store (NMS).

## Health Service Delivery

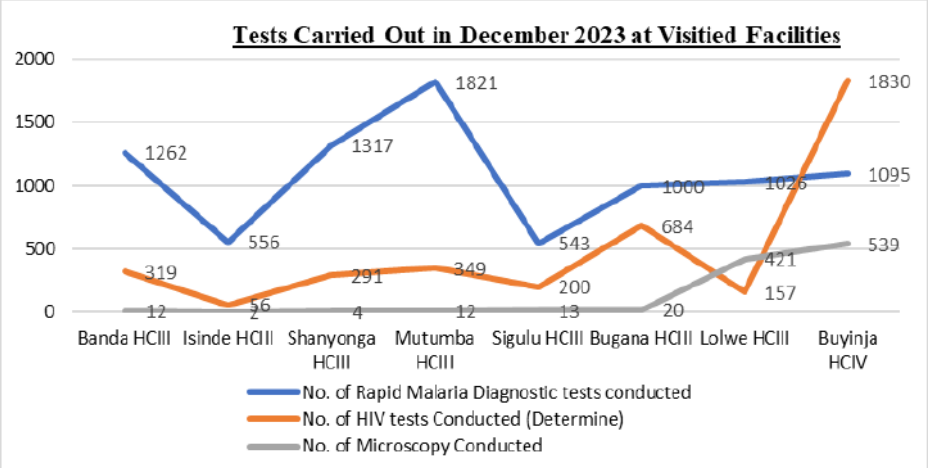
The assessment considered the management and delivery of health services across various facilities in Namayingo district.

- **Out-Patient Department (OPD):**
  - All visited facilities had functional OPDs, with most registering over 1,000 cases in the previous month. Buyinja HCIV had the highest OPD volume.
  - Five facilities (Mutumba, Bugana, Lolwe, Banda, Isinde HCIIIs) exceeded their monthly OPD attendance targets, with performance ranging from 105% (Isinde) to 210% (Mutumba).

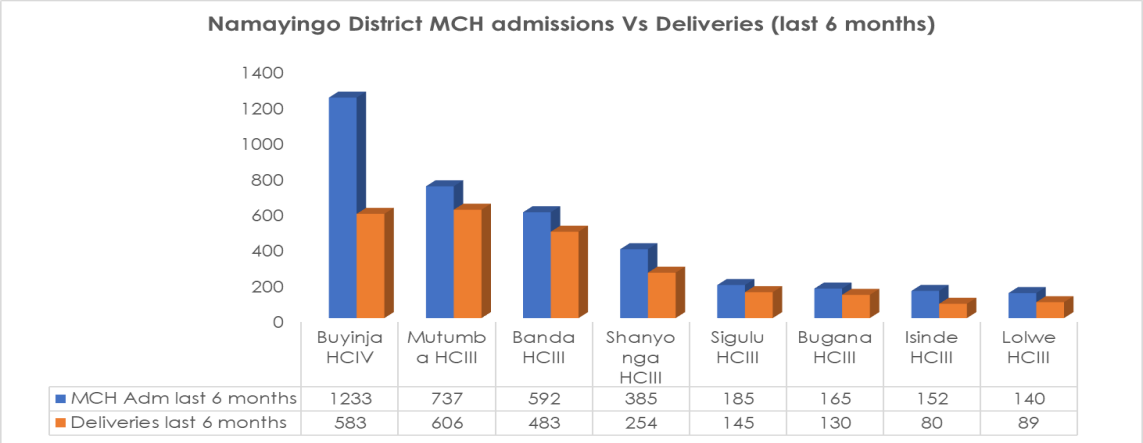
- Two facilities (Buyinja HCIV at 87% and Sigulu HCIII at 76%) failed to meet their targets, likely due to high absenteeism affecting public confidence. Complaints of staff absenteeism were noted specifically at Buyinja and Lolwe, facilities with high patient volumes.

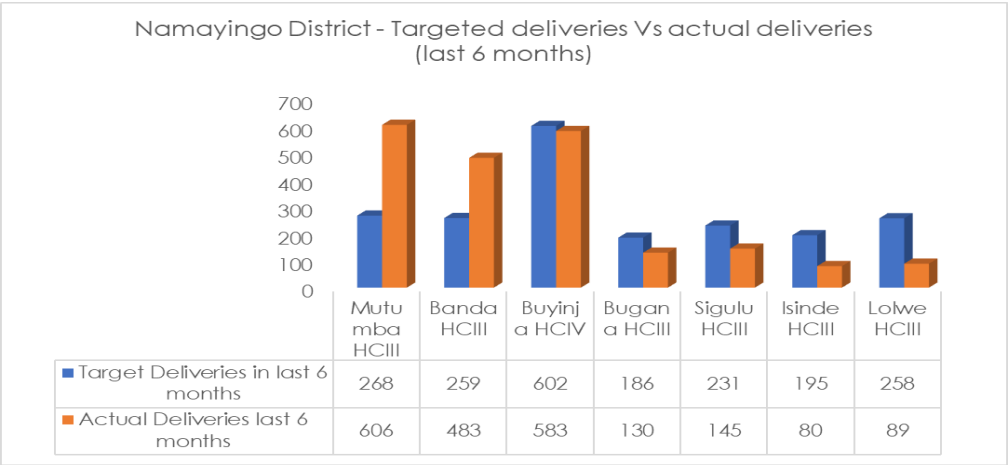



- **Laboratory Services:**
  - All facilities had functional laboratories, although some faced space constraints.
  - Buyinja HCIV had the best-equipped laboratory in terms of infrastructure and equipment.
  - A concern noted was the diminished use of microscopes, potentially leading to a loss of competence among lab technicians.
  - A case of stolen Rapid Diagnostic Tests (RDTs) at Lolwe HCIV highlighted inventory management weaknesses.

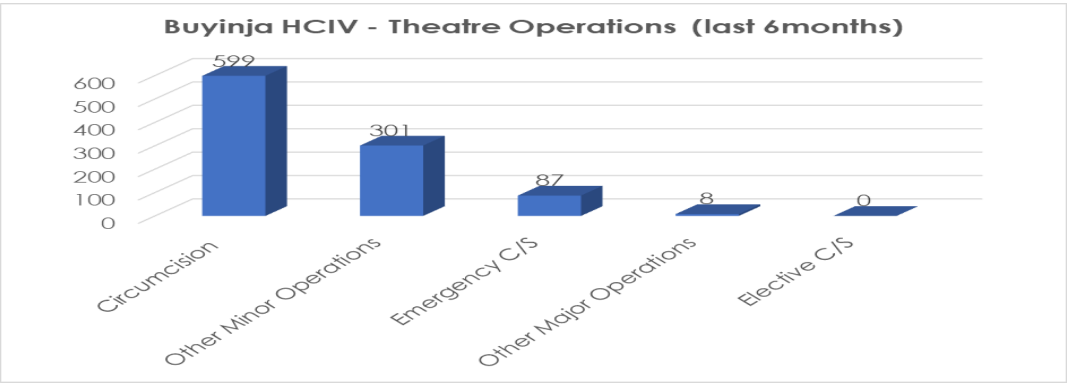



- **Maternity and Antenatal Care (ANC) Services:**
  - All visited facilities provided ANC services. Isinde HCIII had the highest ANC first Trimester attendances (240), while Sigulu HCIII had the least (28).
  - Delivery volumes varied: Mutumba HCIII had the highest number over 6 months (606), followed by Buyinja HCIV (583) and Banda HCIII (483). Isinde HCIII had the least (80).
  - Maternity services were notably impressive at Mutumba and Banda HCIIIs due to new maternity units constructed with UGIFT support. These two facilities exceeded their delivery targets (Mutumba 226%, Banda 186%).
  - Other facilities did not meet delivery targets (Buyinja 97%, Sigulu 63%, Isinde 41%, Lolwe 34%).

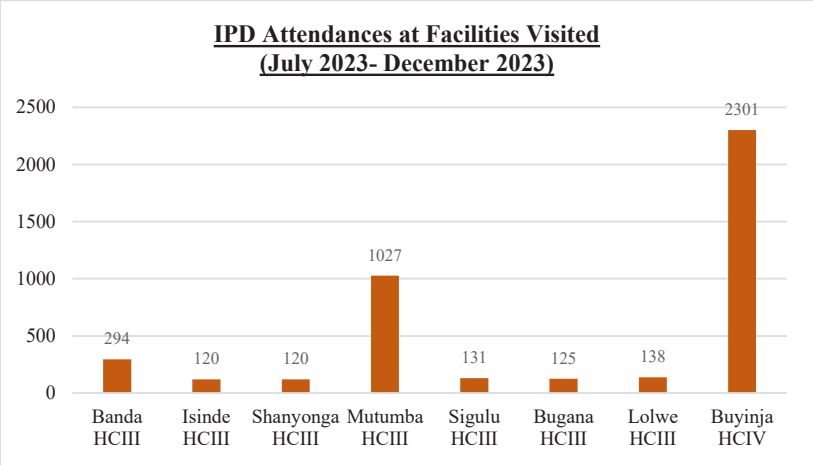



- **Theatre Services (Buyinja HCIV):**
  - The theatre at Buyinja HCIV is fully equipped with an anaesthetic officer and two doctors (though one is on study leave).
  - However, it is significantly underutilized for its primary purpose of Emergency Obstetric Care (EMOC). Over the last six months, out of 995 total operations:
    - Circumcision accounted for 60% (599 cases).
    - Other minor operations: 30% (301 cases).
    - Emergency Caesarean sections: 9% (94 cases).
    - Other major operations: 1% (1 case).
    - No Elective caesarean sections were conducted.
  - Allegations of extortion at the theatre require investigation. Complaints regarding the sale of blood were also reported.



- **In-Patient Department (IPD):**
  - Buyinja HCIV had the highest IPD admissions over the last six months (2,301), followed by Mutumba (1027) and Banda (294) HCIIIs. Isinde and Shanyonga HCIIIs had the lowest (120 each).




- **Referral System and Access:**
  - The referral system is functioning better than during HMU's last visit in 2016.
  - Access to healthcare on the islands (Lolwe, Sigulu) has significantly improved due to the presence of a water ambulance for expectant mothers and a ferry service at Lolwe, facilitating easier referrals.

## Infrastructure and Equipment Management

- **Key Infrastructure Developments:**
  - New structures were noted at Lolwe HCIII.
  - A modern ferry service has greatly improved referrals from island facilities (Sigulu HCIII, Lolwe HCIII), a significant improvement since 2016 when canoes were used.
  - Construction of a theatre is ongoing at Sigulu HCIII, which will enable surgeries at the HCIII level on the island.
  - The Uganda Government Inter-governmental Fiscal Transfers Program (UGIFT) has been instrumental, funding the construction of new maternity units, especially at Banda HCIII and Mutumba HCIII where delivery rates are high.

| | |
|---|---|
|  |  |
| Poor Waste Management at Buyinja HCIV | Poor disposal of obsolete equipment at Sigulu HCIII |

- **Facility Management:**
  - All facilities possess land titles, which is commendable.
  - Fencing is present in all facilities, also a positive finding.
  - However, compounds in all facilities were unkempt, despite having a high number of porters. (It was reported that becoming a porter is considered the easiest entry into district service).
  - Gardens on facility land were a common feature.
- **Equipment Issues:**
  - The Chemistry machine at Buyinja HCIV is not functional.
- **Procurement:** Reports of widespread flouting of procurement procedures are under investigation by HMU.
- **Waste Management and Infection Control:**
  - Color-coded waste bins and sharps containers were present across facilities.
  - Functional hand-washing facilities were noted in some facilities.
  - Rudimentary placenta pits were observed in some locations.
  - Sterilizers, protective gear (like aprons) were available in almost all facilities.
  - JIK (bleach) was used for surface disinfection in some facilities.
  - However, cases of poor infection control and waste management were noted, particularly highlighted at Buyinja HCIV.

| | | | | |
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| Well kempt compound at Bumooli HCIII after HMU intervention | Poor disposal of obsolete equipment at Sigulu HCIII | HMU travel to the islands in 2016 vs 2024 | HMU intervention at Buyinja HCIV | Gardens on facility land |

**Public Engagement and Dissemination**

HMU conducted a District Dissemination meeting at the Council Hall, attended by key stakeholders including the LC5 Chairman, RDC, DHO, DPC, OC-CID, DHT members, District Councilors, facility in-charges (general, maternity, stores), and the press.

- **Topics Covered:**
  - Establishment and mandate of HMU.
  - Corruption and lack of accountability for government assets (including medicines).
  - Flouting procurement procedures for potential embezzlement.
  - Lack of strong leadership and stewardship in the health sector.
  - Medical-legal issues in service delivery.
  - Submission of fictitious fuel accountabilities.
  - Attitude disorientation among selected health workers.
  - Organized absenteeism.
  - HMU interventions and arrests within the district.

    - Recognition of best-performing health workers.
    - Medicine mismanagement and expiries.
    - Salary enhancement for health workers.
    - Performance of maternity services.
- **Reactions from the Audience:**
    - Requests for HMU to release all suspects.
    - Suggestion for special sections for health workers in prisons.
    - Complaints about late drug supplies from NMS.
    - Acknowledgement that medicine accountability is weak.
    - Acknowledgement that service delivery has improved since HMU's last visit.
    - Appreciation for the government's provision of the ferry, improving referrals.
- **Follow-up:** HMU, along with the RDC, addressed questions and offered to escalate structural issues to the Ministry of Health. The district was advised to follow up with HMU.
- **Community Engagement Strategy:** HMU emphasizes improving citizen ownership of health services as part of its strategic direction to transform the health sector.

**HMU INTERVENTIONS**

Based on the findings, HMU undertook or noted the following interventions:

- Initiated investigations into reports of widespread flouting of procurement procedures.
- Discussed HMU interventions and related arrests during the District Dissemination meeting.
- Held an on-site meeting with NMS officials regarding erratic delivery schedules (attributed to funding shortages). NMS stated issues were resolved and backlogs would be supplied.
- The DHO wrote to NMS requesting the collection of expired commodities (valued at ~UGX 300 million) for destruction (compliance pending).
- Reminded NMS to stop pushing short-dated stock to lower health units.
- Planned to investigate specific suspects identified in the theft/loss of EMHS.

**RECOMMENDATIONS**

Based on the assessment findings, the following recommendations were made:

- **Leadership and Governance:**
    - Address the leadership vacuum and political interference in the health sector.
    - Strengthen supervision mechanisms and ensure accountability for funds allocated for supervision (e.g., RBF).
    - Improve budget prioritization and enforce transparent financial accountability, including the display of PHC fund utilization.
- **Human Resources for Health:**
    - Address widespread absenteeism through stricter enforcement mechanisms and/or incentives for attendance.
    - Establish and utilize functional Rewards and Sanctions mechanisms.
    - The District Service Commission should rigorously vet qualifications during recruitment.
    - Expedite the implementation of the new functional structure, including recruiting pharmacy technicians as planned.
- **Health Service Delivery:**
    - Investigate and address allegations of extortion at the Buyinja HCIV theatre and complaints of blood sales.
    - Improve the utilization of the Buyinja HCIV theatre for its primary purpose (EMOC).
    - Strengthen inventory management systems, particularly for diagnostic tests (like RDTs), to prevent theft and stockouts.
- **Essential Medicines and Health Supplies (EMHS):**
    - Hold responsible officers in departments accountable for missing drugs and supplies identified during audits.

- Implement strict use of stock cards and dispensing logs in all user departments, ensuring they are updated regularly.
- Institute mandatory physical stock counts at the end of every calendar month.
- Utilize an expired drugs register and strictly adhere to FIFO (First-In, First-Out) and FEFO (First-Expiry, First-Out) principles to minimize expiries.
- NMS should cease supplying health facilities with medicines that have a short shelf life.
- NMS should adhere to delivery schedules and stop deliveries after 7 pm.
- Implement a policy regarding the inter-facility transfer of medicines to manage stock levels effectively.
- Ensure discrepancy forms are filled out immediately upon arrival of supplies if issues are noted.
- Consider the embossment of sundries to deter leakage.
- The government should prioritize adequate and timely funding for EMHS (Vote 116) to prevent stockouts.
- HMU should continue investigations into suspected theft of EMHS.
- The Ministry of Health (MOH) should expedite the implementation of electronic logistics management information systems (ELMIS) and Electronic Medical Records (EMR) in health facilities.
- Review the planning processes for HIV/TB medicines to reduce and prevent expiries.

### 4.2.7 Pader District

Thirteen health facilities visited: HCIV (Pajule) and 12 HCIIIs (Latanya, Pader, Lapul, Lapulocwida, Atanga, Laguti, Acholi Bur, Puranga, Ogonyo, Awere, Kilak, Angangura, and Ogom).

#### Key Findings

- The substantive DHO position has been vacant for over 10 years (since 2013). The Acting DHO has not completed internship and is not registered to practice medicine.
- District-wide staffing at 32% using new staffing guidelines; HCIIIs at 27% midwife staffing (32/117 positions filled).
- Only 4 of 13 facility in-charges were present during the monitoring visit.
- Medicines worth UGX 14,751,000 unaccounted for at Pajule HCIV (Aug 2023–Feb 2024): ACTs, Ceftriaxone, Determine kits, and Mama Kits.
- Pajule HCIV conducted only 68 caesarean sections in six months from 2,738 deliveries (2.48%) — far below the 20–25% target.
- No NICU in the entire district; no facility utilized eHMIS or ELMIS.
- UGX 7.5M allocated to Lapul HCIII mismanaged; UGX 6.5M recovered following HMU intervention and arrests.

## Leadership and Governance

- **District Health Team (DHT) Staffing:** Only four out of eight technical team members are substantively appointed. Key vacant positions include the DHO, Assistant District Health Officer-Environmental Health (ADHO-EH), and Biostatistician.
- **Acting DHO Status:** The Acting DHO had not completed the required medical internship and is not registered to practice as a Medical Doctor, raising concerns about qualifications for the role. This situation persists despite the presence of qualified medical officers at Pajule HCIV who could potentially act in this capacity. The substantive DHO position has been vacant for over ten years, since 2013.
- **Support Supervision:** While supervisor reports were available at all facilities, there was no evidence of support supervision visits from the Acting DHO or the Assistant DHO (MCH/Nursing) to Health Centre IIIs (HCIIIs). Records of visits from the Chief Administrative

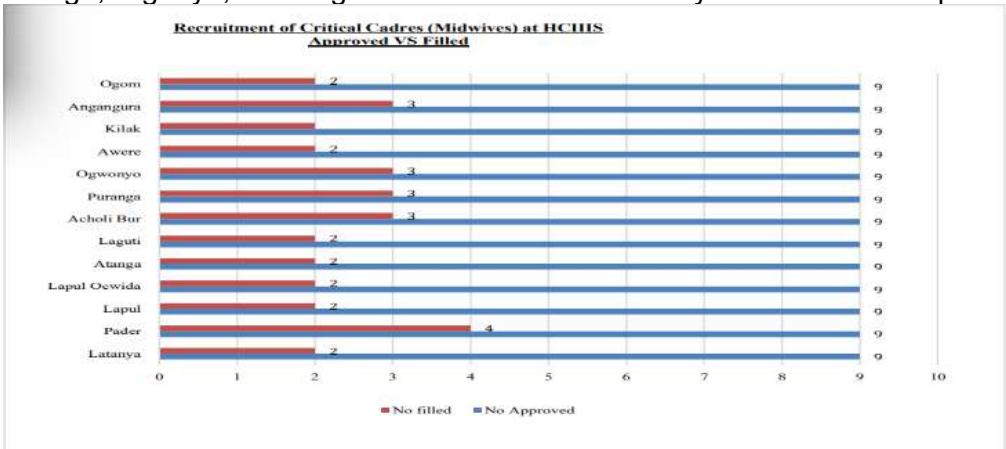
Officer (CAO) or Resident District Commissioner (RDC) were also absent at HCIIIs, with only single visits noted for each at Pajule Health Centre IV (HCIV).

- **Continuing Professional Development:** No facility had conducted a general staff Continuing Professional Development (CPD) session on the Client Charter in the past six months, although Continuing Medical Education (CMEs) were conducted.

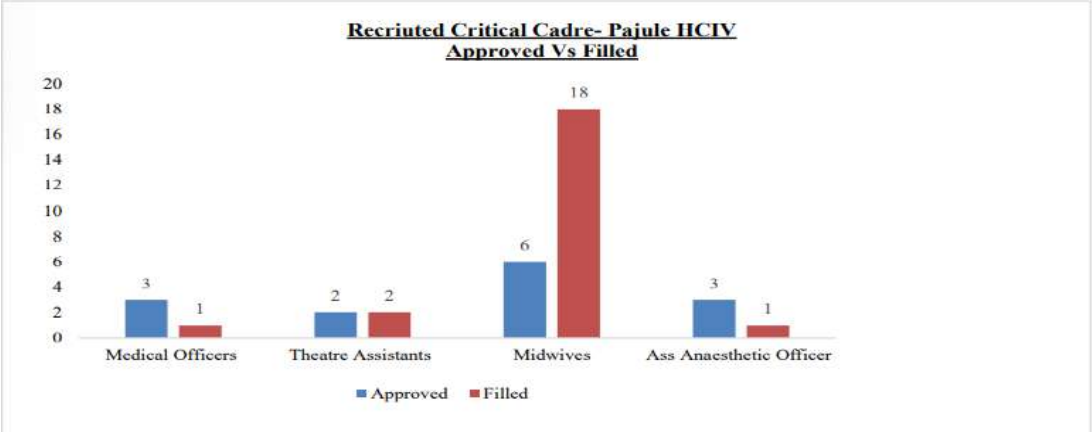
## Human Resources for Health

- **Overall Staffing Levels:** District-wide staffing across government Health Centres (HCIV, HCIIIs, and HCIIs) stands at 32% based on the new staffing guidelines. This low level is partly attributed to a recruitment ban by the Ministry of Public Service.
  - Pajule HCIV: 34% (44/130).
  - Pader HCIII: Highest among HCIIIs at 36% (20/55).
  - Ogonyo HCIII & Lapulocwida HCIII: Lowest among HCIIIs at 22% (12/55).
  - Bolo HCII: Highest among HCIIs at 75% (6/8).

- **Recruitment of Critical Cadres (Midwives) at HCIIIs:** HCIIIs collectively have 32 midwives out of an approved 117 (27%) under the new staffing guideline. Latanya, Lapulocwida, Atanga, Ogonyo, and Ogom HCIIIs each have only 2 out of the required 9 midwives.




- **Recruitment of Critical Cadres at Pajule HCIV:**
  - Medical Officers: 2 out of 3 approved positions filled.
  - Theater Assistants: 2 out of 2 approved positions filled.
  - Midwives: 6 out of 18 approved positions filled.
  - Assistant Anesthetic Officers: 1 out of 3 approved positions filled.



- **Staff Attendance and Professionalism:**
  - High absenteeism, late coming, and poor attitudes towards work were noted. Unsanctioned study leave contributes to absenteeism.
  - Only 4 out of 13 facility in-charges were present during the monitoring visit. Only in-charges at Awere, Laguti, Acholi Bur, and Lapul HCIIIs met the attendance guidelines. Most in-charges do not clerk patients and spend limited time at facilities.
  - Uniform adherence varied: All staff were in uniform at Awere and Lapul HCIIIs, but no staff were in full uniform at Pajule HCIV, where a student nurse manned the maternity wing. Most midwives across facilities were in full uniform.

**Table 3 In charge Total Number of days Present Vs Guideline**

| S/N | Health Facility | Presence of In-charge | Reason for Incharge Absence | Total Number of days facility's in-charge has been present in the past 2 months (*from attendance book*): | Gov't Guidelines (2months) |
|---|---|---|---|---|---|
| 1 | Pajule HCIV | No | sick | 12 | 30 |
| 2 | Latanya HCIII | No | Leave | 0 | 30 |
| 3 | Pader HCIII | No | Circumscission in Puranga | 28 | 30 |
| 4 | Lapul HCIII | Yes | | 38 | 30 |
| 5 | Lapul Ocwida HCIII | Yes | | 29 | 30 |
| 6 | Atanga HCIII | Yes | | 25 | 30 |
| 7 | Laguti HCIII | No | TB Data review | 32 | 30 |
| 8 | AcholiBur HCIII | No | Private engagements | 35 | 30 |
| 9 | Puranga HCIII | No | District TB meetig | 21 | 30 |
| 10 | Ogonyo HCIII | No | PMCT SUPERVISOR | 22 | 30 |
| 11 | Awere HCIII | Yes | N/A | 34 | 30 |
| 12 | Kilak HCIII | No | Sick | 29 | 30 |
| 13 | Ogom HCIII | No | Annual Leave | 0 | 30 |

- **Staff Housing:** Staff accommodation is generally inadequate across the district.
  - Pajule HCIV has only 2 units, accommodating 1 Medical Doctor.
  - HCIIIs have varying numbers of units, often shared, with families occupying single rooms.
  - Staff accommodation at Angagura HCIII was dilapidated and unsafe.

*Angangura HCIII- dilapidated staff accommodation*

## Essential Medicines and Health Supplies (EMHS)

- **Supply Chain Issues:** The last delivery from National Medical Stores (NMS) was in October 2023, leading to stockouts of fast-moving commodities in most facilities. The average stockout duration was 30 days.
- **Stock Management and Accountability:**
  - Discrepancies between stock card balances and physical counts were found, particularly at Pajule HCIV, where medicines worth UGX 14,751,000 were unaccounted for between August 2023 and February 2024. This included issues with

ACTs, Ceftriaxone, Determine test kits, and Mama Kits. Subsequent investigation clarified some discrepancies, but poor documentation remained an issue.
    - Significant variances were noted between quantities issued from stores and consumed at departments, especially for Artesunate (1,445 units variance) and Ceftriaxone (1,068 units variance) at Pajule HCIV IPD, and Ceftriaxone at Pader HCIII (588 units variance at IPD, 480 at Maternity).
    - Poor storage practices were observed, including lack of temperature monitoring in most facilities (except Pader and Awere HCIIIs).
    - Lack of inventory for expired medicines and poor documentation for managing expiries were common.
    - Evidence of potential pilferage of testing kits (MRDT, Determine) through outreach programs was suggested due to poor accountability.
    - Forgeries on stock cards were noted at Kilak HCIII.
- **Stockouts:** Specific stockouts included:
    - Pader HCIII: Ceftriaxone (two months), Artesunate (three months), Determine (three months).
    - Angagura HCIII: ACT (34 days), Artesunate (30 days), Ceftriaxone (180 days).
    - Pajule HCIV: MRDT (8 days due to poor management/possible theft).
- **HMIS Tools:** No facility was using electronic health management information systems (eHMIS) or electronic logistics management information systems (ELMIS).

## Health Service Delivery

- **Overall Facility Performance:**
    - Best performing HCIIIs: Awere, Acholibur, and Lapul, attributed to strong leadership and staff presence.
    - Worst performing HCIIIs: Ogom, Latanya, and Atanga HCIIIs.
- **Out-Patient Department (OPD) Attendances:**
    - OPD attendance targets (Aug 2023 - Jan 2024) were often missed, ranging from 64% (Ogonyo HCIII) to 88% (Awere HCIII) of targets.
    - Awere HCIII (88%) achieved high performance due to strong leadership and staff presence. Acholibur HCIII (81%) also performed well.
    - Pajule HCIV (81%) and Lapulocwida HCIII (76%) had moderate attendance.
    - Several facilities including Puranga, Pader, Angagura, Kilak, and Laguti HCIIIs (73-75%) struggled to meet targets.
    - Latanya HCIII (71%), Ogom HCIII (70%), and Ogonyo HCIII (64%) showed severe service delivery issues.
    - Medicine stockouts were the most common reason cited for under-performance. Staff absence and leadership issues at Pajule HCIV were also noted.
- **In-Patient Department (IPD):**
    - All facilities except Latanya, Ogom, and Lapulocwida HCIIIs had functional IPDs.
    - However, no patients were admitted at Pader, Angagura, Ogonyo, Atanga, and Laguti HCIIIs during the visit, despite having functional IPDs.
    - IPD wards at Pajule HCIV, Pader HCIII, and Atanga HCIII were in poor condition (broken louvers, leaking ceilings). Ogonyo HCIII ward was very dirty.
- **Maternal and Child Health (MCH):**
    - All visited facilities provided Antenatal Care (ANC) and maternal delivery services.
    - Pajule HCIV is the only facility offering Comprehensive Emergency Obstetric Care (CEMOC), including caesarean sections.
    - Total Figures: 3,808 first ANC visits, 4,303 maternity admissions, 2,738 deliveries (63.6% of admissions).
    - Maternity admissions varied, often due to complications like malaria, anemia, and pre-eclampsia leading to early admissions or referrals.
    - Referrals were common to Pajule HCIV, Kitgum General Hospital, Dr. Ambrosoli Memorial Hospital, and Gulu Regional Referral Hospital.
    - Crowded maternity spaces were noted in Lapulocwida HCIII, Angagura HCIII, and Pajule HCIV.

- No maternal deaths were recorded during the review period. Two perinatal deaths (due to birth asphyxia) were audited at Pajule HCIV.

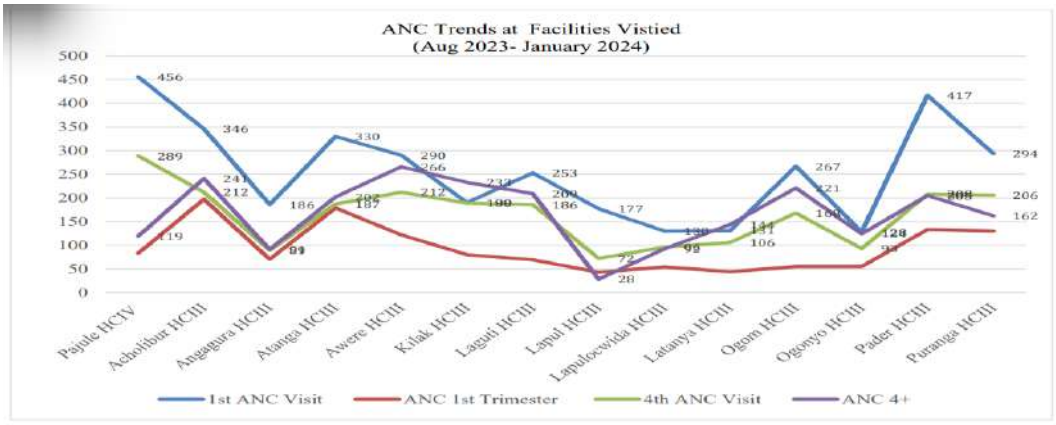



**Figure 3 ANC Trends at the Visited Health Facilities**

- **Surgical and Theatre Services:**
  - Pajule HCIV is the only facility performing major surgeries. It has an excellent, well-equipped theatre. Equipment includes functional delivery sets, suction machines, oxygen concentrators, and anesthetic machines. General and spinal anesthesia are provided.
  - Low Surgical Output at Pajule HCIV:
    - Only 68 caesarean sections were conducted in a six-month period out of 2,738 deliveries (2.48%), significantly below the 20-25% target rate. Individual doctor performance varied.
    - Only 10 major non-Caesarean surgeries were performed in one year, despite having four qualified Medical Officers with a well established theatre.
- **Laboratory and Diagnostic Services:**
  - Pajule HCIV has an excellent laboratory serving as the district hub, with dedicated staff and real-time result delivery.
  - All visited facilities had functional labs. Pajule, Awere, Atanga, and Pader HCIIIs excelled in space, organization, and staff competence.
  - Challenges:
    - Angagura HCIII: Lacked adequate space, running water, key test reagents (antimalarials, Determine), and Gene Xpert TB testing was not done.
    - Ogonyo, Atanga, Ogom, and Pader HCIIIs: Lacked essential diagnostic equipment (Gene Xpert for TB, CBC machine, Haemoglobin estimation).
  - Blood Transfusion: Only available at Pajule HCIV, with high demand during malaria peak seasons. Blood is sourced from Kitgum General Hospital and Gulu Regional Blood Bank.
- **Neonatal Intensive Care Unit (NICU):** There is no NICU in the district. Pajule HCIV should establish one.

## Infrastructure and Equipment Management

- **General Condition:**
  - Infrastructure challenges hindered operations, such as Latanya HCIII's collapsed OPD roof (operating in temporary space) and Lapulocwida HCIII's limited space.
  - Compounds varied: Well-kept at Pajule HCIV, Pader HCIII, Lapul HCIII, Laguti HCIII, Acholi Bur HCIII, Puranga HCIII, Awere HCIII. Unkempt or bushy at Latanya HCIII, Atanga HCIII, Ogonyo HCIII, Kilak HCIII, Ogom HCIII, Angagura HCIII.
  - Fencing: Most facilities were fenced, but Pader HCIII, Lapulocwida HCIII, and Kilak HCIII were not.
  - Latrines were generally available.

- **Specific Facility Issues (from Aide Memoires & Findings):**
  - Pajule HCIV: Dilapidated inpatient wards, beds/mattresses in poor condition.
  - Pader HCIII: Theatre block dilapidated and used for storage, broken windows, lack of curtains, issues with water tank valve, no perimeter fence, no access road, land wrangle.
  - Atanga HCIII: Broken fence and windows, poor ventilation and condition of medicine store, rusted delivery bed, untiled floor and irregular water in maternity, crowded wards, obsolete equipment in wards.
  - Lapulocwida HCIII: Small space, incomplete maternity/staff blocks, lack of land title, lack of fence, electricity, staff toilets, cracked maternity floor, no running water in maternity.
  - Angagura HCIII: Old/rusted delivery bed, untiled maternity floor without running water, limited ANC/postnatal space, bushy/unswept compound, dilapidated/dirty staff quarters, damaged water tanks.
  - Kilak HCIII: No land title, unfenced, dilapidated ceiling, broken staff quarter door, inadequate/insecure lab space, lacking HB machine and running water in lab, rusty delivery bed, untiled labour suite.
  - Latanya HCIII: Operating OPD in temporary space due to collapsed roof.
- **Land Titles and Encroachment:**
  - Land titles confirmed for Pajule HCIV, Acholi Bur HCIII, Ogonyo HCIII, Kilak HCIII. Laguti HCIII has title but also encroachment.
  - No title/status unsure for Pader HCIII, Latanya HCIII, Lapul HCIII, Lapulocwida HCIII, Atanga HCIII (land dispute), Puranga HCIII, Awere HCIII, Ogom HCIII, Angagura HCIII.
- **Waste Management:**
  - All facilities used open burning within the facility premises.
  - All facilities had functional rubbish pits, bins, and placenta pits, generally in good condition.

**Aide Memoire:** Aide Memoires were developed for visited facilities (Pajule HCIV, Pader HCIII, Atanga HCIII, Lapulocwida HCIII, Angagura HCIII, Kilak HCIII) detailing identified issues and agreed actions with responsible persons and timelines.

**Public Engagement and Dissemination**

- **Radio Talk Show:** A talk show was conducted on Luo FM featuring the HMU Team Leader, RDC, and Acting DHO. Key concerns raised by callers included health worker absenteeism, limited facility operating hours, and medicine/supply stockouts since the October 2023 NMS delivery.
- **Community Dialogue (Baraza):** A planned community dialogue in Pader Town Council grounds did not occur due to low turnout and conflicting schedules. District leadership, except the DHO, were absent.
- **Dissemination Meeting:** A meeting was held at the District Health Boardroom on March 1st, 2024, to share findings.

## HMU Interventions

- **Addressing Absenteeism/Performance:**
  - Summoned Health Unit Management Chairpersons (Atanga HCIII, Pajule HCIV, Ogom HCIII) for joint monitoring to address absenteeism.
  - Directed the transfer of poorly performing In-charges, specifically recommending demotion for those at Atanga and Ogom HCIIIs. This was subsequently effected by the DHO.
  - Addressed specific instances like summoning a midwife at Ogom HCIII who had abandoned a mother in labour and directing cleaning at Ogonyo HCIII.

- **Addressing Leadership/Staffing Gaps:**
  - Summoned the CAO, PAS, Secretary District Service Commission, and PHRO to discuss the recruitment of a substantive DHO and essential cadres.
  - Raised the issue of the Acting DHO's lack of registration/internship and the need for him to complete it.
- **Financial Mismanagement Case (CID Action):**
  - Investigated the mismanagement of UGX 7.5 million allocated to Lapul HCIII by the former In-charge (Oola Paul), the Senior Assistant Secretary (Ociiti Francis), and the Accounts Assistant (Obalim Denis). Funds were disbursed without proper documentation for planned activities (power connection, grass planting, kitchen structure) that were not implemented. The former in-charge failed to hand over funds upon transfer.
  - Following intervention and arrests, UGX 6.5 million was refunded and deposited into the facility's account.
- **Medicines Management Interventions:**
  - Investigated stock discrepancies at Pajule HCIV, summoning the store manager and uncovering issues with unaccounted-for items and attempts to falsify records for test kits involving lab staff.
  - Summoned IPD and Maternity in-charges at Pader HCIII regarding drug accountability.
  - Instructed facilities with expired medicines to quantify them for NMS collection.
  - Provided temperature monitoring tools/guidance. Tasked facilities to segregate and quantify expired drugs.

## Specific Recommendations

- **Leadership, Governance & Monitoring:**
  - Induct the District Service Commission (DSC), District Health Team (DHT), and Health Unit Management Committees (HUMCs) on the service delivery monitoring framework and performance improvement.
  - DSC to recruit a substantive DHO, ADHO-EH, Biostatistician, and fill all key vacant DHT positions.
  - Empower the RDC's office to monitor service delivery more effectively.
- **Human Resources:**
  - Recruit more staff across all facilities to address the 68% staffing gap. Focus on critical cadres like midwives.
  - Ensure qualified doctors at Pajule HCIV and Pader HCIII currently employed as Clinical Officers are formally appointed as Medical Officers.
  - Relieve non-performing/poorly performing facility In-charges of their duties, allowing them to focus on clinical roles.
- **Service Delivery:**
  - Ensure HCIIIs provide 24-hour maternity services to reduce referrals.
  - Doctors at Pajule HCIV must provide consistent 24-hour emergency obstetric care, especially C-sections.
  - Optimize the use of the Pajule HCIV operating theatre for surgical operations, emergencies, and general HCIV-level services. Set and assess caseload targets for doctors.
  - Establish a Neonatal Intensive Care Unit (NICU) at Pajule HCIV.
- **Essential Medicines and Health Supplies:**
  - Recruit a district pharmacist.
  - Implement stricter controls and oversight for EMHS utilization, issuance, and receipt processes to prevent diversion.
  - Conduct regular monthly stocktaking in drug stores.
  - The DHO should coordinate the transfer and disposal of expired drugs.
  - All facilities should draft and implement Standard Operating Procedures (SOPs) for drug stores and other operations.

- **Financial Accountability:**
  - Conduct a financial audit for all facilities.
  - The District Internal Auditor should provide timely internal audit reports to the CAO, RDC, and LCV Chair bi-annually.

### Recommendations — Pader

- DSC to immediately recruit substantive DHO, ADHO-EH, Biostatistician, and all key vacant DHT positions.
- Establish NICU at Pajule HCIV.
- All doctors at Pajule HCIV to provide 24-hour emergency obstetric care; set and assess caseload targets.
- Recruit district pharmacist and implement EMHS SOPs in all facilities.

## 4.2.8 Mukono District

Thirteen health facilities visited: Mukono General Hospital, Kojja HCIV, and 11 HCIIIs.

### Key Findings

- District has not had a substantive DHO since March 2021; no functional District Service Commission for 3 years.
- Strife between Mukono DLG and Municipality regarding governance of Mukono General Hospital remains unresolved.
- Overall district staffing at 30% (319 filled positions total). Mukono GH at 29%.
- Mukono GH: UGX 265,970,511 in missing payment vouchers; UGX 260,958,362 unaccounted for; UGX 13,517,050 in NTR receipts spent before banking.
- Mukono DHO: UGX 154,934,935 in unaccounted funds across FY 2021/22 and 2022/23.
- NMS shortfall of UGX 225,070,768 worth of EMHS for visited facilities.
- Chronic extortion from delivering mothers and patients requiring C-sections at Mukono GH and Kojja HCIV.
- Mukono GH: 1,875 caesarean sections in six months (average 312/month; up to 10/day) — primary driver is financial motivation, not clinical need.
- ELMIS on very low usage due to lack of computers.

## Leadership and Governance

- RBF (Results-Based Financing) is implemented in most health facilities.
- Strife between Mukono District Local Government (DLG) and the Municipality regarding the governance of Mukono General Hospital has not been resolved.
- The district has not had a substantive DHO since March 2021.
- For three years, the district has not had a functional district service commission.
- There is a lack of a wage bill for the upgraded Kasenge HCIII.

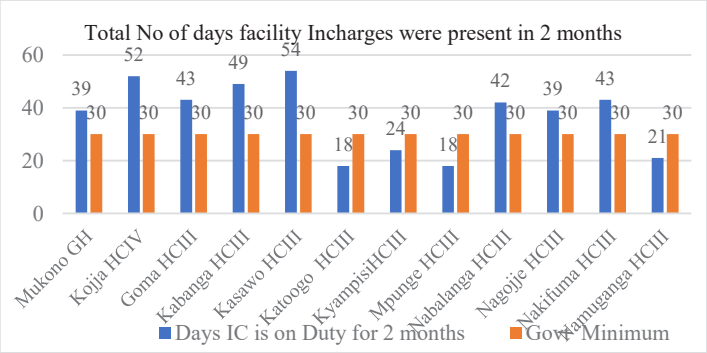
## Human Resources for Health

*Table of details of facility staffing*

| Facility | Ownership | Approved Staffing | Positions filled | %Age Staffing |
|---|---|---|---|---|
| Mukono GH | Government | 343 | 101 | 29 |
| Kojja HCIV | Government | 130 | 41 | 32 |
| Kyampisi HCIII | Government | 55 | 18 | 33 |
| Nakifuma HCIII | Government | 55 | 19 | 35 |
| Nabalanga HCIII | Government | 55 | 15 | 27 |
| Kasawo HCIII | Government | 55 | 17 | 31 |
| Goma HCIII | Government | 55 | 34 | 62 |
| Namuganga HCIII | Government | 55 | 14 | 25 |
| Nagoye HCIII | Government | 55 | 17 | 31 |
| Katoogo HCIII | Government | 55 | 16 | 29 |
| Mpugwe HCIII | Government | 55 | 11 | 20 |
| Kabanga HCIII | Government | 55 | 16 | 29 |
| Seeta Nazigo HCIII | Government | | | 0 |
| **Total District Staffing** | | | **319** | **30** |

- Health worker staffing is 85% without the hospital and 70% with the hospital.
- Kojja HCIV has three medical officers.
- Mukono Hospital is understaffed at 48% staffing levels.
- Inadequate wage bill to cater for vacant positions.
- Insufficient human resources for preventive health activities.
- In many facilities, in-charges exhibited planned absenteeism, as evident from duty rosters.
- Planned absenteeism and absconding from duty has resulted in health workers working a maximum of 4 months in a year.

*Presence of Facility In-charges*




### ESSENTIAL MEDICINES AND HEALTH SUPPLIES (EMHS)

- The failure of NMS to deliver all cycles of EMHS as planned greatly affected service delivery.
- A shortfall of UGX 225,070,768 million worth of EMHS by NMS for the visited facilities.
- Lack of internal EMHS audits within facilities.
- Lack of a Pharmacist at the District and the General Hospital.
- Inadequate designated space for EMHS stores.
- Within the last financial year 2022/23, National Medical Stores was not able to deliver all planned six cycles.
- NMS however sent out a memo to the different facilities with an assurance that the undelivered balances would be included in the deliveries for the FY2023/24.

*Summary table of value of undelivered medicines by NMS (2022/23)*

| FACILITY | UNDELIVERED |
|---|---|
| Mukono General Hospital | UGX 63,558,793 |
| Kojja HCIV | USh64,052,957 |
| Kabanga HCIII | USh9,548,412 |
| Goma HCIII | USh14,761,671 |
| Kasawo HCIII | USh11,925,536 |
| Nagojje HCIII | USh10,742,524 |
| Mpunge HCIII | USh9,277,496 |
| Nakifuma HCIII | USh15,596,639 |
| Kyampisi HCIII | USh11,142,859 |
| Nabalanga HCIII | USh14,463,881 |

## HEALTH SERVICE DELIVERY

- Kojja HCIV provides Emergency Obstetric and Neonatal Care.
- Lack of radiology services in the district.
- Mukono GH mortuary is not in use because of the failure to recruit a mortuary attendant.
- Chronic extortion from delivering mothers and others going for C-section.
- Chasing of patients from facilities [Mukono GH & Kojja HCIV].
- Unnecessary referrals of pregnant mothers from Kojja HCIV.
- Lack of blood transfusion services in Kojja HCIV.
- Delayed referral of COVID-19 cases due to lack of a public ambulance.
- Shortage of testing swabs and PPE buffers.

### Out Patient Department attendance (Mar-Aug-2023)

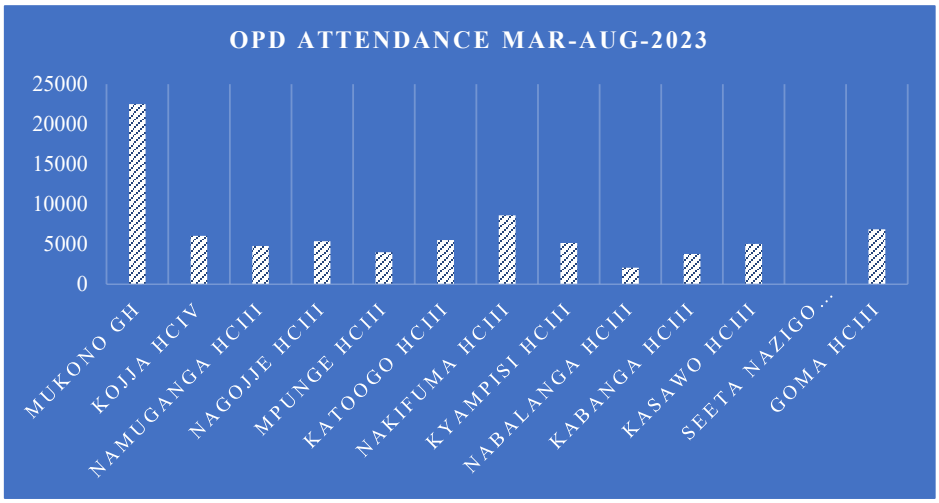



*Figure showing Out-patients' attendances by Facility*

### Antenatal Care services & deliveries

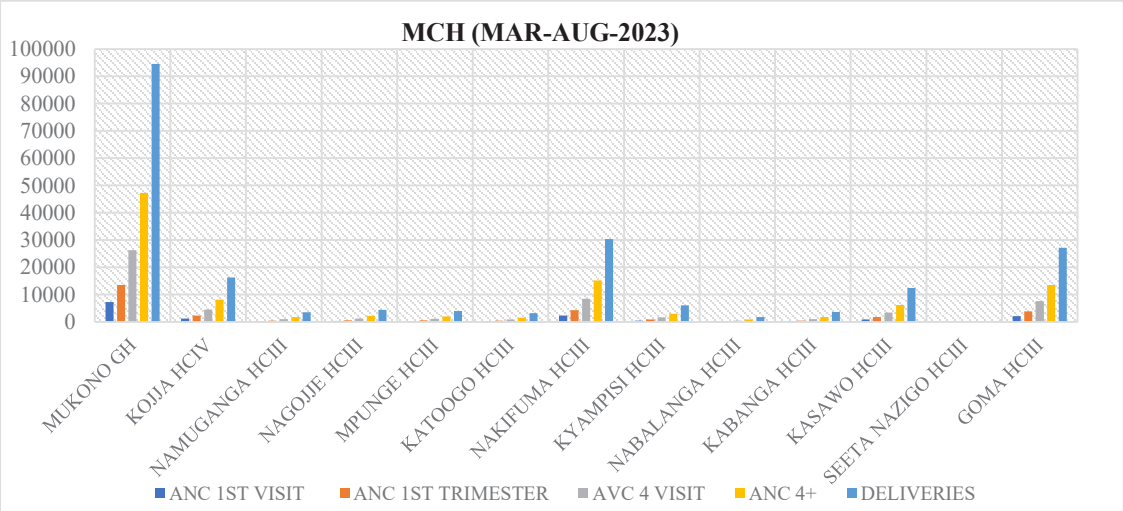



*Figure showing Trends of Antenatal care Visit and Deliveries by facilities*

### Theatre

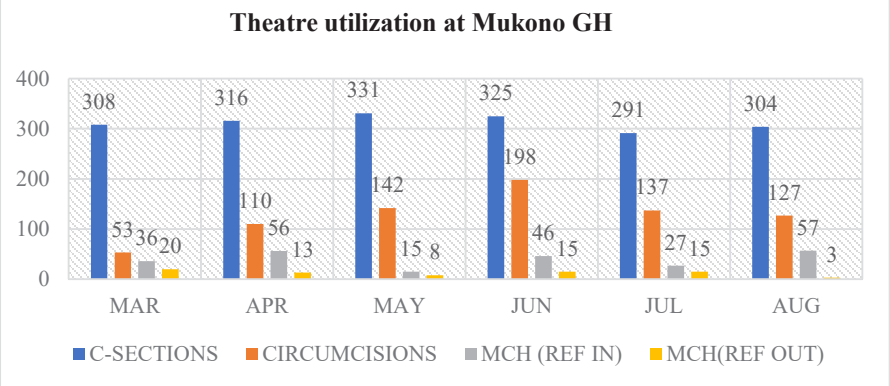



***Figure showing trends of theatre service utilization by Month***

- Mukono GH carried out 1,875 c-sections in six months, with an average of 312 C-sections a month and up to 10 C-sections a day.
    - The number of C-sections done in Mukono GH is worrying, with the most prominent cause being the money factor.

**Finance and Administration**

- The review of the payment voucher files in comparison to the expenditure records as per the various bank statements at Mukono general hospital revealed an amount to the tune of **Ugx 265,970,511** as missing payment vouchers.
- An amount to the tune of **Ugx 260,958,362** still remained as both unaccounted for and insufficiently accounted for funds for the period under review
- The review of the NTR receipts at Mukono general hospital against the amounts banked as per the bank statements seen revealed an amount to the tune of **Ugx. 13,517,050 (Thirteen Million Five Hundred Seventeen Thousand and Fifty Shillings Only)** as money that was not banked. This money was spent before banking. And the accountabilities for this expenditure was not availed to the team.

*Mukono DHO summary of funds not properly accounted for*

| MUKONO DHO SUMMARY OF FUNDS NOT PROPERLY ACCOUNTED FOR | |
|---|---|
| **Financial Year** | **Amount** |
| 2021/22 | 102,416,013 |
| 2022/23 | 52,518,922 |
| **Total** | **154,934,935** |

## INFRASTRUCTURE AND EQUIPMENT MANAGEMENT

- Mukono HCIV upgraded to a hospital.
- Kasenge and Miyende HCIIs were accredited to become HCIIIs.
- Only one HCIV in the district.
- No ICU in the entire district.
- Insufficient oxygen cylinders.
- Under-equipped laboratory with inadequate space.
- No public-controlled ambulance in Mukono.

The issue of mattresses and beds given to MPs by MoH has meant that they never reached the facilities for close to two years. MPs are still holding these items in their custody.

*The IP ward needs, beds, mattresses, furniture, equipment, curtains*

.

**Equipment**

- Two ambulances donated and controlled by Members of Parliament (MPs).
- Redundant CBC machines [Beekman Coulter and Sysmex] in Mukono GH because of lack of reagents.
- Lack of inventory registers tool.
- Equipment not engraved.
- Water pump stolen in Nabalanga HCIII.
- The regional maintenance workshopswere cited to have failed in their role of servicing and maintaining equipment in all district facilities.

*Picture of a store at Mukono GH full of non-functional equipment*

- Incompleteness of HMIS tools.
- ELMIS (Electronic Management Information Systems) are on very low usage in Mukono district because they lack computers.
- Surveillance conducted on the four truck entry points of Katosi, Katosi cape, Kyetume and Namaanve industrial center.
- Formation of Namanve Industrial COVID-19 Task Force that partnered with the National COVID-19 TF and controlled COVID-19 spread in Namaanve IDC, which had become an epicenter in August.
- Tools for implementing HBC were provided.
- District supplied PPEs to police, prisons and army detach.
- Use of masks by the community is improving.
- Received a total of UGX 347 million between April and September for COVID-19 management.
- As of 23rd December, there were 4 deaths from Mukono district due to COVID-19; 1 was a health worker.
- Community spread of COVID-19 has increased; 7 District administrators including CAO contracted COVID-19.
- Not given COVID-19 District TF vehicle.
- Long turnaround time to receive results; can take up to 1 week for COVID-19 tests.
- High testing fee of 185,000 for truck drivers for COVID-19.
- Inadequate PPE buffers; masks, gumboots, coveralls, sanitizer.
- Inadequate facilitation for COVID-19 management.
- None of the HWs in private health facilities have been adequately trained on the management of COVID-19.
- Result Based Financing is available to procure basic PPEs in facilities.
- Partnerships with GOAL and WHO were utilized for COVID-19 control.

## RECOMMENDATIONS

### Leadership and Governance

- The DLG and Municipality leaders should come to an agreement on the governance of Mukono Hospital.

**Health Service Delivery**

- Ensure Kojja HCIV has blood transfusion services.
- Mukono GH must devise means of reducing the number of C-sections done monthly.
- The chasing of patients from Public Facilities must stop. The perpetrators should be sanctioned. Case in point of Mukono GH and Kojja HCIV.
- MOH to reduce testing fee for truck drivers for COVID-19.
- To increase funding for implementing the HBC strategy.
- Security to enforce SOPs.
- MOH to provide more PPEs and testing swabs.

### Human Resources for Health

- Public Service should release the wage bill to recruit the required health workers.
- Ministry of Health (MOH) to increase human resources for preventive strategies.

### Health Training Institutions

- Expand training for health workers on case management and home-based care.
- Ensure COVID-19 training reaches lower health facilities and private sector health workers.

### Essential Medicines and Health Supplies

- Establish internal EMHS audits in all health facilities.
- DHO and CAO should follow up and ensure NMS delivers the balances of the previous cycles of the last financial year 2022/23.
- Urgently recruit a pharmacist for Mukono GH.

**Infrastructure and Equipment**

- MOH to provide required funding, human resources, and equipment to upgrade health facilities.
- MOH to upgrade Kome Island, Nakifuma, and Katogo HCIIIs to HCIV.
- The district must work together with Buganda Land Board and ensure health facilities land is titled. There is an apparent need to engage the government to give a waiver on taxes for processing titles for public facilities.
- DHO/CAO should work hand in hand with MOH and source an ambulance for Mukono district.
- MPs who took beds, mattresses, and blankets should deliver them to CAO/DHO offices for proper distribution.
- MOH to give the DTF a vehicle for control of COVID-19.
- Ministry of Health to provide ambulances under public control.

## HMU Interventions

- Training of 250 VHTs and 50 HWs to implement Home-Based Care (HBC).
- HMU officially requested the Ministry of Health (MoH) to upgrade Kome Island, Nakifuma and Katogo HCIIIs to HCIV.
- DHO is finalizing the process of blood transfusion accreditation for Kojja HCIV.
- CAO has written to Public Service to increase the wage bill.
- CAO Mukono has written to MOH to send Funds for Mukono Hospital to the DLG.
- Waiting for permission from Public Service Commission to recruit health workers.

### Recommendations — Mukono

- MOH to resolve DLG/Municipality governance conflict and clarify accountability for Mukono GH.
- Investigate and stop extortion at Mukono GH and Kojja HCIV; prosecute confirmed cases.
- Institute clinical audit committee to review C-section rates at Mukono GH.
- MOH to recover beds and mattresses from MPs and deliver to health facilities.

## 4.2.9 Sironko District

Twelve health facilities visited: 2 HCIVs (Budadiri and Buwasa) and 10 HCIIIs.

### Key Findings

- Total OPD attendance over 6 months: 54,400. Budadiri HCIV highest (18% of total).
- 1 maternal death (Buwasa HCIV); 22 Fresh Still Births; 30 Macerated Still Births; 4 neonatal deaths in the year.
- Buwasa HCIV AIMO Mr. Slyver Mazaki arrested and charged for mismanagement and theft of medicines.
- ELMIS installed in only 4 of 8 facilities; none up-to-date.
- 7 of 12 facilities unfenced; 8 of 12 lack land titles.
- No incinerators in any visited facility; all relied on open burning for waste disposal.

## Leadership and Governance

**Supervision Gaps:**

- There was a lack of proper supervision at the health facilities by the Chief Administrative Officer (CAO), Assistant District Health Officer (ADHO), Maternal and Child Health (MCH), and Environment Officers over the last six months.
- The Acting Assistant District Health Officer (MCH/Nursing) had not supervised Bulwara, Buteza, and Bunagami HCIIIs in the last six months.
- The Acting District Health Inspector had not supervised Budari and Buwasa HCIVs, Bulwara, Buteza, Buyobo, Bumulisha, Mbaya, Bundege, and Bunagami HCIIIs in the last six months.
- The Acting Assistant District Health Officer (Environmental Health) had not supervised Buwasa HCIV, Bulwara, Buteza, Buyobo, Mbaya, Bundege, Sironko, and Bunagami HCIIIs in the last six months.
- The Resident District Commissioner (RDC) had not supervised Budari HCIV, Bulwara, Buteza, and Bunagami HCIIIs in the last six months.
- Written reports from supervisors were seen in all facilities (Support supervision and Visitors books). However, there was no tangible evidence of support supervision from the Acting Assistant District Health Officer (Environmental Health) and Assistant District Health Officer (MCH/Nursing) in the facilities they had supervised.
- The Chief Administrative Officer and the acting District Health Officer had supervised all 12 facilities in the last six months.

**Training and Development:**

- None of the facilities had conducted general staff Continuing Professional Development (CPD) on the Client Charter in the past six months. Facilities only conducted Continuing Medical Education (CMEs).

**Financial Transparency:**

- Display of released funding for public viewing was only done at Budadiri and Buwasa HCIVs, Buyobo, Bumulisha, Mbaya, and Buwalasi HCIIIs.
- Display of financial accountabilities (expenditures) for public viewing was only done at Budadiri HCIV, Buyobo HCIII, and Mbaya HCIII.
- At Budadiri HCIV, Primary Health Care (PHC) and Results-Based Financing (RBF) funds were mostly used for fuel (for the Area MP's donated ambulance and the facility's old double cabin), vehicle repairs, support supervision, and Subsistence Daily Allowances (SDAs).

## Human Resources for Health

*Dr. Wakooko Paul displays the different awards Sironko district health department has attracted in his tenure as Acting DHO.*

**Staffing Levels:**

- Understaffing at the District Health Officer's (DHO's) Office was recorded at 55% (6/11 positions filled).
- Critical and managerial positions were vacant at the DHO's office: District Health Officer, Assistant District Health Officer (Environmental Health), and Assistant District Health Officer (MCH/Nursing).
- In the lower health facilities, there was understaffing in 23 of the 24 facilities based on April 2023 norms. Only Simu Pondo HCII was overstaffed at 122%.
- Overall staffing at lower health units stood at 31% (356/1148 positions filled).
- Budadiri and Buwasa HCIVs were staffed at 43% (56/130 positions filled) and 38% (50/130 positions filled) respectively.
- All HCIIIs were below 35% staffing, with Sironko HCIII being the highest staffed at 33% (18/55 positions filled).
- Of the 356 health personnel on the PHC payroll, the district has 2 Senior Medical Officers, 4 Medical Officers, 41 Enrolled Midwives, 63 Enrolled Nurses, 18 Medical Clinical Officers, and 14 Medical Laboratory Technicians.

The following critical positions were vacant across facilities: Senior Medical Superintendent (2/2), Medical Superintendent (15/15), Medical Officer (17/21), Anesthetic Officer (4/4), Assistant Anesthetic Officer (5/6), Radiographer (2/2), Pharmacist (2/2), Pharmacy Technician (15/15), Senior Dispenser (2/2), Dispenser (3/4), Enrolled Nurse (80/143), and Enrolled Midwife (102/143).

*Table: Total Number of Staff Present (On Duty) Vs. Total Positions Filled*

| Facility | Filled Positions | Staff Present | % Staff Present |
|---|---|---|---|
| Buteza HC III | 16 | 15 | 94% |
| Mbaya HC III | 11 | 8 | 73% |
| Bumulisha HC III | 15 | 10 | 67% |
| Mutufu HC III | 12 | 8 | 67% |
| Sironko HC III | 18 | 11 | 61% |
| Bundege HC III | 15 | 9 | 60% |
| Buwalasi HC III | 16 | 8 | 50% |
| Buyobo HC III | 13 | 5 | 38% |
| Bunagami HC III | 11 | 4 | 36% |
| Buwasa HC IV | 50 | 15 | 30% |
| Bulwala HC III | 14 | 4 | 29% |
| Budadiri HC IV | 56 | 14 | 25% |

**Attendance and Conduct:**

- Gross absenteeism, abscondment, and late coming were evident, particularly at Budadiri and Buwasa HCIVs.
- Many facilities lacked duty rosters, and existing ones were reportedly manipulated by staff signing for absent colleagues. All facilities used attendance books/registers, and this system was being abused.
- All health facilities had duty rosters in all departments; however, they did not specify the allocation of duties and stations for individual staff.
- The district's health department implemented organized absenteeism, where several staff are given offs beyond the recommended number on the duty roster.
- None of the health facilities were found using a biometric machine for attendance.
- Overall attendance to duty by health facility in-charges was below the public service recommendation of a minimum of 18 days per month. Attendance ranged from 3-5 days at

Sironko and Mutuufu HCIIIs to 6 and 5 days at Budadiri HCIV and Bunagami HCIII respectively in the past two months.

- Some staff who do not attend duty are still drawing salaries.
- Abandonment of duties by In-charges was noted; these individuals often have other duties outside the hospital, abandon their primary roles, and do not delegate in their absence. The in-charges of Budadiri HCIV, Buwalasi, and Bunagami HCIIIs were found absent on private engagements on the day of the visit.
- Buteza and Mbaya HCIIIs had the highest percentage of staff present relative to their filled positions (15/16 and 8/11 respectively), while Buwasa HCIV, Bulwala HCIII, and Budadiri HCIV had the least (15/50, 4/14, and 14/56 respectively), indicating high absenteeism levels.
- The HMU team identified 18 errant personnel concerning issues ranging from abscondment, absenteeism, unsanctioned study leaves, and failure to report for duty after official transfer.

**Uniforms and Identification:**

- Health facility staff were often not wearing uniforms and name tags. Only Medical Officers were consistently found in complete uniforms.
- However, all staff present on duty at Mbaya and Buteza HCIIIs were found dressed in uniforms and with name tags.

**Allowances and Career Progression:**

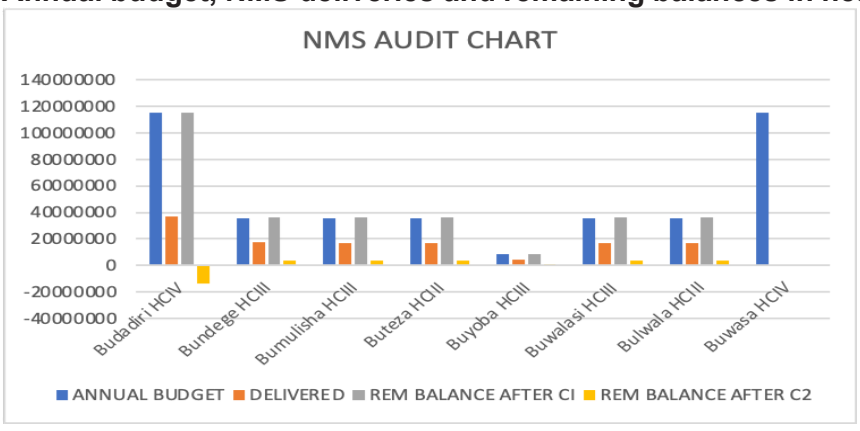
- No allowances are set aside for hard-to-reach areas. Staff in hard-to-reach facilities were not given these allowances.
- Some staff have overstayed in certain facilities for over 7 years.
- Several staff (COs, MOs, Nurses, Midwives) have upgraded their qualifications and are awaiting promotion. Budadiri HCIV had an askari (guard) who had upgraded qualifications in lab and orthopedics.

**Salary Issues:**

- Wanendeya Lukumani (Enrolled Nurse, Bulwara HCIV) had 1 month of salary arrears (January 2024) after being erroneously removed from the payroll.
- Akurut Betty (ANO, Buteza HCIII) and 7 others were erroneously removed from the payroll from April 2023 to December 2023 and receive salary every three months.
- Namono Jackline (Enrolled Nurse, Buwalasi HCIII) was erroneously removed from the payroll in April 2023 and is demanding arrears.

## Essential Medicines and Health Supplies (EMHS)

**Annual budget, NMS deliveries and remaining balances in health facilities in Sironko district.**



**Availability and Stockouts:**

- There were frequent drug stockouts at health facilities.
- National Medical Stores (NMS) deliveries were delayed, sometimes taking months.
- Facilities had undelivered balances carried forward from the previous financial year 2022/23.
- Cycle 2 of the NMS delivery contained 2 cycles in one delivery. NMS delivery returned to a quarterly system.
- Remaining balances after deducting delivered items did not match transactional mathematics.

**Expiry Management:**

- There was an overload of expired medicines delivered from NMS.
- Collection of expired medicines from facilities was delayed. All monitored facilities had huge piles of expired items uncollected for over a year.
- Bulwala HCIII had some expired medicines still on the shelf with viable medicines, which were removed immediately.

**Storage Conditions:**

- All facilities' storage rooms were secure and lockable.
- Buyobo HCII's storeroom was infested with bats.
- Only Bumulisha HCIII and Buteza HCIII had clean stores.
- 5 out of 8 facilities audited lacked Standard Operating Procedures (SOPs) for storage.

**Accountability and Documentation:**

- Non-documentation (e.g., Buwasa HCIV) and data inaccuracy (e.g., Bundege HCIII) were observed. Positive variances occurred because received items (like Mama Kits at Bundege HCIII) were not recorded but later issued.
- At Buwasa HCIV, HMIS tools for medicine accountability were reportedly stolen and lost, with no trace of past records. No delivery notes, requisition/issue vouchers, or stock cards were found.
- Budadiri HCIV and Buteza HCIII stores had the most accurate and complete documentation.
- Negative variances (more administered than supplied) indicated recording of items purchased by patients outside the facility (e.g., artesunate, ceftriaxone at Budadiri HCIV).
- Positive variances indicated non-documentation, incomplete documentation, or potential theft.
- Buwasa HCIV and Budadiri HCIV user departments could not fully account for commodities received from the store due to incomplete documentation in wards.
- The Budadiri HCIV Maternity ward lacked a dispensing logbook; HMU intervened to implement one.
- The Buwasa HCIV Assistant Inventory Management Officer (AIMO), Mr. Slyver Mazaki, was arrested and charged for mismanagement and theft of medicines.

**Electronic Logistics Management Information System (ELMIS):**

- Of 8 facilities monitored, only 4 had computers with ELMIS (RX solution) installed.
- None of the ELMIS systems were up-to-date.
- Responsible store personnel cited a gap in training on ELMIS use. HMU pharmacist provided basic training where possible (e.g., Bumulisha HCIII).

**Training and Supervision:**

- Staff at all facilities indicated no medicine management training in the last year.
- All facilities indicated no technical supervision from the district in the last six months.

- Only at Buteza HCIII and Bundege HCIII did stores/pharmacy staff receive technical supervision from the facility in-charge in the last six months.
- There remains a gap in technical supervision in the management of essential medicines and supplies.

## Health Service Delivery

**Outpatient Department (OPD) Services:**

- All visited facilities had a General OPD.
- No facility had a Private Wing, Dental Clinic, Eye Clinic, Orthopedic Services, or Physiotherapy services.
- Budadiri and Buwasa HCIVs had functional Ultra-Sound Scan machines but lacked personnel to operate them.
- There were no X-ray services in the entire district.
- Six facilities had adequate OPD space (Sironko, Buteza, Buwalasi, Bulwala, Buyobo, Mbaya HCIIIs), while six had inadequate/congested space (Buwasa, Budadiri HCIVs, Bundege, Bumulisha, Mutufu, Bunagami HCIIIs).
- Most facilities lacked adequate OPD space, especially during rain.
- Only three facilities had an Emergency Tray at OPD (Buteza, Buwalasi, Buyobo HCIIIs).
- Only two facilities had an Emergency Stretcher at OPD (Buyobo, Mbaya HCIIIs).
- Only three facilities had an Emergency Wheelchair at OPD (Budadiri HCIV, Buyobo, Mbaya HCIIIs).
- OPDs were generally busy. Overall OPD attendance for the last six months was 54,400. Budadiri HCIV had the highest attendance (18%), followed by Buwasa HCIV (15%). Bundege HCIII had the highest among HCIIIs (9%), and Mbaya HCIII had the least (4%).
- No OPD deaths were reported in the last year.

**OPD Infection Prevention and Control (IPC):**

- Facilities lacked proper designated triage areas for Tuberculosis (TB) suspected cases. Budadiri HCIV, Buwalasi, and Buyobo HCIIIs had no Triage area for TB Suspects.
- All facilities had Hand Washing Equipment (sink/Washing Can) at OPD.
- Buwasa and Budadiri HCIVs lacked liquid soap at OPD.
- Five facilities lacked sanitizer at OPD (Buwasa HCIV, Sironko, Buteza, Bundege, Buyobo HCIIIs).
- Three facilities lacked gloves at OPD (Buwasa, Budadiri HCIVs, Bumulisha HCIII).
- Budadiri HCIV and Bunagami HCIII lacked surgical masks at OPD.
- All visited facilities had Color-coded bins, Protective Gear/Uniforms, and Sharps Disposal at OPD.
- Five facilities had congested OPDs (Buwasa, Budadiri HCIV, Buteza, Bundege, Mutufu HCIIIs).
- Five facilities had open OPD structures, while seven had closed structures.

**Inpatient Department (IPD) Services:**

- Buteza, Bulwala, Bumulisha, and Bunagami HCIIIs lack gazetted General Wards (with Female, Male, Children sections) and use improvised small rooms.
- All facilities lacked an Emergency Tray in IPD. Only Sironko, Buyobo, and Mbaya HCIIIs had a stretcher in IPD.
- Only Buyobo and Mbaya HCIIIs had a wheelchair in their IPD section.
- Total inpatient numbers for the last six months stood at 3,794. Budadiri HCIV had the highest (1,678), followed by Buwasa HCIV (643) and Buwalasi HCIII (503). Buwasa HCIV showed underutilization of inpatient services.
- No inpatient deaths were reported for general admission wards in the last year.

**Health Records Management:**

- Buwalasi, Bundege, Bulwala, Bumulisha, and Buyobo HCIIIs did not have discharge records available.
- Only Bulwala HCIII, Buwasa, and Budadiri HCIVs had death records from NIRA available.
- Buteza, Bundege, and Mbaya HCIIIs did not have referral records.

**Blood Transfusion Services:**

- Available only at Budadiri and Buwasa HCIVs.
- Records (transfusion logs, delivery notes, dispensing logs) were available, but blood supply was inadequate.

**Maternity and ANC Services:**

*On spot training; HMU Deputy Director, Dr. Julianne Nabatanzi and midwives prepare delivery sets for sterilization at Budadiri HCIV*

- Deliveries were higher than 4th/4+ ANC attendances at Buwasa HCIV, Sironko, Buwalasi, Bumulisha, Bunagami, and Bulwala HCIIIs, possibly due to mothers attending fewer ANC visits but delivering at the facility.
- Higher ANC attendance than deliveries (Bundege, Buyobo, Mutuufu HCIIIs) may suggest client satisfaction gaps, lack of motivation to deliver at the facility, or use of private/TBA services.
- Highest 4th/4+ ANC attendances were at Buteza HCIII (466) and Sironko HCIII (317). Lowest were at Bunagami HCIII (25).
- Deliveries were highest at Budadiri HCIV (1,743), followed by Buwasa HCIV (520) and Sironko HCIII (406). Mutuufu HCIII had the lowest (81).
- Referrals (last six months): Budadiri HCIV (589 in, 9 out); Buwasa HCIV (28 in, 12 out).
- Caesarean sections (HCIVs, last six months): 527/2,254 total deliveries (23%) were C-sections. Budadiri HCIV performed more (129) than Buwasa HCIV (82).

**Maternal and Neonatal Deaths (Last Year):**

- 1 Maternal Death at Buwasa HCIV.
- 22 Fresh Still Births (FSB): 16 at Budadiri HCIV, 6 at Buwasa HCIV.
- 30 Macerated Still Births (MSB): 26 at Budadiri HCIV, 2 at Buwasa HCIV, 1 at Mutuufu HCIII, 1 at Bunagami HCIII.
- 4 Neonatal Deaths: 2 each at Buwasa and Budadiri HCIVs.
- 143 Preterm Deaths (<2.5Kgs): 141 at Budadiri HCIV, 2 at Mutuufu HCIII.
- Death Audits were conducted only at Buwasa, Budadiri HCIVs, Mutufu, and Mbaya HCIIIs.

**Labour Ward Equipment and IPC:**

- Emergency Trays were missing in Buwasa, Budadiri HCIVs, Buwalasi, Bundege, Bulwala, Bumulisha HCIIIs. At Mutuufu HCIII, it was locked with a lost key.
- Only Bundege and Bumulisha HCIIIs had functional Doppler machines.

- Delivery Lamps were missing in Buwasa, Budadiri HCIVs, Sironko, Bulwala, Bunagami HCIIIs.
- All facilities had handwashing equipment in the Labour Suit.
- Liquid soap was missing in Buwasa, Budadiri HCIVs, Buwalasi, Bundege, Mutufu HCIIIs.
- Sanitizer was missing in Budadiri HCIV, Bundege, Buyobo HCIIIs.
- Gloves were available in all except Buwasa HCIV.
- All had color-coded bins, surgical masks, sharps disposal, and protective gear.
- All facilities except Buwalasi, Bundege, Bunagami HCIIIs had rubbish bins; only Budadiri HCIV lacked bin liners.
- Storage drums for sterilized equipment, gauze, and cotton were missing in several facilities.
- Gumboots were missing in Budadiri HCIV, Bundege, Bulwala, Bumulisha, Mutufu HCIIIs.
- Only Buteza and Mbaya HCIIIs had sterilized delivery sets.
- Only Buteza, Buwalasi, Bulwala, Buyobo, Mbaya HCIIIs had an equipment cupboard.
- Sluice rooms and sterilization rooms were missing in seven facilities.

**Cleanliness of Labour Suit:** Varied significantly across facilities regarding walls, floors, windows, delivery beds, doors, curtains, resuscitation equipment, and weighing scales.

**Labour Suit Waste Management:** Timely disposal occurred in all except Budadiri HCIV. Cleaning responsibility varied (Porter, Midwife, or both).

**Neonatal Intensive Care Unit (NICU):** No facility in the district offered NICU services.

**Laboratory Services:**

- Sironko and Bunagami HCIIIs had improvised lab working spaces; others had inadequate space.
- Sironko and Bunagami HCIIIs lacked lab working tables. Buwalasi, Bulwala, Bunagami HCIIIs lacked sinks.
- Reagent fridges were missing in most HCIIIs. Only Budadiri HCIV lab had a fridge for blood.
- Record shelves were missing at Sironko and Bulwala HCIIIs.
- Chemistry Analyzer, Gene Xpert, and Centrifuge were only at Budadiri HCIV.

## Infrastructure and Equipment Management


*Mbaya HCIII: well maintained and cleanest facility in the entire district.*

**Facility Condition and Cleanliness:**

- Most facilities were not well-kempt, with uncleaned/unmowed compounds and strewn rubbish. All facilities had well-kempt compounds *except* Buwasa HCIV. Mbaya HCIII was noted for cleanliness.
- All facilities had clean drainage systems except Buwasa and Budadiri HCIV (blocked) and Bunagami HCIII (no drainage).
- All OPD stations were clean except Buwasa HCIV and Mutuufu HCIII (very dirty).
- Mutuufu HCIII, Buwasa, and Budadiri HCIVs had dilapidated OPD structures.
- Budadiri HCIV had 2 filled pit latrines.

**Ward Infrastructure:**

- Sironko, Bulwala, and Bumulisha HCIIIs had no maternity wards.
- Buteza, Bulwala, Bumulisha, and Bunagami HCIIIs lacked gazetted General Wards with sections for Female, Male, and Children.
- At Bundege HCIII, obsolete equipment was kept in the inpatient general ward.

**Staff Housing:**

- Staff housing at many facilities was inadequate. Budadiri HCIV, Buwalasi, and Bumulisha HCIIIs had dilapidated structures and dirty compounds.
- One staff house at Sironko HCIII was found being used as a store by the in-charge and Dr. Otuko.

**Construction:**

- Ongoing constructions (2 staff quarters) were found at Budadiri HCIV and Mutuufu HCIII.)
- Mutuufu HCIII had a stalled construction of a new Laboratory.

**Vehicles and Ambulance:**

- The district health department has 5 cars total: 1 old pickup at Budadiri HCIV, 4 fairly new cars at the DHO's office.
- The district lacks a government ambulance. The one at Budadiri HCIV was donated by the area MP.

**Land, Fencing, and Encroachment:**

- Five facilities were fenced (Budadiri HCIV, Sironko, Buteza, Bumulisha, Mbaya HCIIIs).
- Seven facilities were not fenced (Buwasa HCIV, Buwalasi, Bundege, Bulwala, Buyobo, Mutufu, Bunagami HCIIIs).
- Four facilities had land titles (Budadiri HCIV, Buteza, Buyobo, Mutufu HCIIIs).
- Eight facilities lacked land titles (Buwasa HCIV, Sironko, Buwalasi, Bundege, Bulwala, Bumulisha, Mbaya, Bunagami HCIIIs).
- Land encroachment was reported at Buwasa HCIV, with no action taken.

**Utilities (Electricity and Water):**

- Nine facilities were powered by Umeme (national grid). Three had no access (Bumulisha, Mbaya, Bunagami HCIIIs).
- No facility had a standby generator.
- All facilities except Buyobo HCIII had solar systems in maternity sections, but Bunagami HCIII's system was non-functional.
- Eight facilities had access to piped water. Four lacked access (Bundege, Bumulisha, Mbaya, Bunagami HCIIIs) and rely on rainwater harvesting. Bundege HCIII hires people to fetch water from a borehole in the dry season.
- Mbaya HCIII, Buwasa, and Budadiri HCIVs also had boreholes, but Buwasa's was nonfunctional.

**Equipment Inventory:**

- Eight facilities had updated Equipment Inventory registers (Sironko, Buteza, Buwalasi, Bundege, Bulwala, Bumulisha, Buyobo, Mbaya HCIIIs).
- Four facilities had outdated registers (Buwasa, Budadiri HCIVs, Mutufu, Bunagami HCIIIs).

**Infection, Vector Control, and Waste Disposal:**

- No facility had an incinerator. Three (Bundege HCIII, Buwasa, Budadiri HCIVs) used a contracted company for highly infectious waste disposal.
- All facilities used open burning within the facility for waste disposal. No dumping outside or within without burning was reported.
- All facilities had functional rubbish pits, rubbish bins, and placenta pits in good condition.
- Vector Infestation: Bats (Budadiri HCIV, Mutufu HCIII); Termites (Budadiri HCIV, Bundege, Bumulisha HCIIIs); Rats (Budadiri HCIV, Bundege HCIII); Cockroaches (Bunagami HCIII). Buyonbo HCII store room infested with bats.
- Fumigation had only been done in four facilities (Budadiri HCIV, Buteza, Bulwala, Buyobo HCIIIs) within the last year. Nine facilities had not fumigated.

**Aide Memoire**

- An Aide Memoire meeting was held on February 28, 2024, in the district council hall.
- Attendees included the Chief Administrative Officer (CAO), District Health Officer's (DHOs) Office, and representatives of health workers from all health facilities in the district.
- In this meeting, the HMU team took the leaders of the health facilities through the development of an Aide-memoire (memory aid) listing the identified gaps or challenges in each of their departments and an action plan to tackle the gaps was agreed upon.
- Health workers (Doctors and Nurses) renewed their professional Oath to better serve the residents of Sironko district.

**Public Engagement and Dissemination**

**Dissemination Meeting:** HMU Findings from the monitoring exercises carried out in Sironko district were disseminated at a district and stakeholders' meeting held on March 1, 2024, in the district council hall.

**Community Dialogue (Baraza):**

- The Health Monitoring Unit (HMU) held a community baraza at St. Anthony Catholic Sub-Parish Church in Buwasa on February 29, 2024.
- Key issues raised by the community included: unidentified health workers, rude/unhelpful staff including midwives requesting payment, shortages of blood, Mama Kits, drugs, and water, poor infrastructure (lighting, broken fixtures, overflowing taps), unethical conduct (negligence, extortion, unqualified personnel), lack of accountability and misuse of medications, and lack of emergency transport for the Buwasa LC Chairperson.
- The HMU provided toll-free (0800 200 447) and direct (031 228 300) numbers for reporting concerns.
- The RDC acknowledged the need for improved leadership and accountability.
- Training and knowledge sharing for healthcare workers were identified as future focus areas.

**Radio Talk Show:**

- The HMU team, along with the RDC and DHO's office, held radio talk shows on Elgon FM on February 28, 2024. Feedback on health service delivery challenges was shared. The talk show was broadcast in Lumasaba (local dialect) to encourage participation.
- Participants included Dr. Julianne Nabatanzi (Deputy Director, HMU), Acting DHO, Deputy RDC, and a Health Educator.
- The RDC, CAO, DHO's office, and health worker representatives responded directly to public questions during the Baraza and radio programme to foster accountability and citizen ownership.

**Pictorial**

*Mr. Nelson Kirenga (the CAO Sironko) and Dr. Julianne Nabatanzi (HMU deputy director) discussing during the Aide Memoire meeting.*

*Mr. Nelson Kirenga (the CAO Sironko) addressing health workers during the Aide Memoire meeting.*

*Team building and discussion at the Aide Memoire meeting*

*Ms. Achan Jane (midwife at Budadiri HCIV) presenting agreed upon solutions to the identified gaps in Maternal and Child Health.*

*Mr. Nagasuka Innocent (In charge Mutuufu HCIV) presenting agreed upon solutions to the identified gaps in Human Resources.*

*Dr. Julianne Nabatanzi supporting Nurses and mid wives in coming up with solutions to MCH gaps.*

*Deputy RDC, HMU's deputy Director, Ag DHO and district health educator at a radio talk show on Elgon FM in Mbale city*

*Community Dialogue at Buwasa*

*Deputy CAO addressing the health workers and stake holders during the district dissemination meeting.*

## HMU Interventions

**Accountability and Enforcement:**

- The HMU team, working alongside the Uganda Police, opened case files against errant officers; these cases are currently with the DPP/Court.
- The Buwasa HCIV Assistant Inventory Management Officer (AIMO), Mr. Slyver Mazaki, was arrested and charged for mismanagement of stores and theft of medicines.
- The Health Monitoring Unit will investigate all reported incidents of medical negligence, abscondment, extortion, and unqualified medical personnel.

**Capacity Building:**

- The HMU conducted capacity building for health workers and medicines' management personnel on proper documentation and medicines accountability. Basic ELMIS training was provided by the HMU pharmacist where possible.
- An intervention was done by HMU to implement a dispensing log in the Budadiri HCIV maternity ward.
- The district medicines management supervisor was tasked to increase support supervision efforts and organize stores management training for all relevant personnel.
- The HMU plans to educate the community about the client charter and their rights as patients.

**Policy and System Improvements:**

- The government plans to increase staffing levels at Health Centre IVs (HCIVs) under the National Health Insurance Scheme (NHIS).
- The Health Monitoring Unit will require all health workers to wear identification badges clearly stating their names and areas of expertise.
- The HMU is working with National Medical Stores (NMS) to ensure timely deliveries of medication to health facilities.
- The HMU will work with healthcare facilities to establish a clear referral system.

**Infrastructure Support:**

- The Health Monitoring Unit will work with the district to address infrastructure issues at health facilities, including repairs, lighting, and water access.

## Recommendations — Sironko

- Implement monthly physical stock counts in drug stores with mandatory stock card updates.
- Process land titles for 8 facilities without titles; resolve encroachment at Buwasa HCIV.
- District to address missing land titles and construct incinerators at all HCIVs.
- The Health Monitoring Unit will continue to work with Sironko District leadership and healthcare facilities to address the concerns raised by the community.
- The next community dialogue will provide a platform to discuss progress made on the action points and identify any new areas requiring attention.
- Promote open communication between the community and healthcare providers.
- Identify and address ongoing challenges in healthcare delivery.
- Monitor progress on action points.
- Build trust and collaboration between the community and healthcare officials.
- Improve leadership and accountability from district officials.
- Focus on training for healthcare workers and improved knowledge sharing.

### 4.2.10 Kitagwenda District

Nine health facilities visited: Ntara HCIV, four HCIIIs (Kanara, Nyabbani, Mahyoro, Kicheche), and four HCIIs. Kanara HCII was upgraded to HCIII during the monitoring period.

#### Key Findings

- UGX 813 million in unaccounted funds due to mismanagement, forged fuel receipts, and fraudulent procurement.
- UGX 200 million mismanaged in health projects via "Force on Account" with poor-quality construction under investigation.
- District-wide staffing at 40%; Ntara HCIV at 36%, Kanara HCIII at 25%.
- 44% of HCIII and 26% of HCIV staff absent during scheduled duties.
- Ghost workers and impersonation confirmed; unqualified staff performing medical procedures.
- Only one theatre in the entire district; lacks reliable power backup.
- Neonatal sepsis linked to cultural practices and poor IPC education.

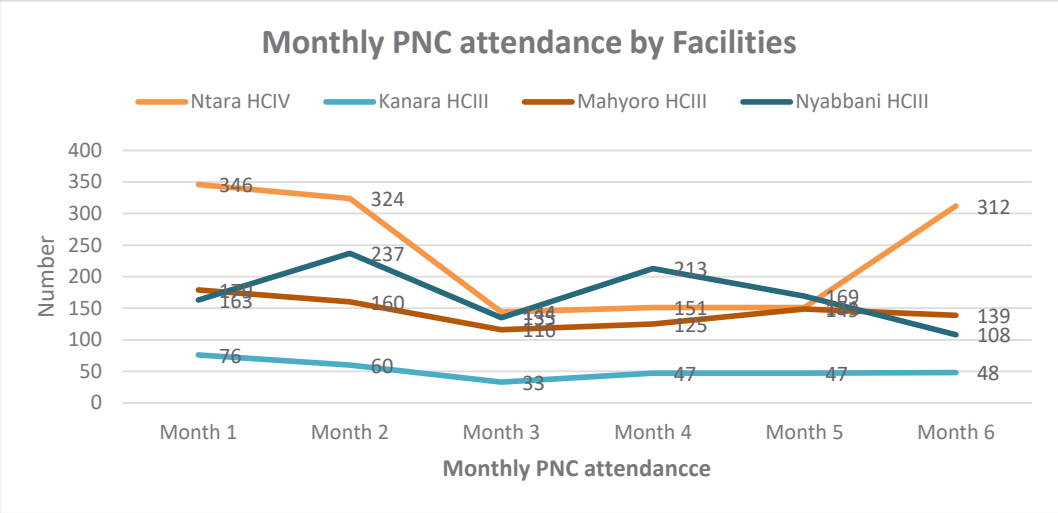
## Leadership and Governance

- The District Health Team (DHT) faced operational challenges due to the lack of a confirmed DHO, causing instability and mismanagement.
- There were UGX 813M (eight hundred thirteen million) in unaccounted funds due to mismanagement and fraudulent procurement practices, including misallocation of funds, forged fuel receipts, and failure to segregate funding sources.
- NMS stockouts, budget mismanagement, and pilferage were affecting patient care.
- There was an urgent need for improved accountability and electronic health record management.
- Inadequate monitoring of facility in-charges was observed, with some attending fewer than 30 days in two months.
- UGX 200M (two hundred million shillings) was mismanaged in health projects via “Force on Account,” and poor-quality construction at multiple facilities is under investigation.
- NMS stockouts, budget mismanagement, and pilferage were affecting patient care, with a need for improved accountability and electronic health record management.
- UGSH 22,350,862 of unspent funds were due to supply discrepancies in facilities across the district.

## Human Resources for Health

- District-wide staffing was at 40%, with Ntara HCIV at 36% and Kanara HCIII at 25% due to recruitment bans and funding shortages.
- High referral rates at Ntara HCIV were partly due to night shift reluctance.
- Critical cadre shortages existed at HCIIIs, particularly midwives (below 50% staffing).
- Absenteeism was high, with 44% of HCIII and 26% of HCIV staff absent during scheduled duties.
- Issues of impersonation were reported, including unqualified staff performing medical procedures.
- Abscondment cases were reported, requiring disciplinary action.
- Staff housing was inadequate, with all existing units occupied, highlighting an urgent need for expansion.
- Outpatient departments (OPDs) were operational in all facilities, but inpatient departments (IPDs) were underutilized partly due to night shift absenteeism.
- Limited maternity and antenatal services were available due to inadequate staffing.

- CID Findings and Actions revealed multiple cases of ghost workers and impersonation, prompting an investigation into the hiring and deployment practices at HCIIIs and HCIVs.



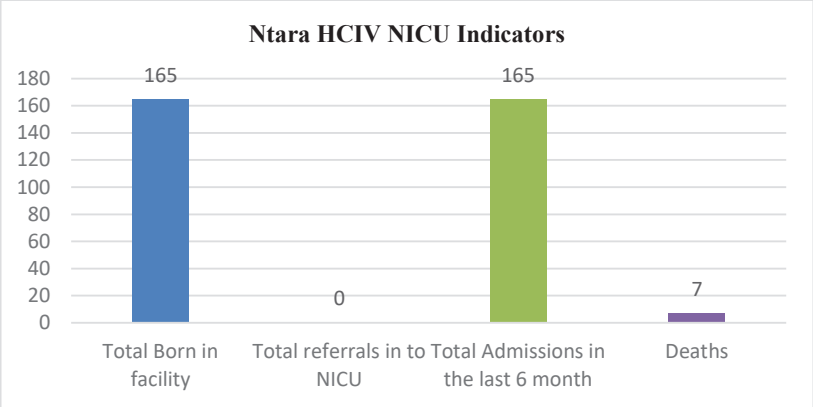

## Essential Medicines and Health Supplies (EMHS)

- High referral rates at Ntara HCIV were partly due to stockouts.
- Poor supply chain issues were noted.
- NMS stockouts were affecting patient care.
- Gaps in perinatal death audits and idle IPDs were partly due to stockouts.
- Outpatient departments (OPDs) were operational in all facilities, but inpatient departments (IPDs) were underutilized due to medicine stockouts.
- NMS stockouts, budget mismanagement, and pilferage were affecting patient care.
- UGSH 22,350,862 of unspent funds were due to supply discrepancies in facilities across the district.
- Fraudulent procurement of medical supplies and equipment was detected, necessitating further investigation.

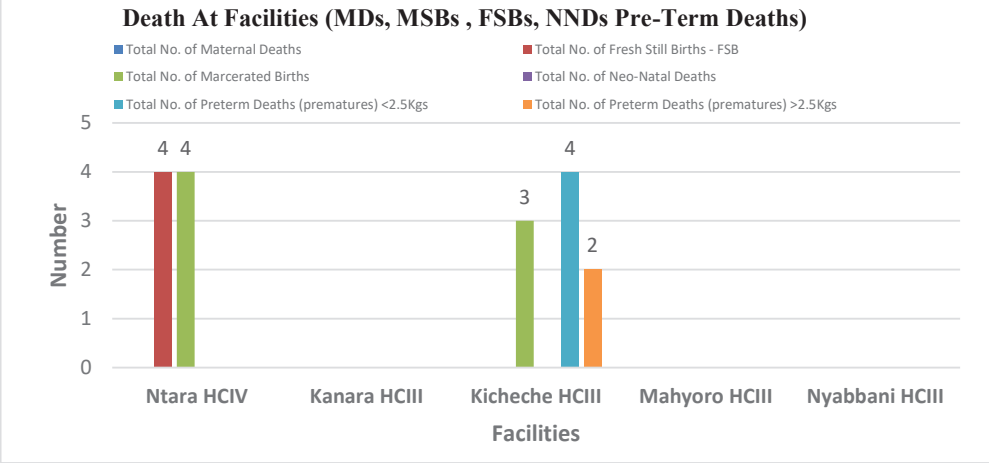
## Health Service Delivery

- Facilities over 20 km apart hinder referrals, indicating an urgent need to upgrade HCIIs.
- High referral rates were observed at Ntara HCIV.
- Poor IPC practices were noted.
- Neonatal sepsis was linked to cultural practices and poor IPC education.
- Gaps existed in perinatal death audits, and IPDs were idle.
- Outpatient departments (OPDs) were operational in all facilities, but inpatient departments (IPDs) were underutilized.
- Limited maternity and antenatal services were available due to inadequate staffing and infrastructure.
- There was a need for better informed consent processes and standardization of maternal service protocols.
- High variance in maternity admissions and deliveries indicated gaps in ANC services.
- Only one theatre was available in the district, lacking reliable power backup.
- Blood transfusion registers were incomplete, missing doctor's name and HB levels.
- Lack of ambulances and sonography machines hindered service delivery.
- Kanara HCII was upgraded to HCIII, improving IPC and handling 70 deliveries per month.
- Efforts were made towards decongesting OPDs and establishing temporary waiting shades.
- HMU allocated staff housing to two Medical Doctors to reduce increased weekend referrals handled by midwives on weekends.
- Kakasi HCII midwife piloted deliveries, assisting two births in a month.

*Key NICU indicators*




*Facility perinatal deaths*




## Infrastructure and Equipment Management

- Idle IPDs were partly due to staffing issues.
- Urgent need for improved electronic health record management was identified.
- Staff housing was inadequate, with all existing units occupied, highlighting an urgent need for expansion.
- Outpatient departments (OPDs) were operational in all facilities, but inpatient departments (IPDs) were underutilized due to limited infrastructure.
- Most health facilities had functional labs but lacked critical equipment like CBC machines and electric hemoglobin meters.
- Only one theatre was available in the district, lacking reliable power backup.
- Lack of ambulances, sonography machines, and clean water was noted, with an urgent need for facility upgrades and equipment procurement.
- Construction Malpractices: Poor-quality construction at several facilities is under review, with legal actions against contractors involved in substandard work.
- Land Encroachment: Reports of land encroachment at health facility sites are under investigation to avert future disputes.
- Neonatal sepsis was linked to cultural practices and poor IPC education, suggesting a need for public health education.
- Studies were needed on neonatal sepsis, HCIII referral trends, and idle IPDs, with a suggestion for collaboration with MPH students for cost-effective research insights.


L-The Deputy Director of the Health Monitoring Unit, Dr. Julianne Nabatanzi (in black dress) supervising the OPD ward at Kanara HCIII
R- Health workers at Kanara HCIII in Kitagwenda district

### HMU Interventions — Kitagwenda

- Kanara HCII upgraded to HCIII — now handling 70 deliveries per month with improved IPC.
- CME training provided for midwives.
- HMU allocated staff housing to two Medical Doctors to reduce weekend referrals.

### Recommendations — Kitagwenda

- Confirm Dr. Irene Kahimakazi as substantive DHO to restore stable governance.
- Investigate all fraudulent procurement practices and take legal action against contractors involved in substandard works.
- MoH and DLG to construct mortuaries; upgrade HCIIs to HCIIIs where needed.

## 4.2.11 Mpigi District

Eleven health facilities visited: Mpigi HCIV and 10 HCIIIs (Butoolo, Kampiringisa, Sekiwunga, Kyali, Mudduma, Buwama, Bunjako, Kituntu, Ggolo, Nindye).

### Key Findings

- Overall staffing at 29.8% (210/705 positions filled); Mpigi HCIV at 38% (59/155).
- Enrolled Midwives at HCIIIs at 28% (22/80 positions filled).
- Rampant extortion and poor quality of care at Nindye HCIII and Mpigi HCIV maternity and theatre.
- No official government ambulance in the district. All referrals to Kawempe, Kiruddu, and Mulago — over 70 km away.
- NMS did not deliver 2/6 cycles worth UGX 128,864,211 in FY 2022/23.
- Medicines theft and forgeries confirmed: 200 vials of Artesunate delivered to Kituntu HCIII on 30/01/2024; only 28 recorded on stock card.
- Mpigi HCIV recorded 302 caesarean sections (22% of deliveries) in six months; 234 referrals out despite functional theatre.

## Leadership and Governance

- The District Health Officer's (DHOs) office lacked the following critical substantive cadres; District Health Officer (DHO), ADHO Environment, and the Cold Chain Technician.

## Human Resources for Health

| S/N | Health Facility | No. Approved | No. filled | % Staffing |
|---|---|---|---|---|
| 1 | Mpigi HCIV | 155 | 59 | 38% |
| 2 | Buwama HCIII | 55 | 23 | 42% |
| 3 | Mudduma HCIII | 55 | 21 | 38% |
| 4 | Butoolo HCIII | 55 | 15 | 27% |
| 5 | Sekiwunga HCIII | 55 | 14 | 25% |
| 6 | Kituntu HCIII | 55 | 14 | 25% |
| 7 | Ggolo HCIII | 55 | 13 | 24% |
| 8 | Kampiringisa HCIII | 55 | 13 | 24% |
| 9 | Kyali HCIII | 55 | 13 | 24% |
| 10 | Nindye HCIII | 55 | 13 | 24% |
| 11 | Bunjako HCIII | 55 | 12 | 22% |

- Critical understaffing for the entire district health department; DHO's office, HCIV and HCIIIs. Overall Staffing level was at 29.8% (210 out of 705 positions filled). Mpigi HCIV, the highest level of health care in the district had 38% staffing (59 out of 155 positions are filled).
- Mpigi HCIV lacked the following critical cadres; 1/1 Radiographer, 4/5 Anaesthetic Officers, 1/3 Theatre Assistants, and 11/18 Enrolled Midwives attributed to government's ban on recruitment.
- Enrolled Midwives staffing levels at the monitored 10 HCIIIs stood at 28% (22/80 enrolled midwives positions filled).
- In charges attendance to duty for the past two months averaged at 26.7 days contrary to the public service standing orders which recommend a minimum of 15 working days per month. Buwama HCIII in charge had the highest number of days (47) attended to duty in the past two months while Kyali HCIII in charge had the least days on duty; Buwama (47 days), Ggolo (39 days), Nindye (32 days), Kampiringisa (27 days), Butoolo (26 days), Kituntu (26 days), Mpigi HCIV (24 days), Bunjako (24 days), Mudduma (22 days), Sekiwunga (18 days), Kyali (9 days).
- Scheduled absenteeism was identified in most facilities while the few staff on duty were also not in staff uniforms.
- Concerns of poor attitudes and behaviour of health workers towards patients evidenced in the long queues at OPD waiting lines, and in the Labour suit.
- Most health facilities had facilities for accommodating critical staff, with well-maintained units that were fully occupied apart from Kampiringisa HCIII which had no staff accommodation and its staff were being accommodated by Kampiringisa Rehabilitation Center.
- Mpigi HCIV had inadequate and dilapidated staff houses as well and most of the houses were constructed in the early 1970s. In some facilities most staff commute from Mpigi town council despite being allocated staff houses.
- Rampant extortion and poor quality of health care reported at Nindye HCIII and Mpigi HCIV maternity and theatre.

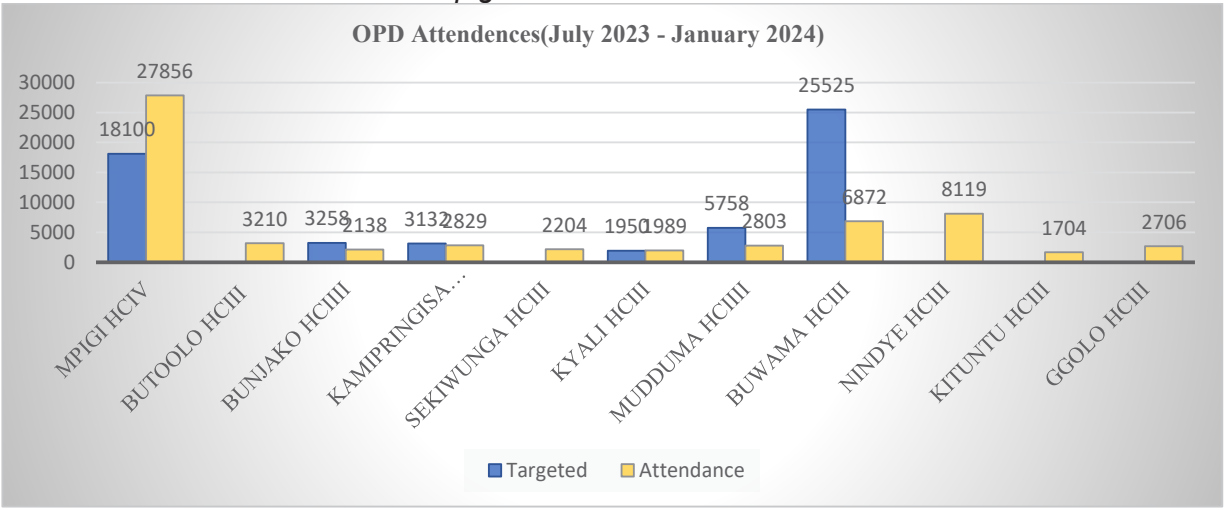
**Recommendations**

- The CAO to fast track the recruitment of key critical cadres.
- The CAO and PHRO to sanction absentee officers in accordance with the Public Service Standing Orders.
- The DHT to intensify support supervision to the lower health facilities.
- Advocate for the construction of more staff houses to address housing shortages.

## Health Service Delivery

- Only Mpigi HCIV and Mudduma HCIII had functional inpatient departments (IPDs).
- Most laboratories at HCIIIs were non-functional. All HCIIIs had inadequate improvised spaces and had had no equipment, specifically; the fridge, CD4, CBC, doppler and Haemoglobin machines, with various cases of redistribution of drug kits.
- Only Mpigi HCIV and Mudduma HCIII had an Emergency Tray at OPD.
- Stretcher at OPD were only found at Mpigi HCIV, Nindye and Bunkako HCIIIs while, only Mpigi HCIV had a wheelchair at OPD.

*OPD Attendances at HCIIIs and Mpigi HCIV*




**Comparison of Monthly OPD attendance achieved and Targets by facilities**

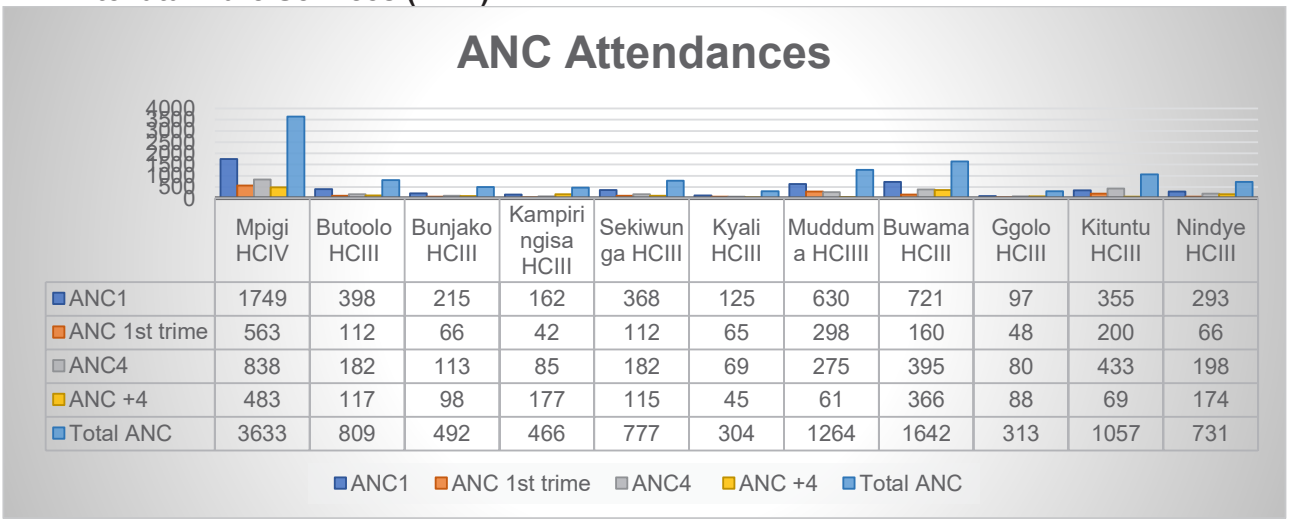
- The data above reveals a general underperformance across all facilities when compared against their predetermined targets. The poor attendance rates were attributed to; understaffing, chronic absence of existing staff, poor quality of care for example chasing away of patients and instances of extortion, particularly at Mpigi HCIV.
- Over the last six months period, Health Centre IIIs recorded an average of 3457.4 attendances at the Outpatient Department (OPD). Notably, Nindye HCIII recorded the highest attendance (8119 visits), while Kyali HCIII exhibited the lowest attendance (1,950 visits).
- Of significant concern was the state of Ssekiwunga and Kyali HCIII, which required immediate interventions in the managerial sphere due to; in-charge absenteeism from duty, negative staff attitudes, and substandard infrastructure.

### In patient Department Functionality

- Mpigi HCIV recorded an average of 169.8 IPD admissions in the previous 7 months with a total of 1,189 total IPD admissions.
- Facility In-Charges are not inventive enough in coming up with solutions of ensuring facilities admit patients. In Bunjako HCIII, the IPD ward had been turned into a store for obsolete equipment.

### Maternal Child Health Care Services

#### Antenatal Care Services (ANC)



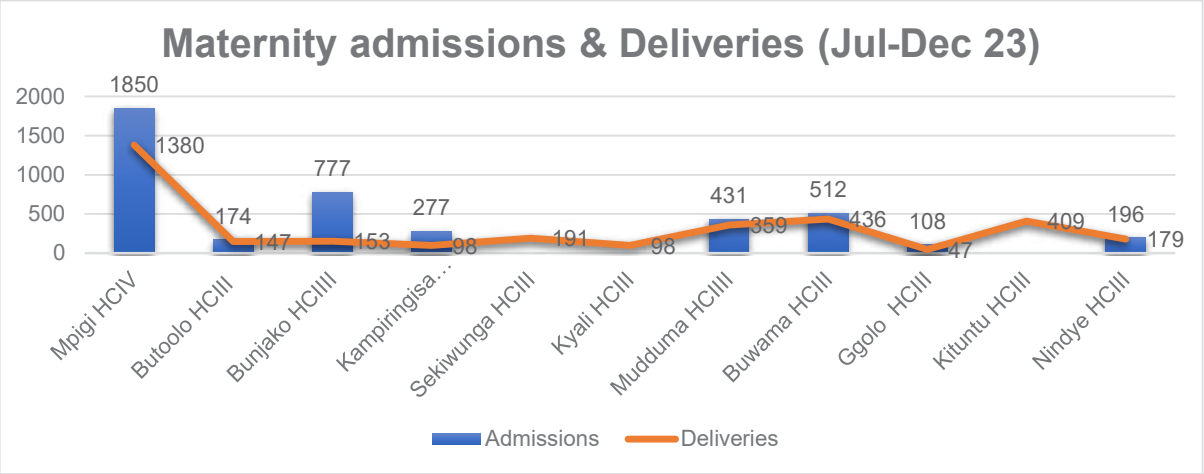

| | Mpigi HCIV | Butoolo HCIII | Bunjako HCIII | Kampiri ngisa HCIII | Sekiwun ga HCIII | Kyali HCIII | Muddum a HCIIII | Buwama HCIII | Ggolo HCIII | Kituntu HCIII | Nindye HCIII |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ANC1 | 1749 | 398 | 215 | 162 | 368 | 125 | 630 | 721 | 97 | 355 | 293 |
| ANC 1st trime | 563 | 112 | 66 | 42 | 112 | 65 | 298 | 160 | 48 | 200 | 66 |
| ANC4 | 838 | 182 | 113 | 85 | 182 | 69 | 275 | 395 | 80 | 433 | 198 |
| ANC +4 | 483 | 117 | 98 | 177 | 115 | 45 | 61 | 366 | 88 | 69 | 174 |
| Total ANC | 3633 | 809 | 492 | 466 | 777 | 304 | 1264 | 1642 | 313 | 1057 | 731 |

Trends in uptake of ANC services.

**Actions**

- Facilities unaware of ANC targets, not displayed at any facilities, and the ones displayed were outdated.
- The DHT to formulate strategies aimed at enhancing ANC coverage, particularly during the 1st trimester. This emphasizes the necessity for targeted interventions to boost ANC utilization and encourage holistic care.
- Recruit a Radiographer for Mpigi HCIV which has sonography machines.
- Procure Doppler machines for all HCIIIs.

### Maternity Admissions, Deliveries & Referrals




### Comparison Analysis of Admissions, Deliveries and Targets by Facility

- No facility had a display of their delivery targets. It was obvious that the facilities were underperforming which could be attributed to population attitudes for some government facilities, mainly due to staff absence, patient extortion, stockouts and some facilities completely abandoned by staff on several instances (e.g., Kyali HCIII).

**Referral Patterns IN and Out- January 2023 to December 2023**

| Facility Name | Referrals In | Referrals Out |
|---|---|---|
| Mpigi HCIV | 58 | 234 |
| Mudduma HCIII | 0 | 71 |
| Buwama HCIII | 0 | 58 |
| Sekiwunga HCIII | 0 | 32 |
| Kituntu HCIII | 0 | 21 |
| Bunjako HCIII | 0 | 19 |
| Butoolo HCIII | 0 | 16 |
| Nindye HCIII | 0 | 16 |
| Kampiringisa HCIII | 0 | 15 |
| Ggolo HCIII | 0 | 12 |
| Kyali HCIII | 0 | 9 |

- The district lacked an ambulance.
- Majority of referrals at Mpigi HCIV were directed to Kawempe, Kiruddu specialized hospitals and Mulago National Referral Hospital, and all situated more than 70 kilometres away. All the other HCIII's refer to Mpigi HCIV.
- High referrals numbers from Mpigi HCIV (234) despite the facility having a fully functional theatre, an Anaesthetic Officer, three Medical Officers and a Senior Medical Officer could be attributed to; absentee Medical Officers, clients failing to raise funds for operations and a skills gap among health workers.

- None of the HCIIIs received any referrals in the past one (1) year.
- Kituntu HCIII had an incomplete maternity block that the community managed to raise to the wall plate.

*Mpigi HCIV maternity was undergoing renovation by the UPDF. The Antenatal Care (ANC), Labour, Postnatal Care (PNC), female and male surgical clinical services were all being done under the same roof.*

- Kampiringisa HCIII's OPD roof was blown off by the wind. A new OPD block was under construction by the UPDF brigade. Staff at the facility were being housed in the quarters of the rehabilitation center and thus in direct daily contact with children under rehabilitation.
- Use of Pantographs: Mpigi HCIV, Buwama and Nindye HCIIIs stood out for consistently using partographs for maternal monitoring. Barriers to partograph usage included, lack of readily available partograph forms, none or malfunctioning photocopy machines, coupled with insufficient funds for copying and some midwives expressed reluctance to use partographs, due to unfamiliarity and time constraint.
- Mpigi HCIV recorded 16 fresh stillbirths (FSBs) and 19 macerated stillbirths (MSBs) in the period between January to December 2023.
- The district had no Neo-natal Intensive Care Unit (NICU) facilities.

**Theatre**

- Mpigi HCIV recorded 302 Caesarean section deliveries (22% of the total deliveries -1380) in the period between July to December 2023.

## Essential Medicines and Health Supplies (EMHS)

- NMS did not deliver 2/6 cycles of medicines and sundries in the last FY 2022/23 worth UGX 128,864,211 to; Mpigi HCIV (UGX 93,537,799), Nindye HCIIII (UGX 6,416,552) and Kyali HCIII (UGX 28,909,860).
- Medicines theft and forgeries were Identified in most facilities. e.g., on 30/01/2024, NMS delivered 200 vials of Artesunate Injection to Kituntu HCIII, and only 28 vials were entered on the stock card.
- All the visited facilities failed to account for medicines and sundries received in the previous financial year.
- Stores generally have limited space which get strained during NMS deliveries.
- All the facilities lacked fridges for cold chain storage.
- Non-completeness of HMIS tools in the facilities, which is the major cause of rampant medicines theft. e.g., stores personnel issued out medicines without authorization from the facility In charges.
- RX solution was in use in the different facilities for information management.

## HMU Interventions

- The Uganda Police opened case files against the errant personnel for failure to account for government medicines and sundries.
- Capacity building was done for all store personnel to ensure better stores management and proper documentation.
- Ensure proper storage, record-keeping, and disposal of expired and unusable medicines and supplies.
- Assign substantive government staff to manage medicines stores, rather than relying on implementing partner or peer staff, to ensure clear accountability.

- The DHO and District medicines supervisor to train the stores personnel and In-charges concerning proper procedures for medicines management and redistribution as per the Ministry of Health guidelines; i.e., at Bunjako & Kituntu HCIIIs.

## Infrastructure and Equipment Management

- No official government ambulance.
- Absolute and abandoned equipment spread all over the facilities; Mpigi HCIV, Ssekiwunga, Kifampa and Bunjako HCIIIs.
- Unkempt facility compounds; Mpigi HCIV, Butoolo, Nindye, Kampiringisa, Ggolo and Bunjako HCIIIs.
- Unfenced facilities; Mpigi HCIV, Butoolo and Kampiringisa HCIIIs.
- No admission wards apart from Nindye and Buwama HCIIIs.
- There was an updated inventory register at all facilities except for Mpigi HCIV, Nindye and Buwama HCIIIs.
- Facility land not titled apart from Mpigi HCIV. However, no encroachment on facility land was reported.
- Apart from Mpigi HCIV, none of the facilities were on the National Water Grid lines, and most facilities depended on rain water harvesting. Some use boreholes but these interventions don't work due to the nature of their land.
- Mortuary at Mpigi HCIV has no fridges. Being located near the road, the stench that comes from the facility is unbearable when bodies delay in the mortuary.

**HMU INTERVENTIONS**

- Secure Land Titles: Expedite land titling for all health facilities, encourage fencing (natural or planted) to protect facility property.
- Construct IPD's for all HCIII's in the district to deliver comprehensive services.
- Conduct Infrastructure Audit: Assess the infrastructure needs of all facilities and allocate necessary funds, including RBF resources, for repairs and upgrades.
- Address Maintenance issues: Allocate budget for ongoing facility maintenance, utilizing RBF funds where applicable.
- Construct new EMHS stores and laboratory blocks throughout the district facilities.

## Public Engagement

**Radio Talk Show**

Other prominent issues raised during the radio talk show and community dialogue include; Upgrading Mpigi HCIV to a Hospital, theft of GoU EMHS, Extortion at Maternity and theatre, medicines stockouts in public facilities, Lack of an ambulance in the district.
Public Engagement and Dissemination

**Community Dialogue (Baraza)**

**Major Issues Raised at the Community Dialogue:**

- Extortion by health workers
- Absenteeism and abandoned facilities
- Lack of medicine at health facilities
- Health workers chasing away patients

**HMU INTERVENTIONS**

- The public was advised to report health workers involves in extortion for money to the Health Monitoring Unit (HMU). If caught, they were prosecuted.
- The Chief Administrative Officer (CAO)and the Rewards and Sanctions Committee to sanction the errant health workers according to the Public Service Standing Orders.
- The Health Monitoring Unit confirmed cases of medicine theft in all facilities that were visited and the Uganda Police to process the culprits for prosecution. They advised the public to be more vigilant and report emerging cases to police or call HMU's toll free line (0800200447) for proper management.

*Community members attending the Community Dialogue in Mpigi*

### Recommendations — Mpigi

- Upgrade Mpigi HCIV to General Hospital to meet service delivery needs.
- Procure and deploy a government ambulance for the district.
- Uganda Police to process culprits for medicine theft for prosecution.
- Construct IPDs for all HCIIIs; secure land titles for all facilities.

## 4.2.12 Buyende District

Twelve health facilities visited: 2 HCIVs (Kidera, Bugaya), 4 HCIIIs (Buyende, Nkondo, Kakooge, Irundu), and 6 HCIIs.

| Best Practices — Buyende |
|---|
| • Kakooge HCIII and Nkoone HCII identified as centers of excellence — well-managed OPD, labs, drug stores, and maternity wards. |
| • District conducts regular monitoring visits and has evidence of stern administrative action against errant staff. |
| • All 12 visited facilities display released funding amounts for public viewing. |

### Key Findings

- Considering only government health workers, overall staffing at 53% — significantly higher than other monitored districts.
- Both HCIV Medical Officer positions are vacant and filled by volunteer doctors; recruitment process ongoing.
- No notable discrepancies in medicines management at any Buyende facility — a significant achievement.
- Kidera HCIV conducted 70 caesarean sections in 10 months by volunteer Dr. Mutaka Joel.
- None of the 12 facility in-charges could confirm land title status for their facility.

## Leadership and Governance

- **Oversight and Monitoring:**
  - The Chief Administrative Officer's (CAO) office and the District Health Officer (DHO) have made moderate efforts to combat absenteeism within the health department.
  - It was observed across all visited facilities that the district leadership conducts regular monitoring visits.

- Written reports from supervisors (support supervision book) were available at all visited facilities, indicating a system of supervision is in place.
- There is evidence of stern administrative action being taken against errant staff.

- **Financial Accountability and Transparency:**
  - Availability of funds accountability records was confirmed at eleven out of the twelve facilities visited. Nkondo HCIII lacked records, and those available were grossly inaccurate.
  - Poor or lack of Primary Health Care (PHC) funding accountability records was noted as a challenge.
  - Audited accountability records were only available in two of the twelve facilities. The majority had not been audited for the previous two quarters.
  - All twelve facilities displayed the released funding amounts for public viewing.
  - However, none of the twelve facilities displayed their financial accountabilities for public viewing.

## Human Resources for Health

**Staffing Levels:**

- Generally, the visited facilities are well-staffed.
- The district has substantial District Health Team (DHT) Officers: District Health Officer (DHO), Assistant District Health Officer – Maternity and Child Care (ADHO – MCH), Assistant District Health Officer – Environment Health, and a Biostatistician.
- Considering only government health workers, the overall staffing level at visited facilities was 81%.
- The district utilizes many volunteers of various cadre levels, boosting the active workforce. This results in staffing levels exceeding 100% at some facilities (e.g., Mpunde HCII has at least two volunteer Midwives alongside government staff).

*Table showing staffing levels at the visited facilities as a percentage of the approved norms*

| No. | Name of facility | Approved Positions | Filled Positions | Gap |
|---|---|---|---|---|
| 1 | Kidera HCIV | 48 | 34 | 14 |
| 2 | Bugaya HCIV | 48 | 16 | 32 |
| 3 | Buyende HCIII | 19 | 10 | 09 |
| 4 | Nkondo HCIII | 19 | 13 | 06 |
| 5 | Kakooge HCIII | 19 | 08 | 11 |
| 6 | Irundu HCIII | 19 | 14 | 05 |
| 7 | Bukungu HCII | 05 | 02 | 03 |
| 8 | Mpunde HCII | 05 | 1 | 04 |
| 9 | Nkoone HCII | 05 | 1 | 04 |
| 10 | Ikanda HCII | 05 | 1 | 04 |
| 11 | Kagulu HCII | 05 | 05 | 0 |
| 12 | Namusikizi HCII | 05 | 02 | 03 |
| | **Total Staffing** | **202** | **107** | **95** |
| | | | **53%** | **47%** |

**Vacancies and Recruitment:**

- Both Medical Officer positions (one per HCIV) are vacant.
- These positions are currently filled by two volunteer doctors.
- An ongoing recruitment process aims to regularize these positions.

**Staff Conduct and Management:**

- Duty rosters were present in all health facilities.
- No staff with salary issues were identified in the entire district health service.
- Staff in most health facilities were found in incomplete uniforms or no uniform at all, and without name tags.
- Organized absenteeism was observed at Buyende HCIII, where staff listed on the daily duty roster were absent.
- Instances of errant staff were noted, such as the two staff members at Bugangari HCIV detained for neglect of duty.

## Health Service Delivery

**General Observations:**

- All health facilities were running busy Out-Patient Departments (OPDs), despite shortages of supplies and sundries.
- Kidera HCIV recorded the highest OPD attendances, followed closely by Bugaya HCIV, suggesting a high disease burden in these areas.

**Centers of Excellence:**

- Kakooge HCIII and Nkoone HCII were identified as centres of excellence within the district regarding service delivery and stewardship.
- Their OPD structures, laboratories, examination rooms, injection rooms, and drug stores were well-managed. Staff quarters were very clean, and drug accountability using issue and requisition books was perfect. Their maternity wards were well-managed with all records available.

**Out-Patient Department (OPD):** Functionality was assessed at each visited facility. (Specific functionality details beyond being "busy" are integrated into general observations and centers of excellence).

**In-Patient Department (IPD):**

- All HCIIIs and IVs had fully operational and functional IPDs.
- However, the IPD at Irundu HCIII is heavily congested, with males, females, and children sharing space.

**Maternity, Antenatal Care (ANC), and eMTCT Services:**

- The number of women who ever attended ANC was significantly higher than the number of deliveries across the visited facilities.
- Potential reasons for this discrepancy include client satisfaction gaps, lack of motivation to deliver at the health facility, and utilization of private facilities or traditional birth attendants.

**Caesarean sections:**

- Both HCIVs visited performed caesarean deliveries during the review period.
- These operations are predominantly conducted by volunteer doctors, with the DHO occasionally performing operations at Bugaya HCIV.
- Kidera HCIV conducted 70 caesarean sections in the last 10 months, performed by Dr. Mutaka Joel (volunteer doctor).
- Fewer sections were performed at Bugaya HCIV by Dr. Mulungi Joshua (volunteer doctor) and the DHO, attributed to the lack of a theatre, which was only recently operationalized.

## Essential Medicines and Health Supplies (EMHS)

- **Availability and Management:**
- All health centres visited had drug stores.
- Facilities acknowledged massive stockouts of essential medicines and other supplies, attributed to delays in delivery from National Medical Stores (NMS).
- No notable discrepancies in medicines management were observed at any facility in Buyende District.

## Infrastructure and Equipment Management

**Land and Fencing:**

- All HCIIIs and HCIVs visited were fenced.
- Most HCIIs remain unfenced.
- All 12 facility in-charges and respondents lacked knowledge regarding whether their facilities possess land titles. They were mostly aware of an ongoing district process to title health facility land.
- No facility reported land encroachment issues. Communities in some areas (e.g., Ikanda HCII, Nkoone HCII, Kakooge HCIII) have mobilized to acquire more land for the facilities.

**Equipment:**

- Only one facility (Kakooge HCIII) out of the twelve visited had an updated Equipment Inventory Book. Others had undated and unreliable inventory records.
- Most government and donated equipment in the facilities were not engraved, increasing the risk of theft.

**Staff Accommodation:**

- Most health facilities reported inadequate staff accommodation as a contributing factor to late reporting and early departures from duty.
- Existing staff houses are generally in good condition but are few in number and typically occupied only by critical clinical staff.

**Construction and Renovation:**

- Ongoing construction works are expanding some facilities (e.g., Bukungu HCII, Irundu HCIII).
- Construction of maternity wings was noted at Kakooge HCIII and Nkondo HCIII.
- At Buyende HCIII, the UPDF handed over a newly constructed OPD block.

**Vehicle Management:** A pick-up vehicle (double cabin, originally for COVID response) designated for the district health department is being used by the district LCV Chairman.

## Public Engagement and Dissemination

**Dissemination Meeting:**

- The Health Monitoring Unit (HMU) convened a meeting with district stakeholders at the district headquarters.
- Findings were disseminated during this meeting.
- Corrective measures were recommended to address identified gaps, with responsibilities assigned to different centres.

**Community Dialogue (Baraza):**

- To enhance accountability, the HMU facilitated a community dialogue (baraza).
- The Resident District Commissioner (RDC), Deputy Chief Administrative Officer (DCAO), and District Health Officer (DHO) were invited to respond directly to public questions. The dialogue, held near Bugaya HCIV, was well-attended by community members, including Councillors, LC1 chairpersons, senior citizens, and clergy from surrounding parishes.
- The HMU team briefed attendees on its activities in the district and shared preliminary findings.
- The role of ordinary citizens in ensuring effective health service delivery was emphasized.

**Pictorial:**

*Tricycle motor ambulance at Nkoone HCII*

*Ongoing expansion works at Bukungu HCII*

*OPD block construction at Buyende HCIII.*

*Health worker interaction at Kidera HCIV*

### Recommendations — Buyende

- Regularize volunteer doctor positions through formal recruitment to ensure sustainability.
- All facilities to process land titles — district-level process to be expedited.
- Continue construction of maternity wings at Kakooge and Nkondo HCIIIs.

## 4.2.13 Nwoya District

**Seven health facilities were visited:** Anaka General Hospital, Alero, Koch Goma, Koch Li, Paraa, Purongo, Todora HCIIIs.

**FINDINGS**

## Leadership and Governance

### Leadership Strengths and Challenges

- The Health Unit Management Committee (HUMC) Chairman at Koch Goma HCIII demonstrated strong leadership, effectively guiding staff, including the in-charge.

*Health Unit Management Committee Chair, Koch Goma HCIII*

- The substantive District Health Officer (DHO) position has remained vacant since 2021, following Dr. Janet Oola's passing.
- Dr. Joseph Arike, currently serving as acting DHO, faces concerns regarding his integrity having been recruited while on interdiction in Obongi District Local Government.
- Additionally, strained working relationships among the DHO and two Assistant DHOs have negatively impacted service delivery.
- During the visit, leadership absenteeism and weak supervision were observed: the Acting DHO was absent due to unapproved exam leave, the ADHO for Maternal and Child Health (MCH) was on leave, and the ADHO for Environmental Health was absent without explanation.
- A caretaker officer with limited administrative experience managed DHO duties in their absence.
- Supervision from the DHO's office and the District Health Management Team (DHMT) lacked structure and actionable follow-ups, as evidenced by unaddressed medicine shortages despite visitor books being signed.

### Recruitment and Deployment Irregularities

- The recruitment of the Acting DHO as Principal Medical Officer from Obongi District is under Criminal Investigations Directorate (CID) investigation, with concerns over a questionable release letter.
- Additionally, irregularities in staff deployment were noted, with potential interference from the Chief Administrative Officer's (CAO) office in the District Service Commission's work.
- At Anaka General Hospital, the current Hospital Administrator Ms Nakyanzi Proscovia was allegedly recruited irregularly as a Community Development Officer without interviews and later reassigned to the administrator role while still on probation, yet with different job descriptions and competencies contrary to public service regulations.
- This matter is currently under investigation at by HMU CIDs.

## Finance and Accountability

- A Land Cruiser, registration number M/V LG 0048-71, was found missing but traced to a Gulu garage, where it has remained since 2022 with an escalating repair cost now estimated at UGX 70 million, raising concerns of mismanagement.
- Koch Goma HCIII lacks connection to the national electricity grid due to procurement delays, despite budget allocations for the project in Fiscal Year (FY) 2023/24.
- Some staff allege that the management of Anaka General Hospital prefers to use the diesel generator over electricity to account for money budgeted for fuel for the generator and the Hospital Ambulance.

# Human Resources for Health

### Staffing Levels and Gaps

- There is a staffing gap of 39% across government health facilities.
- Paraa HCIII has the lowest staffing level at 7% (4 out of 55 positions filled), while Koch Goma HCIII has the highest staffing among HCIIIs at 35% (19 out of 55 positions filled).
- Anaka General Hospital has a staffing level of 45%, highlighting the ongoing need for recruitment.
- Detailed staffing levels for various facilities are provided in the table below:

| S/N | Facility | Approved Positions | Filled Positions | Percentage Staffing |
|---|---|---|---|---|
| 1 | Anaka General Hospital | 343 | 156 | 45 |
| 2 | Alero HCIII | 55 | 14 | 25 |
| 3 | Koch Goma HCIII | 55 | 19 | 35 |
| 4 | Koch Li HCIII | 55 | 12 | 22 |
| 5 | Paraa HCIII | 55 | 4 | 7 |
| 6 | Purongo HCIII | 55 | 16 | 29 |
| 7 | Todora HCIII | 55 | 15 | 27 |
| 8 | Panokrach HCII | 8 | 5 | 63 |
| 9 | Latoro HCII | 8 | 8 | 100 |
| 10 | Kibar HCII | 8 | 7 | 88 |
| 11 | Langol HCII | 8 | 8 | 100 |
| 12 | Lulyango HCII | 8 | 5 | 63 |
| 13 | Coo-Rom HCII | 8 | 4 | 50 |
| 14 | Oruka HCII | 8 | 6 | 75 |
| 15 | Aparanga HCII | 8 | 5 | 63 |
| **Total Staffing** | | **737** | **284** | **39** |

- **In-charge Attendance to Duty**

| Health Facility | In-charges attendance in two months (days) | Remarks |
|---|---|---|
| Alero HCIII | 36 (78.26%) | Above average |
| Koch Goma HCIII | 39 (84.78%) | Very Good |
| Koch Li HCIII | 30 (65.22%) | Average |
| Purongo HCIII | 40 (86.96%) | Above Average |

- In-charge attendance across visited health facilities varied over a two-month assessment period.
- Purongo HCIII recorded the highest attendance at 86.96% (40 days), followed by Koch Goma HCIII at 84.78% (39 days) and Alero HCIII at 78.26% (36 days).
- Koch Li HCIII recorded the lowest attendance at 65.22% (30 days), highlighting concerns over absenteeism.
- Absence was primarily attributed to additional district-level responsibilities and unsanctioned leave.

*Patients were observed stranded at Koch Li HCIII by 11:00 am with only two staff attending at the Outpatient Department (OPD), attributed to the in-charge's absence who claimed to have gone to get back statement, a non critical task.*

- **Staff Motivation:** Salary enhancements and timely payments motivated health workers, leading to increased delivery rates and high antenatal care (ANC) attendance across most facilities.

## Essential Medicines and Health Supplies (EMHS)

- Unaddressed medicine shortages were noted despite visitor books being signed by the supervisors from the district.
- Todora HCIII demonstrated gaps in essential medicines and health supplies management, including an untidy and disorganized drug store, excess medical supplies, missing stock cards, and a lack of proper shelving.

## Health Service Delivery

### Neonatal Intensive Care Unit (NICU)

- Anaka General Hospital has a neonatal unit with two rooms providing Neonatal Intensive Care Unit (NICU) services, which are functioning very well.

NICU is clean and well-manned by trained Midwives.

### Maternal Health Services

Key Maternity Indices summarized in the table for facilities monitored.

| Key Maternity Indicators (May–October 2023) | Anaka GH | Alero HCII | Koch Goma HCII | Koch Li HCII | Paraa HCIII | Purongo HCIII | Todora HCII | Total |
|---|---|---|---|---|---|---|---|---|
| 1st ANC attendance | 1,225 | 457 | 694 | 829 | 0 | 375 | 228 | **3,808** |
| 4th ANC attendance | 851 | 348 | 353 | 467 | 0 | 211 | 142 | **2,372** |
| Maternity Admission | 2,327 | 382 | 531 | 487 | 0 | 416 | 160 | **4,303** |
| Delivery in Facilities | 1,438 | 307 | 319 | 349 | 0 | 215 | 110 | **2,738** |
| Fresh Still Birth | 7 | 0 | 2 | 0 | 0 | 0 | 0 | **9** |
| Maternity Referral in | 101 | 0 | 1 | 0 | 0 | 12 | 0 | **114** |
| Maternity Referral Out | 6 | 71 | 124 | 43 | 0 | 64 | 32 | **340** |
| Caesarean sections (June–November) | 215 | - | - | - | - | - | - | **215** |

- No maternal deaths were recorded across all visited facilities during the assessment period, reflecting success in maternal health service delivery.
- The Private Wing, Operating Theatre, and Maternity Units at Anaka General Hospital were clean, efficient, and delivered high patient volumes, including 215 caesarean sections in six months.
- The Caesarean section rate at Anaka General Hospital stands at 14.95% (215 out of 1438 deliveries) which is slightly below the WHO recommended of 20-25%.
- However, the overall district rate is likely lower, as Anaka General Hospital is the only facility providing caesarean sections.
- Anaka General Hospital effectively manages referrals for pregnant mothers, with 101 incoming referrals compared to only six outgoing referrals over six months implying good handling of incoming referrals as well as managing cases effectively at the facility.
- Paraa HCIII exists only nominally — offering no inpatient, maternity, or antenatal care services. Only two clinical staff manage OPD cases, representing a wasteful misuse of government investment in a fully designated HCIII.

*L- Excellent Maternity Ward at Koch Li HCIII*

*R- Newly constructed maternity block at Koch Li HCIII*

## Outpatient Department (OPD) Functionality

- All visited health facilities had functional and busy Outpatient Departments (OPDs).
- Anaka General Hospital stood out for its well-organized OPD, characterized by clear patient flow and a clean environment.
- However, at Anaka General Hospital and Todora HCIII, motorbikes were found occupying OPD spaces even during patient consultations, raising concerns about space utilization and infection control.

*(L) Motor bikes being kept at OPD in Todora HCIII  Motor bikes at Anaka GH OPD block (R)*

- Furthermore, service delivery at the OPDs of Paraa, Todora, and Purongo HCIIIs was found to be suboptimal, marked by low patient attendance and poor staff commitment.

## In-Patient Departments (IPDs)

- Paraa and Todora HCIIIs did not have functional In-Patient Departments (IPDs), effectively operating as Health Centre IIs (HCIIs).

## Surgical and Blood Transfusion Services

*Anaka GH Theatre, well set and equipped*

*Committed and competent Anaesthetists on duty*

- Anaka General Hospital remains the only facility offering major surgical operations and blood transfusions in the district.
- Between May and October 2023, 240 units of blood were transfused out of 437 requested, with shortages in June and September necessitating referrals to Gulu Regional Referral Hospital.
- Over six months, the hospital performed 309 major surgeries, excluding caesarean sections, primarily consisting of Laparotomies and Herniorrhaphies.

### Laboratory Services

- Anaka General Hospital demonstrated excellence in laboratory services, featuring well-equipped facilities, skilled staff, and an organized results dispatch system.
- The hospital's laboratory is well-equipped and organized, with clear sample processing systems and adequate reagents.

*L Dedicated laboratory staff at Anaka General Hospital*


*R Laboratory pigeon holes for results dispatch*

*Well arranged laboratory workstation at Anaka General Hospital*

## Infrastructure and Equipment Management

### Construction and Maintenance Issues

- Purongo and Todora HCIIIs had stalled constructions and renovations.
- Alero, Koch Goma, and Todora HCIIIs had unkempt and bushy compounds and broken fences, posing health and safety risks that require regular maintenance.
- None of the facilities visited had land titles.
- Purongo HCIII infrastructure is inadequate, with an incomplete general ward, a dilapidated Outpatient Department (OPD) block, and a vandalized fence compromising security.
- Araa HCIII, located within Murchison Falls National Park, has excellent infrastructure and equipment but remains grossly underutilized due to manpower shortages.

### Utilities and Space

- Water shortages persist at Alero, Koch Goma, Todora, and Paraa HCIIIs.
- Laboratory spaces at the six Health Centre IIIs (HCIIIs) were found to be small, with irregular water supply identified as a key challenge.

### Asset Management

- Todora HCIII has multiple infrastructure and equipment gaps, including unengraved assets, a lack of proper shelving, running water, and laboratory equipment, all requiring urgent corrective actions.

## Recommendations

- To address the persistent water shortage in Anaka General Hospital, the Health Monitoring Unit (HMU) audit team should conduct an analysis of the cost of pumping water, comparing the use of the diesel generator versus UMEME electricity. This analysis may help to establish facts, as some staff allege that management prefers to use the diesel generator to account for money budgeted for fuel for the generator and the Hospital Ambulance.

- Further investigations should be conducted to establish why the hospital Land Cruiser Reg. No. LG 0048-71, which was in fair mechanical condition, was taken and abandoned in Rescue Motors (U) Ltd garage in Gulu City.
- The Chief Administrative Officer (CAO) Nwoya District Local Government (DLG) should prioritize the acquisition of land titles for all health facilities under its jurisdiction.
- The District Health Officer (DHO) should ensure that all in-charges of facilities have all their equipment engraved.
- The DHO/CAO should explain the current arrangement between the district and Green Label company, which is supposed to collect hazardous medical waste from all health facilities but has not been doing so recently.
- The District Local Government (DLG) should prioritize the construction of permanent staff houses, especially in Koch Li HCIII, where the majority of staff sleep in temporary grass-thatched structures.
- District authorities should implement measures to curtail theft and vandalism of facility infrastructure, such as fences, as observed in Koch Goma HCIII and Alero HCIII.
- Facilities that are not fenced should be prioritized during budgeting. A case in point is Paraa HCIII, where staff are exposed to the threat of wild animals due to a lack of fencing.
- Provision should be made for the staff and patients of Alero HCIII to access and utilize water from the new solar water project, which is currently underutilized despite high demand.

*Staff at Todora HCIII being addressed by the In-charge to implement HMU finding recommendations*

### 4.2.14 Gomba District

**Ten Health facilities visited;** Maddu HCIV, Mamba, Kifampa, Kyaayi, Kisozi, Ngomanene, Mpenia and Kanoni HCIIIs, Buyanja HCII and Canaan Medical Clinic (PFP).

**FINDINGS**

## Leadership and Governance

- The prolonged absence of the substantive District Health Officer (DHO) led disruptions in critical decision-making processes, impediments to the recruitment of critical personnel, inadequate technical support and resultant delays in the implementation of health service delivery projects, notably the construction of a new HCIII which faced delays despite available donated funds.

- The gaps in substantive leadership created operational disruptions directly affecting health service delivery in the district, deficiencies in health sector supervision practices and the associated reporting mechanisms, despite the utilization of support supervision funds. This inconsistency raised concerns about the effectiveness of the allocated resources in relation to the identified gaps in supervisory processes.

## Human Resources for Health

Staffing norms per facility monitored

| Health Facility | Ownership | Number Approved | Positions Filled | % Staffing |
|---|---|---|---|---|
| Maddu HCIV | Government | 130 | 29 | 22% |
| Kisozi HCIII | Government | 55 | 11 | 20% |
| Kifampa HCIII | Government | 55 | 14 | 25% |
| Kyaayi HCIII | Government | 55 | 14 | 25% |
| Mamba HCIII | Government | 55 | 11 | 20% |
| Mpenja HCIII | Government | 55 | 14 | 25% |
| Kanoni HCIII | Government | 55 | 19 | 35% |
| Ngomanene HCIII | Government | 55 | 15 | 27% |
| **Total** | | **515** | **127** | **25%** |

- Critical understaffing for both the district health team and lower health facilities; staffing levels stood at 28% (164 out of the approved 578 positions) filled. This shortage was primarily attributed to the inadequate wage at the district level, the government's ban on recruitment and the extended absence of the substantive DHO, who had been on unsanctioned study leave for over 4 years.
- Lack of critical cadres;
- No radiographers despite having all the necessary equipment available in all facilities.
- Apart from Kanoni HCIII which had 5/9 midwives' positions filled, the rest of the HCIIIs had 2/9 midwives' positions filled.
- Maddu HCIV had 26% (12/30) critical cadre positions filled; 1/5 anaesthetic officers, 1/3 theatre assistants, 1/4 medical officers, and 5/18 midwives.
- Gross absence from duty by the in charges was observed, abuse of attendance registers where some In charges asked askaris to sign for them, some signed in margins while some signed twice on the same days thus affecting facility performance. Absentee In charges had the poorest performing facilities.
- Most In charges attendance to duty in the last two months was far below the recommended minimum of 15 days per month by the public service standing orders; Kisozi HCIII (36 days), Kyaayi HCIII (24 days), Maddu HCIV (20 days), Mamba and Mpenja HCIIIs (17 days), Kanoni HCIII (16 days), Ngomanene (15 days) and Kifampa (10 days).
- No updated duty rotas in most facilities making it difficult to analyse and track staff attendance. Attendance books were in use but were being carelessly signed, abused and poorly managed. Some staff collaborated to sign in for absentee colleagues.
- Majority of the staff present at facilities visited were not in uniform. Other concerns were raised regarding the attitudes and behaviour of health workers, particularly evident during waiting lines at OPDs, gaps in monitoring of mothers in labour and general lack of health worker supervision.
- Apart from Kanoni HCIII, there were low OPD numbers and low deliveries with none of the facilities meeting set targets.
- Rampant issues of extortion and poor quality of care of patients at Maddu HCIV which couldn't be proved during the visit.
- Most health facilities had provisions for accommodating critical staff, with well-maintained units that were fully occupied. However, one staff unit at Maddu HCIV was temporarily occupied by a non-staff member.
- The HMU compelled this individual to immediately vacate the premises as an intervention. Mpenja HCIII's staff accommodation units were situated in the UNRA's road reserve and the staff had been instructed to vacate these premises.

### Recommendations

- CAO to advocate for increased wage to implement new staffing structures.
- CAO to fast track the recruitment of Medical Officers at Maddu HCIV.
- CAO to sanction the absentee District Health Officer, absentee health facility In charges, and other errant health workers in accordance with the Public Service Standing Orders.
- CAO to fast track the recruitment of radiographers at Maddu HCIV, Kisozi HCIII and Kanoni HCIII.
- District leadership to implement targeted recruitment for critical cadres at all facilities.

- Develop and enhance capacity building programs for both Assistant Nursing Officers in Midwifery and Enrolled Midwives. For example, continuous education and dissemination of standards and guiding protocols and key resource materials; skills development; and opportunities for specialization need to be supported.
- DHT to supervise and emphasize government guidelines on professionalism and wearing uniforms.
- DHO to ensure that all staff have name tags printed on their uniforms.
- CAO to advocate for the construction of more staff houses to address housing shortages.
- DHT to enhance support supervision activities to the lower health facilities.

## Finances and Administration

- A review of financial expenditures and accountabilities for DHO's office for the FYs 2021/2022 and 2022/23 revealed UGX 276,980,198 that was unaccounted for and or insufficiently accounted for.
- A review of financial expenditures and accountabilities for Maddu HCIV for the FY 2022/23 and Quarters 1 & 2 of FY 2023/24 revealed UGX 65,400,000 unaccounted for, with missing payment vouchers, UGX 173,718,400 that was unaccounted for and or insufficiently accounted for.
- There was no evidence of the Internal Auditor reviewing the documents most especially at Maddu HCIV.
- Financial document filing was thorough — a commendable effort by the two accountants.

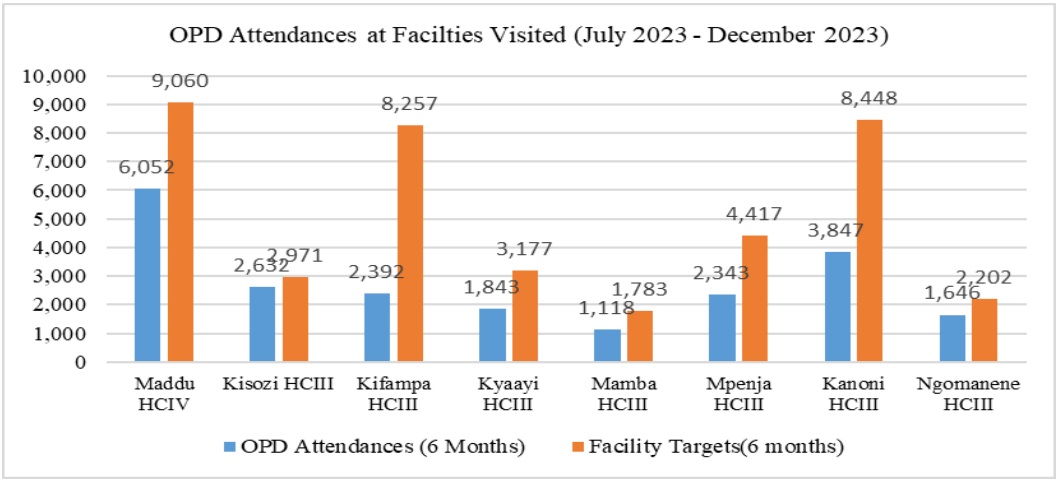
## Health Services Delivery

- All health facilities visited had functional outpatient departments (OPDs). However, Kyaayi HCIII's OPD had no waiting shade / sitting space.
- Most laboratories at HCIIIs were non-functional.
- At Kanoni HCIII, patients were being clerked by a nursing assistant.
- All HCIIIs had no functional Inpatient Departments (IPDS).
- Maddu HCIV's IPD department averaged 10 patients a month. However, the ward was doubling as storage for expired medicines and sundries.
- All the facilities except Kisozi and Ngomanene HCIIIs had no emergency trays at OPD.
- All the health facilities monitored had no stretchers and wheelchairs at OPD.

Kyaayi HCIII OPD - No patient waiting area/space

Maddu HCIV – Dispensing Window

### OPD Attendances



- Over the last six months period, HCIIIs experienced an average of 2,700 attendances at the OPD. Notably, Kanoni HCIII recorded the highest attendance with 3,847 visits, while Kyaayi HCIII exhibited the lowest attendance of 1,843 visits.
- The above data reveals a general underperformance across all facilities when compared against the predetermined facility targets. This was attributed to; understaffing, chronic absenteeism of existing staff, poor quality of care for example chasing away of patients and instances of extortion, particularly at Maddu HCIV.
- The poor OPD performance of Kyaayi HCIII can be characterized as a critical situation requiring immediate interventions. The challenges faced by Kyaayi HCIII included issues related to staff absenteeism, negative staff attitudes, and substandard infrastructure.

## Laboratory Services

- Only Maddu HCIV had a fully functional and well-equipped laboratory.
- All HCIIIs had inadequate and improvised laboratory spaces, no equipment, with various cases of redistribution of drug kits.
- All HCIIIs lacked most of the automated or powered equipment such as CBC machines, electric haemoglobin meter, and centrifuge, among others.

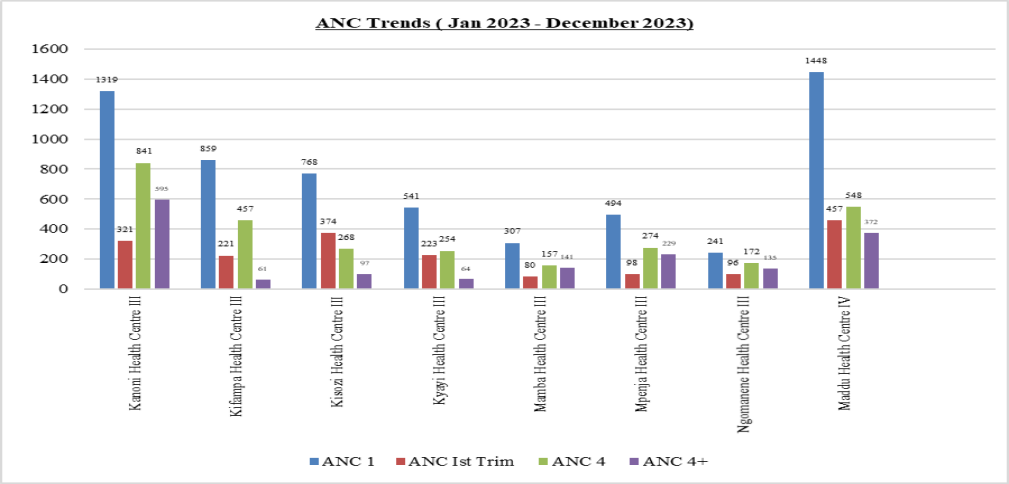
## IPD facilities and functionality

- Despite the Ministry of Health (MoH) providing beds and medicines, all HCIIIs lacked functional IPDs.
- Most facilities were unable to account for IPD medicines, suggesting mismanagement and theft.
- IPD admissions in HCIIIs revealed a trend of two-hour admissions, raising concerns about misuse of services and inefficiencies in patient intake and discharge processes coupled with increased scheduled absenteeism among staff claiming night duty.
- HCIIIs with non-functional IPDs were essentially shifting the burden to higher-level facilities, such as general hospitals (GHs) and HCIVs. This congestion leads to the depletion of supplies in these facilities.

## Maternal Child Health Care (MCH) Services

- Only Maddu HCIV provides emergency obstetric services (EMOC) in the entire district.

### *Antenatal Care Services (ANC)*



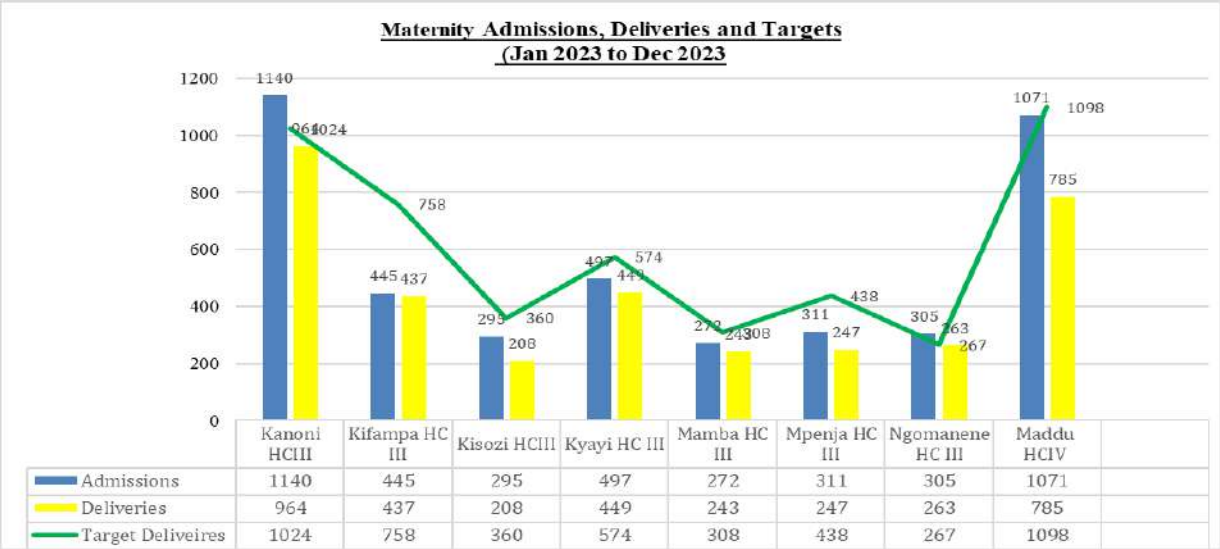

The trends in access to ANC services indicate that:

- Facilities unaware of ANC targets, not displayed at any facilities, the ones displayed were outdated.
- The district should formulate strategies aimed at enhancing ANC coverage, particularly during the 1st trimester. This emphasizes the necessity for targeted interventions to boost ANC utilization and encourage holistic care.

**Recommendations:**

- Recruit a radiographer for Kisozi HCIII and Maddu HCIV who have sonography machines.
- Procure a sonography machine for Kanoni HCIII which registered the highest ANC Attendances.
- ADHO MCH to construct a sluice room and toilet block at Maddu HCIV maternity.

### *Maternity Admissions, Deliveries & Referrals*




- All facilities did not meet their delivery targets. The inability to meet targets was attributed to population attitudes to some government facilities, mainly due to staff absenteeism, patient extortion, medicines stockouts and some facilities completely abandoned by staff on several instances (Kyaayi and Kifampa HCIIIs).
- Variances in admissions versus deliveries were identified. The highest variance of 29% at Kisozi HCIII was primarily attributed to malaria in pregnancy and the distance to the facility. Maddu HCIV exhibited a variance of 27%, with key contributing factors being extortion, malaria in pregnancy, women's preference to avoid returning, opting for private healthcare (specifically Kayanja Medical Centre), and referrals to other hospitals. At Mpenja HCIII, the 21% variance was attributed to malaria in pregnancy and medicine stockouts.

### *Referral Patterns IN and Out- January 2023 to December 2023*

- A total of 783 incoming referrals were received across the facilities compared to 523 outgoing referrals from the facilities.
- Majority of referrals at Maddu HCIV & HCIIIs were directed to Gombe, Mubende, and Ssembabule Hospitals, all situated more than 70 kilometres away.
- The district urgently needs an ambulance.
- Maddu HCIV referred out 182 patients despite having a fully functional theatre, Anaesthetic Officer, and a Medical Officer.

### *Maternity Infrastructure*

- Maddu HCIV Maternity: This multitasks as the Antenatal Care (ANC) room, labour room, Postnatal Care (PNC) room and immunization room and has a total of 8 beds creating overcrowding.
- Significantly, the maternity block lacks a sluice room, posing a notable gap in essential hygiene infrastructure.
- Mothers within this unit currently share a single toilet and bathroom with all patients across the facility in very unhygienic conditions which compromised their health standards in addition to the water shortage in the district.
- Kyaayi HCIII: The dilapidated OPD lacks waiting space, while the unfinished immunization shade doubles as storage room and an animal shelter. The labour suite doubled as a store for files. The only PNC room had no windows leaving no ventilation for mothers and new-borns.
- Termites, bats, and general neglect plague the facility and in general the facility had no IPC practices in place.

### *IPC Practices at all maternity facilities*

- Severe water crisis impacting essential hygiene practices and creating dangerous gaps in infection prevention and control (IPC) and facilities resorted to buying or fetching water, often placing the financial burden on patients.
- Majority of facilities lacked dedicated hand-washing stations. Maternity wards were unclean and sluice rooms which are crucial for cleaning medical equipment, were either non-existent or being used for storage.

### *Use of Partographs*

- Only Ngomanene HCIII consistently used partographs for monitoring mothers in labour.
- Non-partograph usage was attributed to the lack of readily available partograph forms, none or malfunctioned photocopy machines, coupled with insufficient funds for copying while some midwives expressed reluctance to use partographs due to unfamiliarity and time constraint.
- In the period between Jan 2023- Dec 2023, four fresh stillbirths and nine Macerated stillbirths occurred in the entire district. However, there were no death audit reports.

  **Recommendations:** To address gaps in the quality of care revealed by fresh stillbirths, health facilities should actively use perinatal death audit reports, focusing on timely monitoring of deliveries and addressing the delays. For macerated stillbirths indicating ANC service gaps, enhancing ANC quality is crucial through health education.

### *Theatre*

- The theatre was adequately equipped and sustained by rainwater during the wet season but lacked running water in the dry season. Despite being the only theatre in the district, it was underutilized and idle most of the time, attributed to persistent absence of the Medical Officer and understaffing.
- In the period between Jan 2023- Dec 2023, Maddu HCIV conducted 34 Caesarean section deliveries.

### *Canaan Medical Clinic*

- A privately-owned facility supervised by Dr. Kyakulaga Kayembe Moses unearthed numerous deficiencies and potential safety hazards. The facility operated with an expired license and lacked the requisite staff; Enrolled Midwives, Clinical Officers, and Anaesthetic Officers.
- The improvised theatre room lacked essential equipment like an anaesthetic machine, life support monitors and proper sterilization measures thus fundamentally unsuitable for surgical procedures.
- The inappropriate use of the theatre room as a labour suite highlighted a complete disregard for basic standards of patient care and infection control. The absence of a designated maternity area, combined with the improperly located and unscreened placenta pit, further jeopardized the safety of mothers and newborns.
- The facility completely lacked running water, soap, and hand sanitizers representing a critical breach of fundamental hygiene protocols, placing patients and staff at significant risk of infections. The inadequate medical waste management, involving unsafe burning and burying practices, posed a serious environmental and public health threat.



### HMU Intervention

- The HMU's intervention led to the closure of the facility by the district authorities.
- The Uganda Police arrested the proprietor, Dr. Kayanja to ensure accountability while critical issues were addressed.

### *Recommendations*

- Advocate for functionalizing of IPDs at HCIIIs, with wards, and requisite human resources.
- DHT to functionalize IPC Committees across all health facilities.
- DHT and DISO to establish mechanisms to monitor and address extortion.
- Streamline duty rosters across all facilities, requiring submission to the District Health Office (DHO) for transparency and improved workforce management.
- Staff transfers for those that have over stayed at certain work places e.g. the In-charge at Kifampa HCIII.
- Provide administrative training for In-charges and store managers to equip them with the necessary skills and ensure compliance with MoH guidelines on volunteer usage.

## Essential Medicines & Health Supplies

- Only 4/6 cycles were delivered by NMS thus the rampant stockouts in health facilities affecting the quality and consistency of health service delivery. Medicines and sundries worth **UGX 75,709,042** were not delivered in the previous financial year.
- A medicines audit of Ceftriaxone injection and artesunate at Maddu HCIV **revealed losses worth UGX 1,070,000** attributed to deliberate falsifications that were uncovered in entries on stock cards and issue and requisition vouchers.
- All facilities with the exception of Mpenja HCIII, Kifampa HCIII and Kanoni HCIII, had functional digital thermometers, with daily temperature logs.
- Poor handling of expired medicines in most facilities as they could easily be found in the compound, accessible to the general public.
- Electronic Management Information Systems (EMIS): Aside from Kyaayi HCIII and Ngomanene HCIII, all the other facilities use RX solution for medicines management. Only Kifampa and Kanoni HCIIIs had updated RX solutions.

*Expired medicines on the door of a theatre in Maddu HCIV*

*Expired medicines dumped in IPD male ward*

**HMU Interventions**

- Police opened a case file against Namugerwa Caroline (the Assistant Inventory Management Officer - AIMO) attached to Maddu HCIV.
- Capacity building was done for all store personnel to ensure better stores management and proper documentation.

***Recommendations***

- Ensure completion of HMIS forms, i.e., Kifampa HCIII.
- Procure and install pallets to avoid having medicine boxes on the floor i.e., at Kisozi and Kyaayi HCIIIs.
- Ensure proper storage, record-keeping, and disposal of expired and unusable medicines and supplies.
- Deploy public servants to manage medicines stores in public facilities instead of IP and peer staff for easy accountability.
- Capacity building for stores personnel to equip them with supply chain management skills.
- Desist from receiving near-expiry medicine donations which in turn expire and burden the government in disposal, i.e., Kanoni HCIII.
- The DHO and DMMS to train the store personnel and In-charges on proper procedures for medicines redistribution as per the Ministry of Health guidelines.
- Health facilities to desist from conducting wasteful outreaches which result in rapid use of EMHS and thus long stockout periods, i.e., at Mpenja HCIII.

## Infrastructure and Equipment Management

- Buyanja HCII, Kyaayi, Mamba and Mpenja HCIIIs were not fenced.
- All facilities had not inpatient wards apart from Maddu HCIV.
- Only Kisozi HCIII had an updated inventory register.
- Only Mamba HCIII had a land title. Land encroachment was reported at Maddu HCIV, Kanoni HCIII and Buyanja HCII.
- There is no district ambulance.
- Obsolete/abandoned equipment at Kifampa HCIII; unused beds, mattresses, and other unsorted equipment.
- Mamba HCIII not connected to the national electricity gridline (UMEME).
- There were non-functional solar batteries at Maddu HCIV.

- None of the facilities in the district was connected to national water and sewage corporation (NWSC) gridline.
- There are no mortuary services in the entire district.
- Dilapidated Placenta pits at Kyaayi, Mpenja and Kanoni health facilities.
- Inadequate hand washing facilities across all health facilities in addition to spoiled floors in labour suites, rusty and soiled delivery beds, and improper management of sharps containers compromise infection control.
- The lack of designated cough corners and uncovered waste pits heightens the risk of spreading infectious diseases to the community.
- Bats were discovered at Kyaayi HCIII and Kifampa HCIII, birds found at Kyaayi HCIII, Kanoni HCIII, and Buyanja HCII. Whereas termites were unearthed at Kyaayi HCIII, and rats found at Kyaayi HCIII.

**Recommendations**

- Expedite land titling for all health facilities, resolve encroachment issues, and encourage fencing (natural or planted) to protect facility property.
- Engrave facility property with clear identification markings to avoid theft and vandalism.
- Allocate budget for ongoing facility maintenance, utilizing RBF funds where applicable. Prioritize specific renovations for Kyaayi HCIII and Maddu HCIV.
- Advocate for NWSC connection and prioritize power connection for Kifampa and Maddu HCIII.

**Public Engagement and Dissemination**

***Community Dialogue***

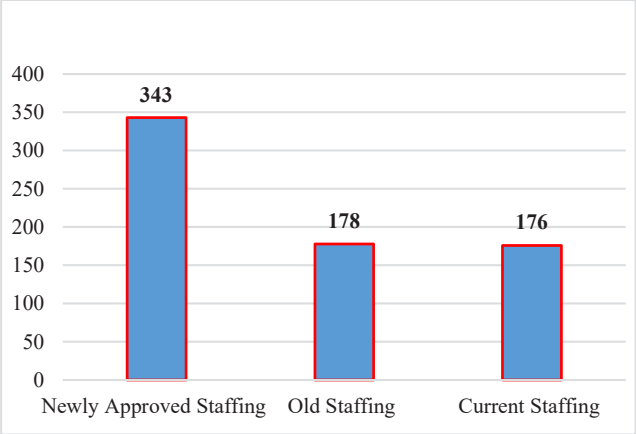
| Issue Raised | HMU Intervention/Response |
|---|---|
| Extortion by Health Workers | Capacity building of health workers, to reemphasize the need to offer free services in public facilities based on government guidelines. If caught, they will be prosecuted. |
| Absenteeism and abandoned facilities | To setup systems to apprehend errant officers. CAO and SACA teams to supervise attendance and sanction errant officers. |
| No medicines at facilities | Uganda Police arrested the store's manager at Maddu HCIV. |
| Chasing away of patients | Advised the public to be more vigilant and report cases to the police or call HMUs toll free line (0800200447). |
| Dr Kayanja – the community asked that he be forgiven and allowed to continue his operations. | The matter was in the hands of the law and HMU would do everything to support him to follow guidelines for him to be allowed to start operations. |
| Facility land encroachment issues. | Police case file on encroachment of land at Maddu HCIV was opened. CAO to follow up and evict land encroachers and expedite processing of land titles at the district and with Buganda Land Board. |

## 4.2.15 Mityana District

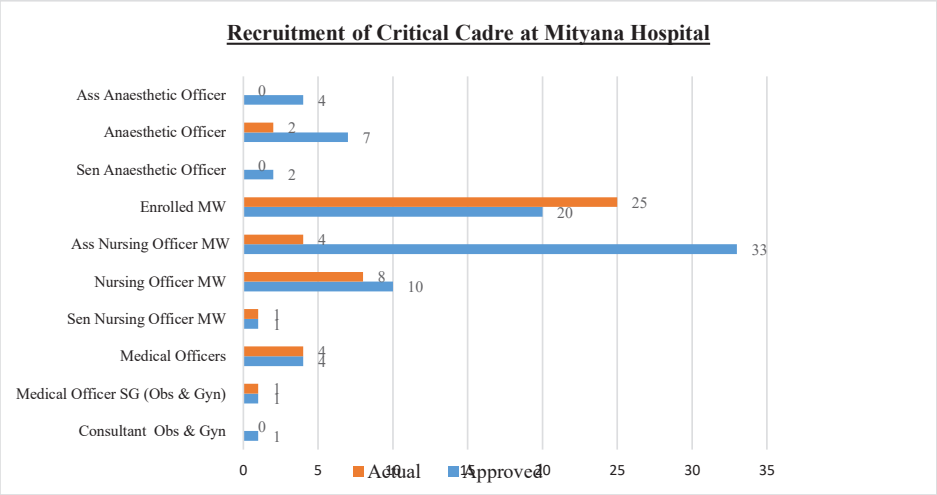
**1** Health Facility Visited, Mityana Hospital

## Human Resources for Health

**Overall Staffing Levels:** Mityana Hospital's staffing stands at 51% (176 filled positions out of 343) of the newly approved structure. While above average for general hospitals, this level is insufficient for the high patient volume (around 80,000 annually), particularly in the MCH department.




- **Critical Cadre Staffing:** Staffing for critical cadres is at 53% (45 filled positions out of 82). Advocacy for additional staff, especially in critical roles, is crucial.




- Duty rosters were outdated and inconsistently followed, making staff attendance difficult to track. Doctors worked an average of only 9 days per month, with some not reporting at all and department In-charges averaged 18 days off per month.
- Interns were left unsupervised in critical departments like NICU, labour ward, and casualty,
- The hospital relied on a sign-in book, but only support staff used it, biometric system was available but had been non-functional until HMU intervention restored it. Doctors scheduled their own workdays, with some failing to show up at all.
- Of 29 housing units, all were occupied, but only one doctor stayed in staff quarters, preferring private housing. Older staff houses were in poor condition, unkempt, and lacked security staff raised concerns about safety due to a lack of fencing.
- Interns and trainees struggled due to a lack of supervision, scheduled absenteeism and unapproved study leave contributed to the problem.
- Patients faced rude, disrespectful staff and long waiting times at OPD and maternity, unnecessary charges for government-provided medicines and supplies were reported. Extortion at casualty and theatre departments involved bribes as high as UGX 400,000 for surgeries and UGX 50,000 for emergency procedures.

## Essential Medicines and Health Supplies (EMHS)

**NMS Delivery Audit**

The NMS delivers EMHS to the General Hospital. However, it did not achieve the target per the budget in the two FYs reviewed. There is, however, notable improvement for this FY, which has significantly reduced stockouts in facilities.

| MITYANA GENERAL HOSPITAL | | | | |
|---|---|---|---|---|
| **FINANCIAL YEARS** | **BUDGET** | **WORTH OF EMHS DELIVERED (DN)** | **VARIANCE** | **BUDGET PERFORMANCE (%)** |
| **FY 2022/23** | 647,000,000 | 539,091,126 | 107,908,874 | 83.32 |
| **FY 2023/24** | 647,000,000 | 431,333,332 | 215,666,668 | 66.67 |
| **TOTAL** | 1**,294,000,000** | **970,424,458** | **323,575,542** | **75%** |

- Medicines Reconciliation Report In Mityana General Hospital (July 2022 –March 2024)A Review of selected items: Magnesium Sulphate 50%Inj 10ml vial, Tenofovir/lamivudine/dolutegravir TDF/3TC/DTG (90), Tenofovir/lamivudine/dolutegravir TDF/3TC/DTG (30), Ceftriaxone Inj, Artesunate Inj, Artemether/Lumefantrine, Mama Kits and Determine HIV test kit was done.
- Tenofovir/lamivudine/dolutegravir 300/300/50 mg-90T was not well accounted for and had a missing gap, worthy forty-seven million two hundred thirty-one thousand two hundred and sixty-four shillings only (47,231,264 UGX). The responsible personnel have been given time to account. Failure will result into continued investigation into the matter with intent to litigate.

**Pharmacy Storage Conditions**

- The hospital lacks an EMHS store.
- Limited storage space especially when NMS delivers two cycles at once
- urgent need to install HMIS
- Lack of fridge In EMHS store
- Failure to account for EMHS
- Part of the space used to store EMHS urgently needs partitioning

**Other Key Findings**

- The National Medical Stores (NMS) delivered enough supplies for two cycles simultaneously, overwhelming the hospital. The general hospital lacks a dedicated Emergency Medicines and Health Supplies (EMHS) storage area and cannot handle large volumes. Shockingly, they resorted to storing IV fluids and Mama Kits (maternal health kits) in public toilets!
- NMS deliveries no longer follow the established schedule, making it difficult for the hospital to predict when they will receive essential supplies.
- The oxygen plant at Mityana General Hospital is in dire need of maintenance. This is likely true for other facilities with similar oxygen equipment.
- The EMHS supply chain is understaffed and lacks sufficient support and technical personnel to manage operations effectively.

The EMHS- store shade before and after collecting back the MAAMA KITS & IV FLUIDS from public toilets.

Hospital lavatory and bathrooms in the maternity ward stuck with IV fluids and MAAMA KITS (Closed from public use)

The maternity ward lavatory of Mityana GH after removing IV fluids and MAAMA KITS is now ready for public use

## Health Service Delivery

OPD attendances surged to over 72,000, far exceeding the target of 35,000, leading to medicine stockouts and overworked staff.

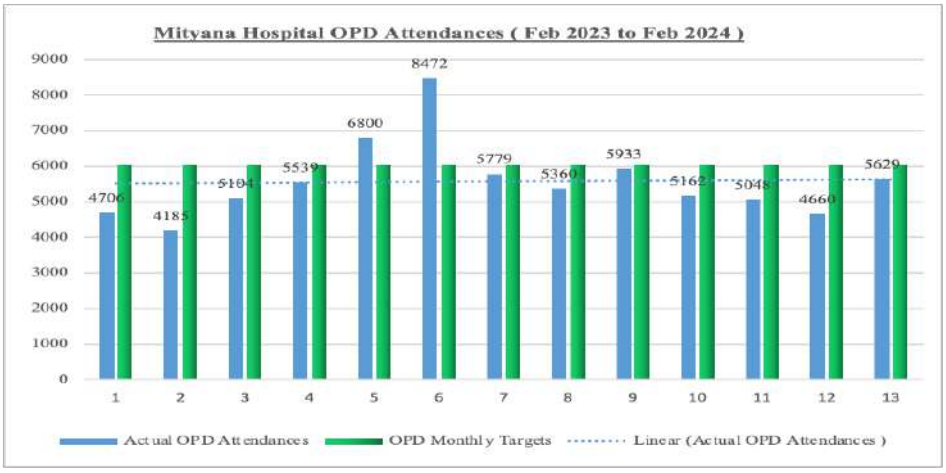



*Table showing OPD attendances at Mityana Hospital*

- Maternal and Child Health

ANC trends revealed a high uptake of ANC 1(3,268 attendances); there was a low uptake of ANC in 1st trimester (675 attendances), a vital period in which to access ANC services for better child outcomes. We recommend that the District formulate strategies to enhance ANC coverage, particularly during the 1st trimester.

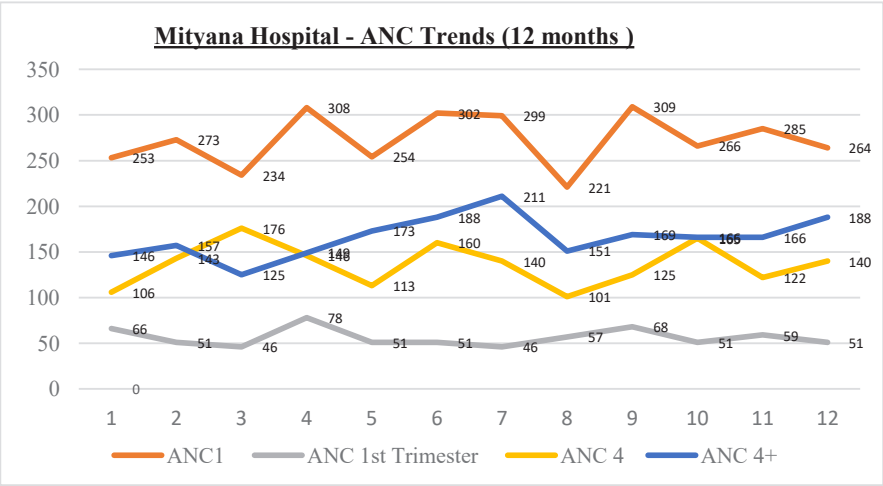
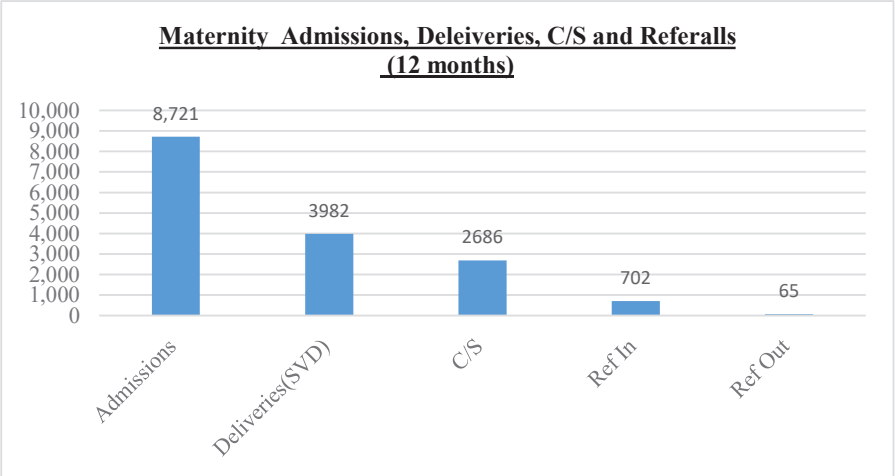



Table showing ANC attendance at Mityana Hospital

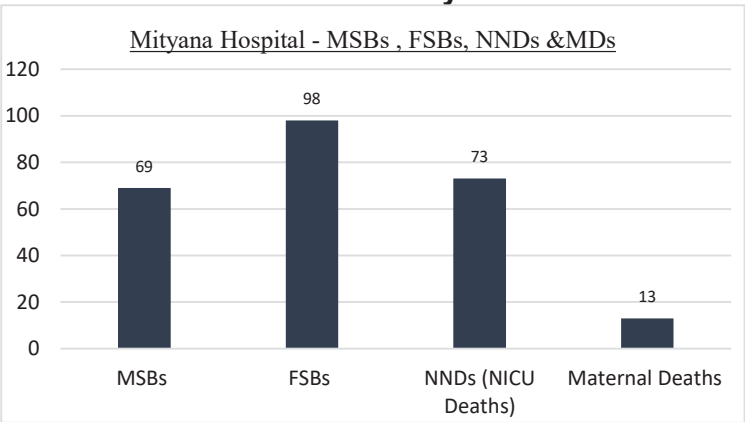
The maternity ward had high patient volumes (8,700 admissions, 6,668 deliveries), indicating poor service at lower facilities and an influx from outside the hospital's catchment leading to medicine stockouts, unhygienic conditions for example maggot-infested toilets.




*The table below shows critical maternity indicators.*

*Very dirty Toilets at the maternity ward*

- **Maternal and Neonatal Mortality**




**Maternal and Neonatal Mortality:** 13 maternal deaths (7 from referrals), 69 macerated stillbirths (MSBs), 98 fresh stillbirths (FSBs), and 73 neonatal deaths (NNDs) signal gaps in care and labor monitoring.

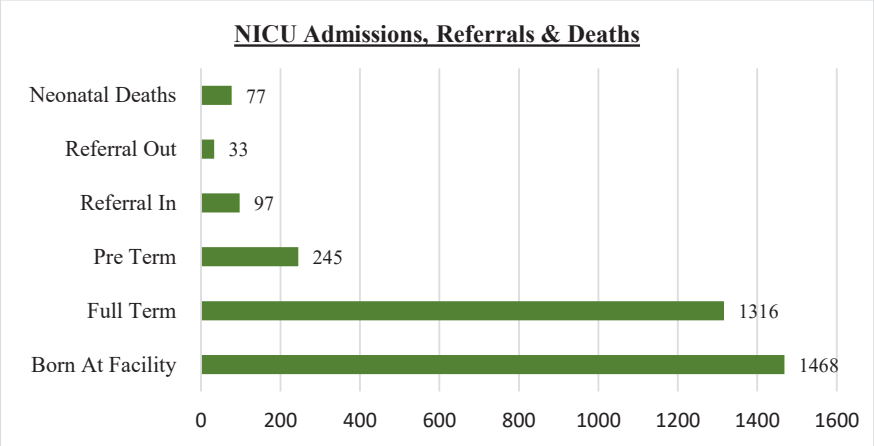
- The theatre is functional but has some obsolete equipment.
- Caesarean section rate (40%) exceeds WHO guidelines (10-15%), raising concerns about medical necessity or extortion.
- Majority of the doctors were absent despite being on payroll and disparities in surgeries performed suggest possible extortion at the theatre.
- 
- NICU was overcrowded, had unreliable power supply, limited or no doctor rounds and poor hygiene threatening neonatal survival. Causes of death were mainly birth asphyxia and neonatal sepsis.


*Unsupervised trainees in NICU* *View of the crowded NICU at the hospital*

NMS delivers EMHS to the hospital, which has improved but still not met budget targets in the past two financial years. Performance improved in **FY 2022/23 (83.32%)** but dropped significantly in **FY 2023/24 (66.67%),** leading to supply shortages. NMS doesn't follow a set schedule, disrupting supply planning.

- Discrepancies in key medicines, including:
  - TDF/3TC/DTG (30): 4,045 units missing (worth UGX 107.9million)
  - Magnesium Sulphate: 30 units unaccounted for
  - Artesunate: 80 vials missing
- The hospital lacks a dedicated EMHS store, leading to improper storage which worsens when NMS delivers two cycles at once, no fridge for temperature-sensitive medicines and electronic inventory system (Rx-Solution) is required. IV fluids and Mama Kits were stored in public toilets due to space constraints.

Urgent servicing required to ensure a reliable oxygen supply.




During the period assessed, the NICU recorded 1,468 admissions, 97 referrals in , 33 referrals out and seven perinatal deaths. Most admissions were attributed to birth asphyxia and neonatal sepsis, also in turn attributed to monitoring of mothers in labor and poor IPC practices at maternity.

## Infrastructure and Equipment Management

- **Laboratory:** The laboratory was noted as well-equipped and fully functional.
- **Radiology Department:**
  - The radiology department is non-functional and closed.
  - The X-ray machine broke down completely in November 2018. Despite investigations and part replacements by Ministry of Health engineers, it remains non-functional. The hospital could not afford repair costs quoted by the supplier (Dash Technologies) after the MoH warranty/service contract expired.
  - An ultrasound scan machine, donated, functioned well initially but developed software glitches. The supplier (Dash Technologies) identified software issues, but malfunctions persisted, hindering service delivery.
- **Oxygen Plant:** The oxygen plant requires urgent servicing to ensure a reliable oxygen supply.
- **Equipment Inventory:** A comprehensive inventory system for hospital machines and property is lacking. Engraving assets for accountability is not consistently done.

- **Waste Management:** Waste management was found to be in a poor state, requiring review of cleaning and garbage collection contracts.
- **Staff Housing:** Older staff housing units are in poor condition and unkempt.
- **Security Infrastructure:** The hospital premises lack perimeter fencing, leading to staff safety concerns.
- **Maternity Ward Infrastructure:** Overcrowding is a major issue, linked to the incomplete Phase II construction. Toilets were in an unhygienic state.

## HMU Interventions

- **Biometric System:** The Health Monitoring Unit's intervention led to the restoration of the previously non-functional biometric attendance system.
- **Waste Management:** Following an HMU visit, the Health Inspector was tasked by the unit to review contracts for cleaning and garbage collection services to address poor waste management.


Before the visit


After the visit

## Recommendations

- MoH should prioritize the completion of Phase II of Mityana Hospital to address overcrowding in the maternity ward.
- Fast-tracking the procurement of an ultrasound scan and restoring the X-ray unit to full functionality.
- M/S and PHA to liaise with the District Security Committee to enhance security measures, including fencing the premises and deploying security personnel to prevent attacks on staff.
- PDU to expedite the collection and disposal of obsolete and dilapidated medical equipment from all hospital departments.
- CAO, DHO should organize training in hospital management for key staff and strengthen oversight mechanisms by enforcing strict adherence to hospital policies, including supervision of interns and trainees to ensure quality patient care.
- The hospital administration should establish and update a comprehensive inventory system, ensuring all hospital machines and property are engraved for accountability.
- The hospital should enhance perinatal care by investigating high perinatal death rates and requesting MoH support for MCH services and enforce SOPs for access to the Neonatal Intensive Care Unit (NICU) should be strictly enforced, including ensuring that all nurses wear scrubs and hand washing stations are functional.
- A committee should be established to oversee the supervision of hospital trainees and ensure their proper integration into the hospital workflow.
- Mityana Hospital should be included in the national ambulance grid to improve patient referrals and emergency response services.

- Hospital administration should work with the district leadership to secure additional ambulance services to reduce delays in emergency transport.
- Hospital management should investigate reported cases of extortion in the maternity ward and theatre and take disciplinary action against staff involved.
- The District Health Office and security teams should track and prosecute staff engaged in unethical practices to restore public trust in hospital services.
- Hospital management should ensure strict adherence to Health Management Information System (HMIS) tools and accountability mechanisms to curb medicine theft and improve the efficiency of the supply chain.
- Establish adequate Essential Medicines & Health Supplies (EMHS) stores.
- The hospital should advocate for additional skilled staff in critical areas such as pharmacy and stores management to enhance accountability and service delivery.

### 4.2.16 Kamwenge District

Eleven health facilities visited: Rukunyu Hospital, Rwamwanja HCIV, Bisozi HCIV, and 8 HCIIIs.

#### Key Findings

- High C/S rate of 31.2% (134/4,293 deliveries) — above recommended 15–20%. Driven by failure of MOs to assess mothers before theatre decisions and leaving C/S decisions to midwives.
- Pre-interns conducting twice the number of C-sections without MO supervision at Rukunyu Hospital.
- Rukunyu registered 14 fresh stillbirths and 36 neonatal deaths — the highest neonatal death count across all monitored districts. MOs never attended NCU or conducted perinatal death audits.
- Labour suites at Bigodi, Kabambiro, Biguli, Bwizi HCIIIs and Rwamwanja HCIV were dirty with blood-stained walls, floors, and delivery beds.
- None of the visited health facilities had a functional mortuary.
- Non-functional IPC committees despite their existence on paper; lack of handwashing equipment at critical points.

#### Leadership and Governance

- The district had a substantive District Health Officer (DHO).
- Rukunyu Hospital lacked a substantive Medical Superintendent (MS) and Senior Hospital Administrator (SHA)
- The DHO was chronically absent from his duty station as evidenced by the deserted status of the DHO's office block.
- The DHO was absent from HMU's monitoring activity.
- The DHO and ADHO MCH lacked support supervision plans and reports.
- The DHT was chronically absent from duty.
- Poor financial management and administration were noted, leading to arrests of various in charges for; abuse of office, fictitious accountabilities, theft, failure to account for government assets and medicines.
- An illegal private wing had been set up at Rukunyu Hospital and staff were extorting money from patients and attendants in form of toilet user fees.
- The DHO failed to submit the agreed upon Aide Memoire developed by the district health workers with HMU's support.

#### Finances and Accountability

- Gross mismanagement of finances especially Rukunyu Hospital and Bisozi HCIV.
- Flouting procurement procedures; Bisozi HCIV.
- Connivance with suppliers resulting in no value for money commodities.
- Abuse of facility funds for personal benefit claiming it as perdiems.
- Forging fuel receipts and stealing money through false fuel receipts.
- Ineligible expenditures by HUMC without reports or meeting minutes.

- HUMC allowances is paid to individuals in the absence of HUMC in Bisozi HCIV.
- Forged outreach activities by ADHO's office supported by PHC, GAVI and UNICEF.
- Financial procedures not followed; mixing funding sources, forging expenses on vouchers.
- Assistant accountants not helping facility in charges to learn financial procedures.

### HMU Interventions

- Debriefed with CAO on the dire status of leadership in the Health Department: DHO and DHT
- Audited finances in DHO's office, Rukunyu Hospital and Bisozi HCIV.
- Arrested errant health facility in charges and investigations instituted .
- Supported the district Health workers to prepare an Aide Memoire to address identified health service delivery gaps.
- Have all income and expenses for the period under audit matched by the CFO, sector Accountant and in charges.
- Accountant at Rukunyu transferred.
- In charge of Bisozi transferred to another facility
- Arrested and investigated all suspects

### Recommendations

- The CAO, PHRO and DSC to recruit and fill the vacant positions of MS and SHA in Rukunyu General Hospital.
- The CAO and MoH to hold the DHO & DHT accountable for abandoning support supervision of health facilities and to take corrective action to ensure the DHO and his team conduct support supervision.
- The DHO and the CAO to routinely verify submitted data on staff attendance to duty before paying monthly emoluments.
- The DHO and the CAO to intensify supervision and monitoring of health units.
- The CAO and DHO to update HMU as to why the government hired staff who were not present for duty at Rwamwanja HCIV.
- Implicated Staff to refund all fraudulently used funds; Dr. Ivan of Rukunyu Hospital and Dr. Ojok of Bisozi HCIV.
- Suppliers to make good the loss in transactions which we proved were forged. Yafa Company Limited (Fuel) and BobCat Engineering (regular electric repairs).
- Produce accountability for all the development costs including UGX 150,000,000 transferred to Kamwenge District account.
- Audit the DHO's office.

## Human Resources for Health

### Staffing Levels

- 30% overall staffing level (312/1043)
- Kyempango HCIII was the highest staffed facility at 71% (39/55).
- Rwamwanja HCIV and Bisozi HCIV were the least staffed by the DLG at 15% (19/130), and 17% (22/130), respectively.
- However, with support from implementing partners, Rwamwanja HCIV had 108 staff supported by implementing partners
- Rukunyu Hospital lacked critical cadres including; the 5 positions of Medical Officers Special Grade, Principal Medical Officer, Principal Nursing Officer, Senior Laboratory Technologist, and Hospital Pharmacist.
- All monitored HCIIIs were understaffed for critical cadres including midwives.
- Kabambiro, Biguli and Kamwenge HCIIIs each had 3/9 midwives
- Bigodi, Kabingo, Bwizi and Binoga HCIIIs each had 2/9 midwives.

### Attendance to duty

- Only Rukunyu Hospital had a biometric machine which was faulty and there was no attendance register.
- Staff presence for duty at Kabingo HCIII was at 100% (12/12) followed by Bwizi HCIII at 89% (17/19)

- 62% (194/312) of the recruited staff in the visited facilities were scheduled for duty while 51 staff were absent due to several personal reasons; 26/51 were formally away (12 on annual leave, 4 on study leave, while 10 were attending a workshop). This gross absenteeism was attributed to the chronic absence of facility in-charges.
- In-charges attendance to duty was below 30 days contrary to the Public Service Standing Orders in; Biguli HCIII (17), Bigodi HCIII (18), Bwizi HCIII (23), Kabambiro HCIII (25) and Binoga HCIII (26).
- The team discovered that all government health workers were absent from duty in Rwamwanja HCIV.
- Kabambiro and Bigodi HCIIIs registered low staff attendance to duty of 43% (3/7) and 53% (8/5) respectively.

Uniform and professional etiquette

- Baylor College of Medicine supported midwives in Binoga HCIII were not uniform
- A midwife in Bigodi HCIII was found wearing slippers despite repeated caution from a senior midwife.
- A staff member was found playing 'matatu' during working hours at Biguli HCIII.
- A volunteer was working at Binoga HCIII without authorization from the CAO.

Staff Housing

- Overall, 36% (112/312) of staff were accommodated at their health facilities.
- The staff houses were generally in good condition but inadequate.
- Gross inadequate housing was found in Bwizi HCIII (13%), Biguli HCIII (21%), Rwamwanja HCIV (22%), Kabambiro HCIII (27%) and Rukunyu hospital (25%).

**Recommendations**

- The CAO, PHRO and DSC to recruit and fill the vacant positions of health workers prioritizing critical cadres; Doctors, Midwives and Anaesthetic Officers.
- MoH to repair the biometric machine at Rukunyu General Hospital.
- The CAO to recover wages from all the officers who abandoned their post from duty, and staff who worked less than 15 days in a month as per the Public Service Standing Orders.
- The CAO sanctions all the errant health facilities in-charges and staff according to the Public Service Standing Orders.
- The DHO and CAO to sanction the staff member who was found playing Cards'matatu'
- MOH and Kamwenge DLG to construct more staff houses.

## Essential Medicines and Health Supplies (EMHS)

NMS Performance

- There had been a significant improvement in the timely supply of EMHS, as evidenced by significantly reduced stockouts.
- The district's procurement plan demonstrated clear planning efforts and achieved a 50% performance rate (NMS delivered 5 out of 10 items on the procurement plan).

Good practices in Medicine management in Kamwenge District

| | | | | | |
|---|---|---|---|---|---|
|  |  |  |  |  |  |
| A Pharmacy technician at Bisozi HCIV doing medicine accountability | A stores in-charge at Kabambiro HCIII accounting for medicines | Good storage management in Rwamwanja HCIV; A refugee facility | A maternity in charge in Rukunyu with her mama kit improvised register | A well signed improvised maternity register in Rukunyu Maternity ward | A dispensing log in the Pharmacy at Rukunyu Hospital |

Stock Status

- Biguli HCIII was overstocked with Coartem, N95K Respiratory Mask, and Mama kits.
- Bigodi HCIII experienced a stockout of HIV testing kits (Determine) for three months.

Expired commodities

- Bwizi HCIII had expired medicines piled up in the waiting area of the Outpatient Department (OPD), causing congestion.
- Biguli HCIII had expired drugs in its medicine store.
- The district store contained a large quantity of expired drugs in a metallic container.

*A 40ft container full if expired medicines and commodities at the district headquarters*

- The expired medicines found in the container were worth about UGX 700 Million. These expired commodities included mainly ARVs, lab reagents, injectables, sample collection accessories among other. But some non-obsolete stock was discovered among obsolete stock posing a significant risk of leakage back into the supply chain especially drug shops across the district.
- Some of non-obsolete items discovered included vacutainers, giving sets, surgical gloves, hospital beds etc. It was clear that this is one of the ways items are siphoned out of the hospital; by camouflaging them as expired items. These expiries were attributed to breakdown in inter-facility transfer of medicine, poor performance at the health units, change of combination treatments, push of short dated stock by the central store.

Storage of EMHS: Good storage practices demonstrated in Rwamwanjwa HCIV and Kabambiro HCIII

Logistics Management Information System (LMIS)

- In all the visited facilities, all units and departments used a single requisition and issue voucher located in the central store which risked EMHS to pilferage in the store.
- Stock cards lacked essential information, such as maximum and minimum stock levels. Kabingo HCIII was using exercise books and paper for stock management.

## HMU INTERVENTIONS

- NMS was contacted to collect all expired commodities in the district for immediate destruction, but they did not comply.
- NMS was directed to cease the distribution of short-dated stock to lower units, with official communication to follow.
- The in-charge was directed to fill out a redistribution form specifying overstocked items, their expiry dates, and quantities to be issued out.
- In-charge Bigodi HCIII was instructed to officially request DHO to facilitate the redistribution of HIV Kits.
- In-charge Biguli HCIII was instructed to separate the expired commodities from the usable stock.
- All incharges were instructed to implement individual requisition and issue vouchers for each department.
- A logistics officer from Baylor was called to provide training on how to complete EMHS stock cards.

### Recommendations

- NMS to consider embossing sundries for enhanced accountability and improve their delivery schedules.
- Deliveries should cease after 7 pm to ensure optimal tracking and management of supplies.
- Stores in-charges should make it a practice to complete discrepancy forms upon receipt of supplies.
- The district should expedite the implementation of the inter-facility transfer of medicine policy within the district to address drug stockouts and oversupply in various units.

- MOH to expedite the implementation of Electronic Medical Records/ Electronic Logistics management System in health facilities.

## Infrastructure and Equipment

- Dirty/ unkempt health facilities; Bigodi, Bunoga and Bwizi HCIIIs and Rukunyu Hospital.
- Only Bugodi HCIII, Bisozi HCIV and Rukunyu Hospital had land titles.
- Land encroachment was reported at Bugodi and Rukunyu Hospital in spite of having land titles.
- Encroachment issues at Kamwenge HCIII were being handled by the district administration.
- Latrines at Kabambiro were filled up.
- Kabambiro HCIII didn't have a consultation room in OPD.

Dirty and disorganized Bugodi HCIII Labour suit

Old Blood from the covered delivery bed

Rusty dirty lamp and resucitation bed

Blood stained walls.

Equipment Inventory and Engraving:

- Only Bunoga and Rwamwanja HCIV had updated equipment inventory books.

Transport

- The district had seven ambulances, three motorcycle ambulances, nine motorcycles and three co-ordination vehicles.
- The many ambulances (mainly at Rwamwanja HCIV) in the district are mainly due to the UNHCR refugee response support program.

Ongoing Constructions and Renovations

- Some renovation works were noted at Rwamwanja HCIV, including remodeling and expanding the OPD and theatre.
- No stalled works were reported in the district.

Disposal of Obsolete/Abandoned Equipment

- Poor storage and disposal of expired and obsolete equipment.
- The obsolete equipment was bundled up and dumped in the compound.

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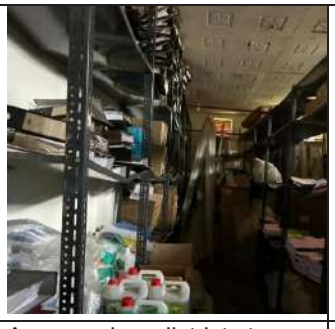
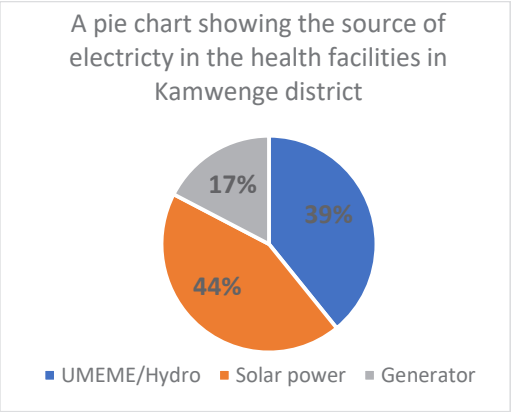
|  |  |  |  |  |
| Usable equipment lying undistributed in the district store | A messed-up district store in Kamwenge | A messed-up store at Kamwenge HCIII | Disposal of equipment at Rwamwanja HCIV | A truck load of expired medicine in Rwamwanja |

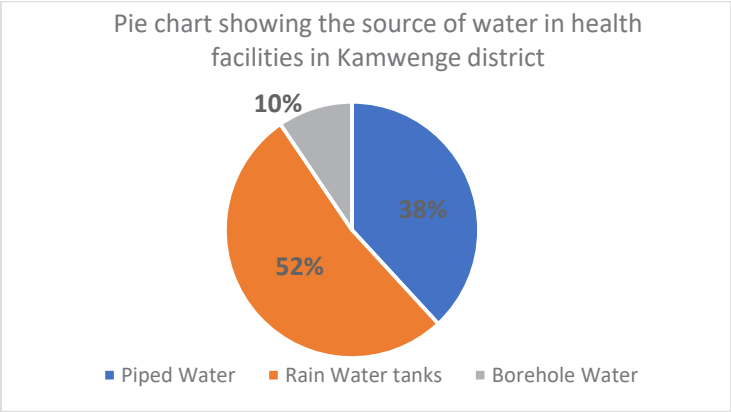
*Pictures of some of the bad storage and disposal behaviours in the district*

- Utilities Management (Power and Water Supply) : All the facilities with the exception of Biguli and Kibingo HCIIIs, were powered by UMEME as their main source of electricity.

The main sources of power and water supply to the visited facilities are summarized in the two pie charts below:




*Main source of power supply*




*Main source of water supply*

- They also have functional solar systems (except for Bisozi HCIV).
- Bigodi HCIII has a solar system but it is not functional.
- All four fuel-powered generators in the facilities (in Rukunyu Hospital, Rwamwanja, Kamwenge and Bigodi HCIII) are functional.
- Rain water is used in 52% of the facilities, piped water was found in 38% of the health facilities and 10% of the facilities had bore holes
- Notably, Binoga HCIII, Bwizi HCIII, Bisozi HCIV rely only on harvested rain water.
- Bigodi HCIII and Rwamwanja HCIV are the only ones with a borehole as a third alternative source of safe water.

Mortuary Services

- None of the health facilities, including Rukunyu Hospital had a functional mortuary.
- All facilities rely on Fort Portal Regional Referral Hospital for mortuary services.

## Infection Prevention and Control (IPC)

- The ANC room in Rukunyu Hospital was dirty with a blocked drainage channel.
- None functional IPC committees despite their presence in the facilities
- There is a lack of handwashing equipment with water and soap at critical points.
- Clinical areas lacked alcohol hand rub or sanitizer in most health facilities.
- Dirty labour suites with exceptions in; Kamwenge HCIII, Rwamwanja HCIII, Bwizi HCIII and Kabambiro HCIII
- Dirty inpatient wards.
- Delivery beds were soiled with dried or fresh blood, making them rusty and not fit for the purpose. The walls of the labour suites were also soiled with dried blood and meconium and looked dusty.
- Dirty and soiled aprons in the labour suites.
- Almost all facilities had visibly dirty aprons stained with blood and meconium. It looks like there.
- The cleaners or porters were not doing a good job.
- Bunoga HCIII was the dirtiest facility.
- Poor menstrual hygiene management among patients and caregivers.
- Poor Waste Management Practices; Healthcare waste was not segregated, bin liners were not used, sharps containers were full beyond capacity, waste disposal was poor with the waste pit not fenced.

## HMU Interventions

- Dirty Health facilities and labour suites were cleaned
- DLG leaders instructed to sort out land encroachment issues and acquire land titles for facilities
- Procurement department instructed to plan for disposal of obsolete equipment.
- All Health Inspectors developed plans for maintaining proper hygiene, sanitation and cleanliness in the health facilities.
- Porters were trained to properly clean health facilities.
- Aide Memoire developed by Health workers to address identified gaps.

**Recommendations**

- MOH and DLG to construct mortuaries in Rukunyu Hospital and Bigodi HCIV
- MOH and DLG to construct new latrine for Kabambiro HCIII
- The health facility in charges to reactivate the IPC committees.
- Health facility in charges to place functional handwashing equipment, liquid soap and hand drying accessories at all departments
- Facility in charges to ensure waste segregation and to fence off the waste pits.

## Health Service Delivery

Out-Patient Department (OPD)

- All facilities had functional OPDs.
- Rwamwanja HCIV has the highest OPD attendance followed by Rukunyu Hospital due to the large refugee population, additional HR supplies and equipment from UNHCR.
- Kyempango HCIII recorded the highest number of OPD attendances among HCIIIs because it attends to the refugee population, coupled with support from implementing partners.
- Kabingo HCIII and Bisozi HCIV had the least number of OPD attendances among HCIIIs and HCIVs respectively; this could partly be due to gross understaffing of 18% and 17% respectively.
- Poor patient diagnosis and management in Bigodi HCIII.
- The district was no longer conducting COVID-19 vaccinations and had vaccines doses above 30,000.

Laboratory services

- All eleven (11) visited facilities had functional laboratories and offered most of the recommended services for their respective levels.
- Rukunyu Hospital possessed all the required laboratory equipment.
- Kabingo HCIII lacked reagents, a fridge with a thermometer, and a CD4 count machine.
- Rwamwanja HCIV lacked a Gene Xpert machine.
- Bisozi HCIV lacked a CD4 count and CBC machines, Gene X pert machine and centrifuge.
- Bunoga and Biguli HCIIIs lacked automated or power equipment.
- The number of mRDTs almost double what the number of blood slides (BS) read on microscopy except in Rwamwanja HCIV and Kyempango HCII. This means that laboratory personnel are under utilizing the microscope which is leading to technical in-competences in the use of the microscope.

Blood Transfusion Services

- Blood transfusion services were offered by Rwamwanja HCIV and Rukunyu hospital though records could not be easily traced.
- Bisozi HCIV lacked a functional theatre and blood transfusion services.

Maternal Child Health Services

- There were new maternity blocks in Bwizi and Kabingo HCIIIs.
- MTN donated an operating lamp, phototherapy machine and warmer to Bwizi HCIII.
- The midwives in Bwizi HCIII exhibited a good attitude.

Antenatal Care

- All health facilities provided ANC.
- Kamwenge HCIII registered the highest number of mothers that reported for ANC towards delivery (ANC4+)
- Kyempango HCIII had the highest number of admissions and deliveries among HCIIIs
- Kabingo HCIII had the least number of ANC4+ and admissions
- Bigodi HCIII registered the lowest number of deliveries. This was due to poor infrastructure and inadequate labour suit space, poor facility management, disorganized and dirty labour suit, blood-stained delivery beds, walls and aprons, rusty lamp and resuscitation bed and a cracked floor. In addition, only 3 un sterilized poorly stored delivery sets

Labour Suites

- The labour suits in Kamwenge HCIII, Kyempango HCIII and Bisozi HCIVs were clean.
- Labour suits in Bigodi, Kabambiro, Biguli, Bwizi HCIIIs and Rwamwanjwa HCIV were dirty.
- The ceiling of Binoga HCIII maternity was falling in/ cracking.
- The floors of the labour suits of Biguli and Bigodi HCIIIs were cracked.

- Partographs were being used in Bigodi, Kamwenge, Bisozi HCIIIs and Kabambiro HCIV.
- There were adequate delivery sets in Rwamwanjwa HCIII, incomplete delivery sets in Binoga HCIII and none in Kabingo HCIII where they were using recycled circumcision equipment.
- Midwives in Kyempago HCIV and Rwamwanjwa HCIII were delivering mothers with sterilized equipment.
- Midwives in Binoga, Biguli, Bigodi and Kabingo HCIIIs were using unsterilized equipment to deliver mothers.
- Binoga had a new delivery bed that was used as an examination coach in the ANC clinic.
- The Placenta pit in Bisozi HCIV was open, unsafe and risky for the clients and health workers.
- The in charges of Binoga and Bigodi HCIIIs did not utilize RBF to prioritize MCH services as evidenced by the poor infrastructure of maternity including the labour suits

Referrals
- Rukunyu hospital registered the highest number of referrals ;215 and Rwamanja 125 in March-August 2023
- High Caesarean section (C/S) rate of 31.2% (134/4293) instead of the recommended 15-20%. This is due to failure of Medical Officers to assess mothers before taking them to theatre and leaving this to midwives or due to poor monitoring of labour leading to complications.
- The above is compounded by the high number of referrals from neighboring districts of Ibanda, Kazo and Kiruhura due to absent doctors.
- Kyempago had the highest number of referrals to Rukunyu despite having the highest number of deliveries due to lack of a theatre in Bisozi HCIV which is the next referral facility in the same Sub County.
- Bisozi referred 69 mothers to Rukunyu Hospital
- Bigodi and Binonga referred 84 and 71 mothers respectively due to poor facility management and missed opportunity of RBF to improve MCH services

Operating Theatre
- The district has 2 functional theaters in Rukunyu and Rwamwanja HCIV.
- Rukunyu had a broken door that was allowing rain into theatre while Rwamanja had a faulty theatre door and Anaesthetic machine.
- Pre-interns conduct twice the number of Caesarean sections without supervision of medical officers who are absent from duty in Rukunyu
- In Rwamanja HCIV doctors paid by UNHCR conduct the Caesarean sections while DLG doctors absent/abscond from duty.

Post-Operative Care
- Medical Officers in Rukunyu do not review patients post operation and abandoning patients to midwives without post op care instructions and monitoring.

Prenatal Deaths
- Rukunyu Hospital registered the highest number of Prenatal deaths; 14 fresh Still births due to delayed Emergency Obstetric Care in the facility and 24 MSBs of which 10 had not been recorded in the HMIS tool thus not reported to MOH.

Neonatal care Unit (NCU)
- Rukunyu registered the highest number of neonatal deaths of 36.
- Medical Officers in Rukunyu never attended to NCU and they never conducted any prenatal death audits. This was attributed to inadequate knowledge and skills in Neonatal care.
- NCU was abandoned to nurses with inadequate numbers, knowledge and skills.

In-Patient Department (IPD)
- All Health facilities had a low inpatient utilization with no or little evidence of admissions except in Rukunyu Hospital, Rwamwanja HCIV and Kyempago HCIII.
- Rukunyu registered the highest number of inpatients, over 5,000 for the period March-August 2023 because it is the only referral point in the area.
- Bisozi HCIV registered low inpatient numbers below 1,000 and this could be related to the gross understaffing (17%), poor facility management, lack of a theatre, laboratory equipment and blood transfusion services.
- Kabingo had the least inpatient numbers less than 100 and to note is that it is grossly understaffed (18%)
- All HCIIIs had a general inpatient ward.

**HMU INTERVENTIONS**

- The DHO and DHT MUST attend to duty if health service delivery is to improve in Kamwenge District
- The CAO to sanction the DHO and DHT for chronic absenteeism and failure to steward as expected health service delivery in the district.
- Instructed the DHO and in-charge to fast-track the establishment of an operating theatre and blood transfusion services at Bisozi HCIV.
- CAO advised to change the management of Bigodi and Binoga HCIIIs
- Health facility in charge Bisozi instructed to construct a safe placenta pit
- Delivery bed in Binoga HCIII to be transferred to labour suit.
- In charge Rukunyu Hospital instructed to closely supervise attendance to duty of Medical Officers
- Medical Officers in Rukunyu instructed to indicate allocated task on the duty rosta
- Medical Officers in Rukunyu instructed to correctly assess mothers before sanctioning for C/S
- Medical Officers in Rukunyu to go to Fort Portal RRH or Mbaraa RRH for in service training in obstetrics and Neonatal care.
- Medical Officers were instructed to attend to all inpatients in the hospitals and HCIVs.
- Aide Memoire prepared with health workers in Rukunyu Hospital and District with support from HMU.

## Public Engagement and Dissemination Findings

### Dissemination Meeting

Findings from the monitoring visits were shared through a district dissemination meeting some of which were held at the Kamwenge district headquarters. These meetings were intended to amplify HMUs message and maximise the impact of its operations in Kamwenge district and beyond.

### Community Dialogue (Baraza)

A community baraza attended by over 3000 people was held in Kahunge Town Council. The public were offered the audience to air their grievances regarding the health care system in the district as the district leaders and the team from HMU listened to come up with solutions to the complaints.

### Radio Talk Show

The HMU team along with some district officials participated in a radio talk show on Voice of Kamwenge (which has a listenership of over 1million listeners) to disseminate the findings from the monitoring efforts and to also offer the public the audience to air their grievances.

**RECOMMENDATIONS**

- MoH and DHO to equip laboratories that are not fully functional.
- DLG to recruit staff in Kabingo HCIII and Bisozi HCIV
- DHT to improve on supervision
- Recruit pharmacist in Rukunyu hospital to build capacity of health workers in rational medicines use and management.
- Integrate COVID 19 vaccination in routine Immunization
- MOH and DLG to improve infrastructure of Maternity in Bigodi, Biguli and Binoga HCIIIs.
- ADHO MCH to provide Binoga and Kabingo delivery sets
- ADHO MCH to ensure all labour suits have a duty rosta for sterilizing delivery sets.
- MOH to expand the infrastructure of Rukunyu Hospital.
- DHO to avail HMU with a copy of the final Aide Memoires for follow up.

*Pictures of community members participating in the community baraza*

*Pictures of the HMU team and DHOs participating in a radio talk show on Voice of Kamwenge*

## Recommendations — Kamwenge

- CAO to sanction DHO and DHT for chronic absenteeism and failure of stewardship.
- MOs at Rukunyu to provide post-operative care and attend to all inpatients.
- MOs to correctly assess mothers before sanctioning C/S — reduce inappropriate C/S rate to recommended 15–20%.
- MoH to expand infrastructure of Rukunyu Hospital.
- MoH and DLG to construct mortuaries at Rukunyu Hospital and Bigodi HCIV.
- Recruit pharmacist for Rukunyu Hospital.

# 5.0 ENTEBBE REGIONAL REFERRAL HOSPITAL

Entebbe Regional Referral Hospital (ERRH) serves as the first-line referral facility for Wakiso district, the President's Office, and Entebbe International Airport. Its strategic location makes its performance and capacity particularly critical. HMU conducted comprehensive monitoring during FY 2023/24.

## 5.1 Leadership and Governance

- Lack of support supervision by Ministry of Health.
- No Hospital Board constituted despite the hospital's RRH status.
- The Hospital was upgraded to RRH but operates at General Hospital level due to inadequate resource allocation.

## 5.2 Human Resources for Health

- Gross understaffing at 18% (215/1,195 approved positions). Approved structure includes 11 Senior Consultants and 10 Consultants; Entebbe RRH has NO Senior Consultant and only 2 Consultants.
- 193 staff found on duty out of 203 scheduled — 10 staff absent on the day of the HMU visit.
- No MoUs between the RRH and private health worker training institutions; student health workers far exceeded the number of staff available to train them.
- Health workers not paid COVID-19 control allowances — a long-standing grievance.

| Approved | Filled | Scheduled for Duty | Found on Duty | I/C Attendance (2 mths) | Salary Issues |
|---|---|---|---|---|---|
| 1,195 | 215 | 203 | 193 | 24 days | COVID allowances unpaid |

## Health Worker Training

- Lack of Memoranda of Understanding between The RRH and private health workers training Institutions
- The number of student health workers were too many for the number of hospital staff to train
- The student health workers did not have the expected minimum knowledge for application during the practicums
- No facilitation to Hospital staff for training private student health workers

## 5.3 Essential Medicines and Health Supplies

- Inadequate EMHS budget: Entebbe RRH allocated UGX 700 million while Moroto and Kayunga RRHs received above UGX 1 billion.
- Medicines budget reduced post-COVID, increasing stockout days despite resumption of full services.

## 5.4 Infrastructure and Equipment

### Grade B Hospital

- The Hospital does not have a land title.
- The Hospital is gazetted/ fenced.
- The Hospital structures of OPD which also houses the; Private wing, Maternity ward, Radiology and other units is in good status but has structural design flaws.
- The OPD patient waiting area has poor ventilation, there is no isolation area, and congested on a busy day.

- Poor plumbing and drainage work that risk to destroy the structural integrity of the building; the staff complain of dampness.
- Lack of staff accommodation quarters.
- Power supply is from UMEME and water supply from NWSC.
- Not all equipment is engraved.

### Grade A Hospital

- The buildings on the Grade A campus are dilapidated and have been condemned.
- HMU was informed that Credit Invest Financing Company was procured to construct a state-of-the-art well-furnished facility/Hospital at Entebbe Grade A premises with 54 staff Units.
- One of the dilapidated blocks (former MoH headquarters) is housing offices for different government Agencies/Departments including; D/RDC, DISO, Judiciary and Meteorology.

*A dilapidated office block at Grade A -*

*Status of some structures in Grade A-*

*Entrance to radiology depart of the isolation center Entebbe RRH*

*A non-functional X-ray, due to lack of software-Entebbe RRH*

*Loose/falling electrical fittings at Isolation center-Entebbe RRH*

*Leaking water pipe of a solar heater at Isolation Center-Entebbe RRH*

### Equipment; Entebbe RRH

- Entebbe RRH does not have an ICU unit despite being the first line of contact for both the President's Office and the busiest entry point to the country the Airport.
- Three Television sets were stolen from the maternity ward of the Hospital and no case was reported at police.
- The software of the X-ray unit of Entebbe Hospital is obsolete.
- The ultra sound was not functional due to software breakdown.

- The boiler in maternity was not in use.
- The washing machine in the isolation center is non-functional awaiting replacement of some spare parts.
- The incubators at Entebbe hospital are faulty.
- General Electronic (GE) supplied anaesthetic machine to Entebbe RRH which was not working.
- Med-Equip is delivering a new anaesthetic machine by mid-June 2023.

- **ICT Equipment;**
  - Entebbe RRH like other selected facilities were given; 25 desktops, 45 laptops and 15 tablets in September of 2020 which were redundant at the time of the HMU visit and MoH had not released plans to utilize the equipment.
  - Entebbe RRH had limited safe storage space for the equipment; which was staff offices that risked the items to theft.

*Installed but non - functional CT- Scan; ERRH*

*ERRHs only functional Mobile X-ray*

*Non-functional suction pump in the Maternity Ward-ERRH*

*A mattress with worn out Mackintosh in OBS & Gyn-ERRH*

### Isolation center for COVID, TB and Ebola

- The Isolation Center was renovated during the COVID 19 pandemic but there is evidence of shoddy work especially in the fittings like door shutters, electricals, gutters, plumbing, and leaking roofs.
- There were no houses to accommodate staff.

## Health Service Delivery

**Pseudo-classification**

- Entebbe Regional Referral Hospital was upgraded but the availed resources and services offered are of a General Hospital.
- **Laboratory services:** The Laboratory is adequately equipped.
- OPD and IPD Services: The Hospital has the highest number of Out and Inpatients in Wakiso.

**Health Management Information System**

- The Hospital has a records facility but it is poorly managed. It lacks shelves and records are strewn within the room making it difficult to find records.
- The room doubles as storage for new and old record books and other equipment that should otherwise not be stored in a records room.

Records storage room with old documents piled and other equipment stored in a records room

## 5.5 HMU Interventions — Entebbe RRH

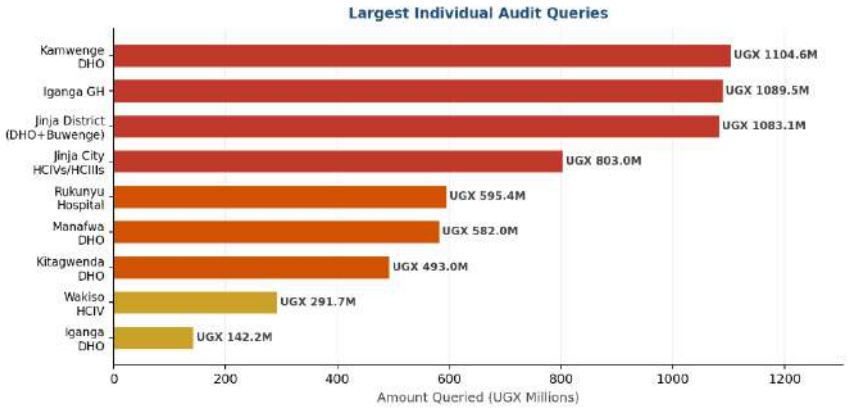
- Boiler in the maternity ward operationalized.
- Washing machine in the isolation center functionalized.
- Incinerator repairs completed.
- Leakage in the CT scan room roof repaired.
- Functional dental chairs and lights restored.

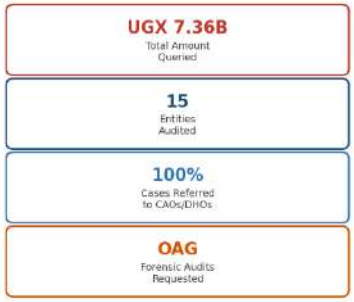
## 5.6 Recommendations — Entebbe RRH

- Hospital Management to process land title urgently.
- MoH to constitute and operationalize a Hospital Board.
- MoH to increase EMHS budget for Entebbe RRH to parity with other RRHs.
- Hospital to plan and develop an ICU as a matter of strategic priority.
- Hospital Director to report TV theft to police; engrave all hospital equipment.
- MoH to ensure completion of oxygen plant installation at the isolation center.
- Renovation of the COVID-19 isolation center fittings to be completed urgently.

# 6.0 FINANCE AND AUDIT OUTPUT 2023/24

HMU conducted comprehensive financial audits across all monitored districts in FY 2023/24. The audits covered receipts from government PHC funds, Results-Based Financing (RBF), Capital Development grants, and other donor sources. A total of UGX 7,361,065,906 (approximately UGX 7.36 billion) was queried as unaccounted for, missing vouchers, or suspicious accountabilities — representing a massive leakage from the public health system.




| District | Facility | Audit Query | Amount Queried (UGX) | Status |
|---|---|---|---|---|
| Tororo District | Tororo General Hospital | Unaccounted funds and suspicious accountabilities | 194,268,130 | Investigations ongoing |
| | Nagongera HCIV | Unaccounted funds | 49,406,000 | UGX 7.6M recovered; ongoing |
| Iganga District | Iganga DHO | Unaccounted funds | 142,226,866 | Investigations ongoing |
| | Iganga General Hospital | Unaccounted funds | 1,089,538,145 | Submitted to OAG for forensic audit |
| | Bugono HCIV | Unaccounted funds | 221,213,600 | Submitted to OAG for forensic audit |
| Wakiso District | Wakiso HCIV | Unaccounted funds | 291,666,170 | Submitted to OAG for forensic audit |
| Kamwenge District | Kamwenge DHO | Unaccounted funds | 1,104,647,277 | Investigations ongoing |
| | Rukunyu Hospital | Unaccounted funds | 595,443,200 | Investigations ongoing |
| | Bisozi HCIV | Unaccounted funds | 150,898,081 | Investigations ongoing |
| Kitagwenda District | Kitagwenda DHO | Unaccounted funds | 493,030,746 | Investigations ongoing |
| | Ntara HCIV | Unaccounted funds | 216,917,000 | Investigations ongoing |
| | HCIIIs (×4) | Missing Vouchers | 138,296,308 | Investigations ongoing |

| District | Facility | Audit Query | Amount Queried (UGX) | Status |
|---|---|---|---|---|
| Manafwa District | Manafwa DHO | Unaccounted funds | 582,043,090 | Responses received; verification pending |
| | Bubulo HCIV | Unaccounted + Missing Vouchers | 118,486,669 | Responses received; verification pending |
| | Bugobero HCIV | Unaccounted + Missing Vouchers | 145,611,644 | Responses received; verification pending |
| Jinja City | All HCIVs and HCIIIs | Unaccounted + Missing Vouchers | 803,040,270 | Responses received; verification pending |
| Jinja District | DHO + Buwenge GH + Buwenge HCIV | Unaccounted + Missing Vouchers | 1,083,117,210 | Responses received; verification pending |
| **TOTAL** | | | **7,361,065,906** | |

All queried amounts have been communicated to the respective Chief Administrative Officers (CAOs), District Health Officers (DHOs), and facility in-charges. Entities that fail to provide satisfactory accountability will be forwarded to the Directorate of Public Prosecution (DPP) for criminal proceedings. Full case status is available through the HMU case management system.

**LINK TO STATUS OF CASES HANDLED BY STATE HOUSE HEALTH MONITORING UNIT DURING FY 2023/24.**

https://drive.google.com/file/d/1FHJJ5GDoiqWFbAJz32YBEhA0damtVxwv/view?usp=sharing

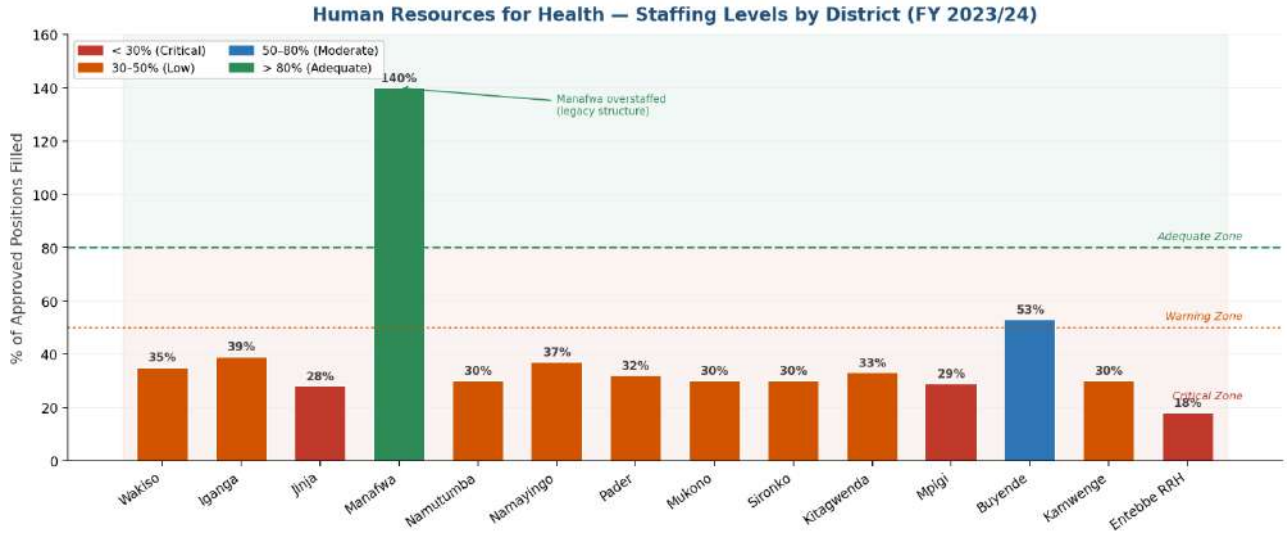
# 7.0 CROSS-CUTTING THEMATIC ANALYSIS, CONCLUSIONS AND RECOMMENDATIONS

The following section synthesizes findings across all 16 monitored districts and more than 235 health facilities into eight thematic domains. Each domain is analyzed comprehensively, drawing on field evidence from all monitored entities to identify patterns, causal chains, and systemic drivers. Conclusions reflect the weight of evidence across the monitoring exercise as a whole, and recommendations are specific, measurable, and directed at named responsible authorities.

## 7.1 Human Resources for Health (HRH)

### Analysis

Human resource adequacy is the foundational prerequisite for health system function, yet it was critically compromised across every monitored district and facility in FY 2023/24. Using the new Ministry of Health approved staffing norms, the average staffing level across all monitored entities was approximately 30% — a figure that makes it structurally impossible to deliver the Ministry's prescribed health care package at any facility level.




The recruitment ban imposed by the Ministry of Public Service on local governments is the single most significant policy driver of the HRH crisis. While the ban was intended to manage the public wage bill, its implementation in the health sector has been indiscriminate, preventing districts from filling even the most critical clinical positions — midwives, anaesthetic officers, and medical officers — whose absence directly translates into maternal and neonatal deaths. Districts such as Buyende and Pader attempted to circumvent this through volunteer arrangements, but this creates a fragile, unsustainable workforce with no legal accountability framework.

Absenteeism and neglect of duty compounded the staffing crisis at every level. HMU documented three distinct patterns: scheduled absenteeism (duty rosters designed to minimise actual duty days, as in Namutumba and Mpigi); unsanctioned absenteeism (staff simply not reporting, as in Pader where 9 of 13 in-charges were absent on the day of the HMU visit); and structural absenteeism (staff assigned additional district or IP duties that drew them away from their primary facility posts, as documented in Iganga, Manafwa, and Kamwenge). Manual attendance registers — the primary accountability tool in most facilities — were consistently abused, with colleagues signing for absent peers. Biometric machines, installed in Wakiso, Namutumba, and others, were frequently non-functional or not maintained.

The quality of health facility in-charges emerged as the strongest predictor of facility performance. Facilities where in-charges demonstrated strong clinical leadership, regular attendance, and governance accountability — Kakooge HCIII in Buyende, Nakalama HCIII in Iganga, Awere HCIII in

Pader — consistently outperformed comparable facilities with poor in-charge attendance. This finding underscores that in a resource-constrained environment, leadership quality is the variable most amenable to improvement within existing system constraints.

Double employment was confirmed in Manafwa (Dr. Mutoo Paul Bukhota employed by both Manafwa DLG and Baylor Uganda), and was suspected in multiple other districts where staff assigned to additional IP duties spent the majority of their working time outside their primary duty stations. This practice diverts government-funded human resources to NGO-supported activities, effectively subsidizing private sector IP programming at public sector cost.

Staff housing inadequacy drove non-residency, contributing to absenteeism and delayed emergency response. In Manafwa, Pader, Sironko, and Mpigi, the majority of clinical in-charges resided in urban centers despite having designated accommodation at their facilities — citing lack of electricity, water, or security at facility quarters. Non-resident health workers systematically arrive late, leave early, and are unavailable for night emergencies.

## Conclusion

The Human Resources for Health crisis in Uganda's public health sector is both structural — driven by the recruitment ban, inadequate wage bill allocations, and slow promotions — and behavioral, driven by weak enforcement of attendance standards, inadequate housing, and a culture of impunity for absenteeism. The consequences are direct and measurable: maternal deaths at facilities without night-shift midwives, perinatal deaths at facilities without Anaesthetic officers, patients turned away from facilities manned by a single health worker, and communities resorting to TBAs when facilities are effectively closed.

Addressing the HRH crisis requires simultaneous action on policy (lifting the recruitment ban), finances (increasing the health wage bill), enforcement (meaningful sanctions for absenteeism), and incentives (adequate housing, prompt promotions, and recognition of best performers). No single intervention will be sufficient. The evidence from Buyende — where relatively better staffing with a full DHT correlated with better accountability and facility performance — demonstrates that investing in HRH delivers system-wide dividends.

## Recommendations

- Ministry of Public Service to issue immediate targeted waivers to the recruitment ban for critical health cadres: midwives, anaesthetic officers, medical officers, pharmacists, and laboratory technicians — with a minimum target of filling 50% of all current vacancies in these cadres within 1two months.
- Ministry of Finance to increase the health wage bill to accommodate new hires and ensure that promotions for staff who have upgraded qualifications are processed within three months of eligibility.
- CAOs and PHROs to strictly enforce Public Service Standing Orders: salary recovery for all days absent without authorization; automatic referral to the Rewards and Sanctions Committee for any officer absent more than 5 days in a month without justification.
- MOH to implement and fully operationalize the Integrated Electronic Management System (IEMS) to track health worker presence, time-on-duty, and volume of work per individual — eliminating manual attendance registers as the sole accountability tool.
- Ministry of Health to institute mandatory monthly performance reporting by all facility in-charges to DHOs, and quarterly reviews by DHOs with CAOs.
- Recentralize recruitment of DHOs, Senior Medical Officers, and Medical Officers to the Health Service Commission, with MOH oversight, to ensure qualifications and independence from district political influence.
- MoH to develop and fund a national staff housing construction Programme, prioritizing facilities where non-residency is highest and where 24-hour emergency obstetric care is most needed.
- DHOs to implement a formal, structured induction Programme for all newly deployed facility in-charges, including mandatory handover from outgoing officers.

- Districts to establish functional Rewards and Sanctions Committees that meet quarterly and implement both consequences (for errant staff) and rewards (for best performers) consistently and transparently.

## 7.2 Leadership and Governance

### Analysis

Governance is the connective tissue of the health system — it determines whether resources are translated into services, whether standards are enforced, and whether accountability functions as intended. In FY 2023/24, HMU found governance failures at every level of the health system, from individual facility management through to district health offices and regional referral hospitals.

At the district level, long-standing DHO vacancies were the most consequential governance gap. Districts without substantive DHOs — Manafwa, Pader, Mukono, and Iganga — demonstrated consistently worse performance across all monitoring dimensions. Acting DHOs, where appointed, frequently lacked the requisite qualifications (Pader's Acting DHO had not completed medical internship and was not registered to practice), creating legal and professional accountability gaps. Even where DHOs were present, as in Kamwenge, active dereliction of duty by the DHO themselves represented the most severe governance failure encountered in this monitoring cycle.

Financial governance was particularly deficient. The review of financial records across all monitored districts revealed systematic patterns of mismanagement: payment vouchers were routinely missing; funds were disbursed without documentation; accountabilities were submitted for activities that were not implemented; and NTR (Non-Tax Revenue) collections were spent before banking. The near-universal failure to publicly display PHC fund receipts and expenditures — a specific legal requirement under the Public Finance Management Act — was especially striking, as this simple transparency measure would enable community-level oversight that is currently absent.

Support supervision, intended as the primary governance mechanism for maintaining service delivery standards at facility level, was widely found to be performative rather than substantive. Supervisors signed visitors' books but not supervision registers; identified gaps were documented but not followed up; and HUMCs held meetings without authenticated minutes or actionable plans. This supervision theatre provided the appearance of governance while failing to deliver its substance.

At the facility level, in-charges who had not received any orientation or handover upon deployment were unable to understand their facilities' financial history, staffing status, or outstanding accountability requirements. This governance gap at the point of transition created fertile ground for mismanagement of resources that could not be attributed to any specific individual.

The community dialogue (Baraza) model deployed by HMU in all monitored districts proved to be a powerful accountability mechanism. In Iganga, where over 2,000 community members confronted facility managers and district officials, and in Kamwenge, where over 3,000 attended the Baraza, public accountability produced visible behavioral changes from health workers and district officials who were visibly shaken by direct community scrutiny. This model demonstrates that community accountability mechanisms can complement formal governance structures where the latter have failed.

### Conclusion

Governance failure in Uganda's health sector is not primarily a resource problem — it is a systems, incentives, and accountability problem. The same resources that are being mismanaged could, under effective governance, be translated into measurably better health outcomes. The evidence from HMU monitoring shows that governance quality is a stronger predictor of health facility performance than resource levels: Buyende, with a full DHT and consistent support supervision, achieved better outcomes than richer districts with weaker governance.

The public Baraza model demonstrates the untapped potential of community accountability to complement formal governance mechanisms. Communities that understand their rights, know the PHC allocations their facilities should receive, and have a credible mechanism to report

mismanagement are an asset to the governance system — not a threat to it. HMU's strategic direction of citizen empowerment is well-aligned with the evidence on what works.

### Recommendations

- Health Service Commission to treat all substantive DHO vacancies as a Level 1 emergency. All positions to be filled within six months using accelerated recruitment processes, including secondment from MoH or RRHs if district-level candidates are unavailable.
- MOH to immediately prohibit the appointment of any Acting DHO who does not hold a valid medical registration and has not completed medical internship.
- CAOs to convene monthly accountability meetings with DHOs covering: staffing status, EMHS management, financial accountability, and service delivery performance — with written minutes and action logs.
- All facilities to publicly display PHC fund receipts and expenditures within 30 days of receipt, as required by law. CAOs to institute a quarterly compliance audit and sanction non-compliant in-charges.
- DHTs to adopt and implement a structured, standardized support supervision tool with written action plans that are shared with the CAO and followed up at the next visit.
- MOH to conduct annual governance audits of all Regional Referral Hospitals and constitute functional Hospital Boards at all RRHs within six months.
- OAG to institute forensic audits of all facilities where HMU has flagged financial queries exceeding UGX 100 million, and to complete these within six months of referral.
- HMU, in collaboration with RDCs and DLGs, to institutionalize annual community dialogues (Barazas) in all districts as a permanent accountability mechanism.
- MoH to develop and issue a binding Ministerial Circular requiring all facility in-charges to receive formal orientation and documented handover from outgoing officers before taking up post.

## 7.3 District Health Officers (DHOs) — Performance, Accountability, and System Stewardship

### Analysis

The District Health Officer is the technical apex of the district health system. The DHO and the District Health Team (DHT) are responsible for health planning, resource allocation, support supervision, EMHS management, HR accountability, and community engagement across all public and private facilities in the district. The performance and presence of the DHO is therefore a critical system variable with direct implications for every other dimension of district health performance.

HMU monitoring in FY 2023/24 produced compelling evidence of the DHO effect. In Buyende — the only monitored district with a full, substantive DHT — staffing levels were 53% (the highest among monitored districts), medicines management showed no discrepancies, community accountability structures were functional, and the district had identified internal centers of excellence. In Iganga, where the DHO position had been vacant since 2021, the hospital operated in a governance vacuum, with the top management team reportedly working in isolation and hospital resources inaccessible to staff. In Pader, where the substantive DHO position has been vacant for over a decade (since 2013), health facility performance across all dimensions was among the lowest observed — staffing at 32%, C-section rates at 2.48% (clinically inadequate), and no ELMIS or eHMIS operationalized anywhere in the district.

The pattern of DHO absenteeism was equally concerning in districts where substantive DHOs were present. In Kamwenge, the DHO and DHT members were documented as chronically absent and failing in their stewardship role. This directly contributed to: the highest C-section rate (31.2%) observed across all monitored districts; the highest neonatal death count in any district; rampant IPC

violations at multiple facilities; and EMHS management failures that included stolen medicines, improper storage, and failure to collect expired commodities.

Acting DHOs with inadequate qualifications (Pader) created an additional accountability gap: they could not provide clinical leadership to facility-level staff, could not engage credibly with professional bodies or the Health Service Commission, and operated in a legally ambiguous space where it was unclear whether their official decisions and signatories had legal standing.

The relationship between DHO performance and NMS supply chain accountability deserves particular attention. DHOs are responsible for facilitating EMHS redistribution across district facilities, coordinating disposal of expired medicines, following up on NMS delivery discrepancies, and ensuring that facilities are enrolled on the NMS grid. In districts with weak DHT leadership, all of these functions failed — as evidenced by the two-year gap since Namayumba Epi-Centre HCIII and Sentema HCII last enrolled on the NMS grid in Wakiso.

### Conclusion

The DHO's office is not one component of the health system — it is the integrating architecture that holds all other components together. When the DHO fails, everything downstream fails. The evidence from FY 2023/24 monitoring is unambiguous: districts with substantive, present, and capable DHOs perform better across every dimension of health system function. The investment case for filling DHO vacancies and enforcing DHO accountability is among the strongest in Uganda's health sector.

The monitoring evidence also points to an important structural reform: the DHO should not be assessed solely on administrative tasks but on measurable district health outcomes — maternal mortality ratios, vaccination coverage, facility delivery rates, medicine stockout rates, and financial accountability compliance. A performance-linked accountability framework for DHOs would transform the incentive environment for district health leadership.

### Recommendations

- Health Service Commission to treat DHO vacancies as a national health emergency and fill all vacancies within six months. Where district-level recruitment fails, MoH to second qualified officers from the national level.
- MOH to develop and implement a performance framework for DHOs and DHT members with quarterly measurable targets linked to district health outcomes — staffing rates, EMHS stockout rates, financial accountability compliance, and MCH indicators.
- CAOs to implement a monthly accountability register for DHOs, documenting: days at work, facilities supervised, financial queries addressed, and HR cases processed.
- Any Acting DHO who does not meet the minimum qualification requirements (medical degree, completion of internship, and valid medical registration) must be relieved of the acting role within 30 days.
- MOH to formally define the supervisory responsibility of DHOs for EMHS management — including quarterly facility EMHS audits, annual NMS enrollment reviews, and coordination of expired medicine collection — and include these in DHO performance assessments.
- MoH to consider recentralizing DHO performance oversight to the MOH/HSC level, with binding performance targets that cannot be overridden by district political dynamics.

## 7.4 Essential Medicines and Health Supplies (EMHS)

### Analysis

Access to essential medicines and health supplies is a fundamental determinant of health service quality. In FY 2023/24, HMU found the EMHS supply chain to be severely compromised across all monitored districts, with dysfunctions operating at three levels: national supply chain (NMS), district management (DHO/pharmacist), and facility management (store managers and clinical staff).

NMS Performance: National Medical Stores failed to deliver the full six planned bimonthly supply cycles to most monitored districts in FY 2022/23. In Namutumba, NMS delivered an average of only 84.5% of the EMHS budget to HCIIIs and 94.8% to Nsinze HCIV. In Manafwa, all HCIIIs experienced three consecutive months without any NMS delivery. In Mpigi, NMS did not deliver 2 of 6 planned cycles worth UGX 128,864,211. Paradoxically, NMS simultaneously delivered three cycles at once to some districts (including Iganga in April 2023), creating a different problem: overstocking of items with short shelf lives that subsequently expired. NMS also routinely delivered short-dated stock to lower-level facilities incapable of consuming it before expiry — a supply chain practice that wastes government resources and creates theft opportunities. The inconsistency and unpredictability of NMS deliveries made facility-level planning and consumption monitoring effectively impossible.

District Management: In the absence of district pharmacists (absent in Mukono, Jinja, Pader, and others), EMHS oversight was either delegated to unqualified store managers or simply not performed. The DHO's office failed in most districts to conduct monthly EMHS audits — the primary mechanism for detecting discrepancies before they accumulate to significant losses. Inter-facility redistribution of medicines — intended as a mechanism to address imbalances between overstocked and understocked facilities — was either delegated entirely to Implementing Partners (MJAP in Jinja, Baylor in Kamwenge) without adequate DHT supervision, or performed informally without documentation, creating further accountability gaps.

Facility Management: Stock cards were the most widely abused documentary system in the health sector. They were rarely updated at the time of transactions, frequently contained incorrect balances, and in some cases (Sironko — Buwasa HCIV) had been entirely lost. Dispensing logs — essential for tracking consumption at the departmental level and for projecting future orders — were absent in the majority of facilities or were maintained for some departments but not others (typically absent for laboratories and theatres). Requisition and Issue Vouchers were routinely signed by a single person who acted simultaneously as requisitioner, authorizer, and recipient — eliminating the triple-party control that the system was designed to provide.

Active theft was confirmed in multiple districts through HMU-led audits and police action. The scale and sophistication of medicine theft varied from individual pilferage (store manager at Bugobero HCIV taking 200 vials of Artesunate) to systemic diversion (empty boxes of HIV Determine kits delivered to Nakalama HCIII, with fake discrepancy forms; possible theft of 2,252 tins of TLD at Butagaya HCIII). ELMIS (Rx-solution) was installed at some facilities as an accountability tool, but was effective nowhere — due to lack of training, infrequent updating, and absence of adequate computers and internet connectivity.

## Conclusion

The EMHS supply chain failure in Uganda's public health sector is costing lives. Patients with malaria who cannot access Artesunate, pregnant mothers who deliver without Mama Kits, neonates born at facilities without Ceftriaxone for sepsis prophylaxis — these are the human consequences of supply chain dysfunction. The financial losses are also substantial: conservative estimates from EMHS audits conducted by HMU in a single year found losses and queries exceeding UGX 100 million in several individual districts.

The evidence indicates that the current paper-based EMHS accountability system is fundamentally inadequate for the scale of activity and the temptation environment in health facilities. The system requires digitalization — not as a luxury, but as a basic accountability tool. Simultaneously, the structural deficiencies must be addressed: more district pharmacists, stricter NMS delivery practices, and enforced internal controls at facility level.

## Recommendations

- NMS Board to institute immediate corrective measures: enforce bimonthly delivery schedules; deliver no more than one cycle per facility per delivery; cease delivery of medicines with less than 6 months' shelf life to any facility; and cease deliveries after 7 pm to enable proper verification.
- MOH and NMS to jointly develop and publish facility-level EMHS delivery tracking dashboards accessible to DHOs and facility in-charges in real time.

- MOH to fast-track the national rollout of ELMIS (Rx-solution) to all public health facilities, with mandatory training and quarterly competency assessment for all store managers.
- MoH to allocate at least one government-employed pharmacist to every district (currently absent in multiple monitored districts) and at least one pharmacy technician to every HCIV.
- All facilities to constitute formal three-person committees for receiving NMS deliveries — no single individual may receive, record, and issue medicines. Non-compliance to be treated as a disciplinary matter by the CAO.
- DHOs to conduct monthly unannounced EMHS spot checks at all facilities within their jurisdiction, with findings reported to the CAO and shared publicly.
- NMS to emboss or mark all sundries and laboratory kits with a traceable code to deter theft and enable tracing of diverted government commodities.
- MOH to develop and implement a national inter-facility EMHS transfer policy that enables redistribution of excess stock between facilities, with mandatory documentation and DHO oversight.
- Districts to implement mandatory monthly physical stock counts in all drug stores, with signed verification forms submitted to the DHO.

## 7.5 Infrastructure and Equipment

### Analysis

Health infrastructure provides the physical platform without which human resources, medicines, and equipment cannot function. In FY 2023/24, HMU documented a pervasive infrastructure deficit across all monitored districts that ranged from the cosmetic (unkempt compounds, dirty wards) to the structurally threatening (condemned buildings at Entebbe RRH Grade A, collapsed OPD roof at Latanya HCIII in Pader, land encroachment threatening facility expansion at multiple sites).

The phenomenon of pseudo-classification — where facilities are designated at one level of care but lack the infrastructure to deliver the services that level requires — was documented across Wakiso, Iganga, Jinja, Sironko, and Mpigi. Facilities classified as HCIIIs that lack maternity wards, HCIIIs that cannot admit patients due to absent general wards, and HCIVs that lack functional theatres — all represent a mismatch between official designation and physical capacity that misleads communities about the services they can expect and distorts resource allocation from NMS (which delivers EMHS based on facility classification).

Equipment failure at regional maintenance workshops was a recurring theme. The Wabigalo Regional Workshop, cited specifically by Wakiso District facilities, failed to return equipment after repair or returned items in a worse state. This systemic failure has rendered large quantities of diagnostic and medical equipment non-functional across the region, while facilities have no alternative procurement pathway and insufficient budgets to replace equipment out-of-pocket. At Entebbe RRH, a CT scanner, ultrasound machines, X-ray equipment, and incubators were all non-functional — in a hospital designated as the first line of contact for the Presidency.

Land encroachment and land titling failures were documented in almost every monitored district and represented a structural threat to health system development. Without land titles, facilities cannot obtain building permits, cannot access infrastructure development financing, and cannot take legal action against encroachers. In several cases (Kasozi HCIII in Wakiso, Watuba HCIII in Wakiso, multiple facilities in Jinja City), encroachment was actively ongoing with complicity or inaction from district technical officials.

The allocation and distribution of beds and mattresses through Members of Parliament — rather than through MoH/DHO channels — represented a governance failure with direct infrastructure consequences. HMU documented cases in Wakiso and Mukono where beds and mattresses remained with MPs for nearly two years without being delivered to intended health facilities. Patients in these facilities were sleeping on bare frames or on beds with torn, blood-stained mattresses without mackintosh covers.

### Conclusion

Infrastructure investment in Uganda's public health sector has been chronically underfunded relative to need, and what funding has been allocated has frequently been diverted through fraudulent procurement (documented in Kitagwenda and Pader) or wasted through poor construction quality (Entebbe RRH isolation center renovation). The evidence from FY 2023/24 monitoring suggests that the priority is not only to invest more but to invest better: through transparent procurement, effective maintenance, land security, and rational facility upgrade planning based on utilization data rather than political considerations.

### Recommendations

- MOH and MoFPED to increase the Capital Development budget for health facilities in the FY 2024/25 and 2025/26 national budgets, with a minimum target of upgrading 5 high-volume HCIIIs to HCIVs and 3 high-volume HCIVs to General Hospitals.
- MOH to review and comprehensively reform the regional equipment maintenance workshop model. Specific reforms to include: binding service level agreements for equipment return timelines; public accountability reporting on workshop performance; and alternative procurement options for facilities where workshops consistently fail.
- All District Local Governments to process and secure land titles for all public health facilities within 1two months. Where encroachment is ongoing, RDCs to coordinate with police and courts to halt it. MoH to provide technical and legal support.
- MOH to immediately halt the practice of distributing health facility infrastructure assets (beds, mattresses, equipment) through Members of Parliament. All such assets to be delivered directly from NMS or MoH stores to the intended facilities, with delivery confirmation signed by the facility in-charge.
- MOH to commission an immediate value-for-money audit of the Entebbe RRH COVID-19 isolation center renovation, and to complete outstanding fittings within six months.
- MOH to develop a national health facility infrastructure database, updated annually, that maps the actual infrastructure and equipment capacity of every public health facility against its designated level — to identify and prioritize pseudo-classification corrections.
- Construct mortuaries with solar-powered refrigeration at all General Hospitals and HCIVs as an immediate priority — currently virtually absent across all monitored districts.
- All health facility equipment to be engraved with government property marks as a theft deterrent, with annual equipment inventory verification.

## 7.6 Health Service Delivery

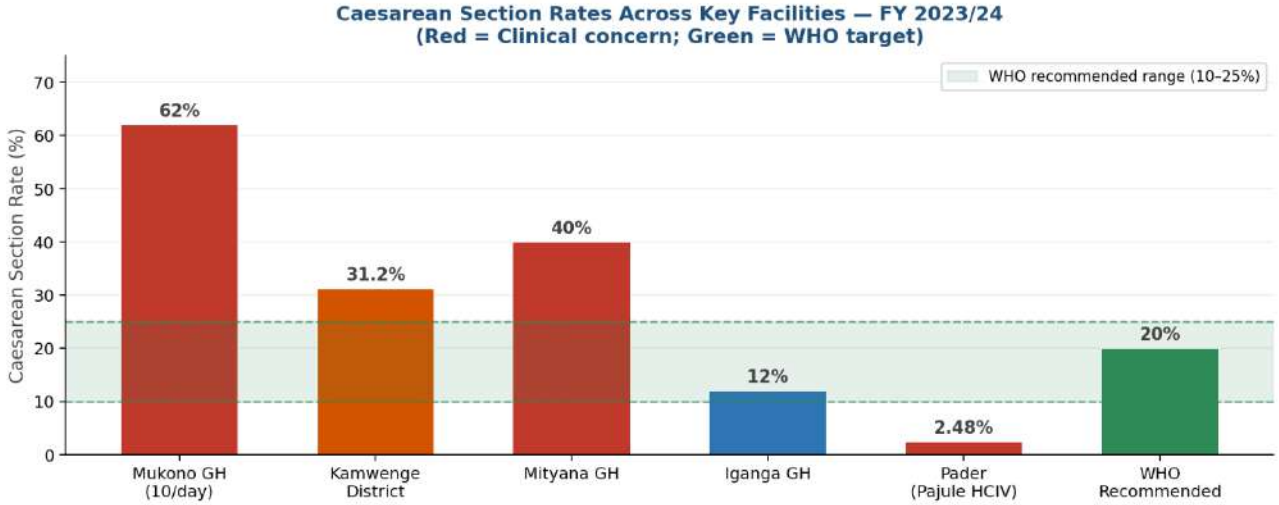
### Analysis

Health service delivery is the ultimate output of the health system — the synthesis of human resources, medicines, infrastructure, governance, and information. In FY 2023/24, HMU found that service delivery across monitored districts was characterized by a paradox: despite severe resource constraints, communities continued to seek care at public facilities, often in larger numbers than facilities were designed to serve; yet the quality, completeness, and reliability of the services offered fell consistently below the Ministry of Health's prescribed minimum package.

Maternal and Child Health (MCH) services emerged across all districts as the most active, organised, and impactful department in visited health facilities. This reflects both the high community demand for facility-based delivery and the disproportionate attention that MCH departments have received from implementing partner support over the years. However, even in this relatively strongest area, significant quality failures were documented: inadequate midwife staffing leading to unsupervised deliveries; absent doppler machines and non-functional delivery lamps; dirty labour suites; and stockouts of Mama Kits and emergency obstetric medicines in facilities with high delivery volumes.

Patient extortion was the most widely reported quality failure and the most directly harmful to patient access. At Mukono GH, Buwenge HCIV (Jinja), Buwenge GH (Jinja), Mpigi HCIV, Nindye HCIII, and Rukunyu Hospital (Kamwenge), patients — particularly delivering mothers and those requiring surgical intervention — were routinely charged illegal fees. Extortion was confirmed through community testimony at Barazas, physical evidence (cash collection noted by HMU teams), and staff admissions. This directly drives avoidance of public health facilities, contributing to late presentation, delivery with TBAs, and preventable mortality.

The C-section paradox observed at Mukono GH (1,875 sections in six months; 10/day) and Kamwenge district (31.2% C-section rate) represents a critical quality failure at the opposite pole from Pader (2.48% C-section rate at Pajule HCIV). Both extremes indicate dysfunction: over-medicalization driven by financial incentives in Mukono, and clinical failure driven by absenteeism in Pader. The recommended C-section rate of 20–25% of deliveries reflects both genuine clinical need and appropriate clinical management — neither systematically denying nor over-providing surgical intervention.




Inpatient services were severely underutilized at many facilities with available wards. In some cases (Nakalama HCIII in Iganga, Kisiima HCIII in Jinja, Bunjako HCIII in Mpigi), available ward rooms had been converted to stores while patients went without inpatient services. In others, beds were empty due to absence of clinical staff willing to admit patients. This underutilization represents a significant missed opportunity for the health system: inpatient services are disproportionately important for serious illness management and maternal complications, and their absence drives costly referrals to higher-level facilities.

Laboratory and diagnostic services were the second most consistently functional service across monitored facilities, though significant equipment gaps (absent CBC machines, CD4 machines, Gene Expert for TB, and ultrasound scanners at HCIV level) limited the range of services. The diminishing use of microscopy in favor of rapid diagnostic tests (RDTs) — documented in Kamwenge and other districts — is creating technical skill atrophy in laboratory staff who are losing microscopy competence, with long-term implications for diagnostic quality and epidemic preparedness.

## Conclusion

Health service delivery in Uganda's public health sector requires a fundamental quality upgrade alongside resource increases. The evidence from FY 2023/24 monitoring shows that resource injection alone — more staff, more medicines, better infrastructure — will not achieve quality improvement in the absence of accountability for how resources are used and how patients are treated. Extortion, unnecessary C-sections, underutilized wards, and absent in-charges all occur in the presence of adequate resources; they are governance and accountability failures, not resource failures.

The community Baraza evidence consistently showed that communities are capable and willing partners in health system accountability. Communities knew which health workers were absent, which were extorting patients, and which were providing excellent care. Empowering communities

with accurate information about their entitlements and effective mechanisms to report abuses is a cost-effective complement to formal accountability mechanisms.

### Recommendations

- MOH and Uganda Police Force to adopt and enforce a zero-tolerance policy for patient extortion in all public health facilities. Prosecute confirmed cases publicly, and publicize outcomes to deter future extortion.
- MOH to commission an immediate clinical audit of C-section rates at Mukono GH and Kamwenge district, with findings reported to the Director General of Health Services. Establish clinical audit committees at all General Hospitals and RRHs to review major surgical decisions monthly.
- All HCIVs with functional theatres to operationalize 24-hour emergency obstetric care, with monthly theatre output targets set and publicly reported for each Medical Officer.
- All facility in-charges to restore inpatient wards to their designated purpose within 30 days; no general ward to be used for storage. DHOs to verify compliance at next supervision visit.
- MOH to upgrade all facilities with consistent OPD attendance above 3,000/month (HCIII) or 5,000/month (HCIV) to the next level of care, using utilization data from the HMIS as the primary criterion.
- MOH to mandate laboratory quality improvement programs in all General Hospitals and HCIVs, including microscopy skills refresher training, to arrest the decline in diagnostic competence.
- All facilities to establish and display monthly MCH performance dashboards (ANC 1, ANC1 in the first trimester, ANC 4, facility deliveries, maternal deaths) accessible to communities.

## 7.7 Infection Prevention and Control (IPC)

### Analysis

Infection Prevention and Control encompasses the practices, protocols, and physical infrastructure that protect patients, health workers, and communities from healthcare-associated infections. In FY 2023/24, HMU found IPC compliance to be one of the weakest dimensions of health system performance, with critical failures documented across all monitored districts and facility levels.

The labour suite was consistently the most IPC-deficient environment in all visited facilities, representing a direct patient safety risk. Blood and meconium-stained delivery beds that were not cleaned between patients, dirty aprons worn throughout multiple deliveries without washing, unsterilized delivery sets reused across patients, walls and floors soiled with biological material — these conditions were not exceptions but the norm across most HCIIIs and several HCIVs. In Kamwenge, HMU documented midwives at Binonga, Biguli, Bigodi, and Kabingo HCIIIs using unsterilized equipment to deliver mothers — a practice that directly risks sepsis for both mother and newborn. In Manafwa, the blood bank refrigerator at Bugobero HCIV was non-functional, with blood for transfusion being stored in the vaccine refrigerator.

Handwashing compliance, the most cost-effective IPC measure globally, was deficient at multiple levels. Physical handwashing infrastructure (sinks, water sources, soap, and sanitizer) was absent at key clinical touch points — OPD consultation desks, labour suite entry points, and medicine dispensing windows — in the majority of monitored facilities. In Jinja district, Buwasa HCIV and Budadiri HCIV lacked liquid soap at OPD. In Iganga, handwashing equipment and soap were absent from the maternity wards of Namungalwe, Nakalama, and Iganga Municipal Health Centres. EMHS supply failures compounded the problem, as liquid soap, hand sanitizer, and bin liners were consistently the first items to stockout.

Waste management practices were universally substandard. In Pader, all facilities used open burning within facility premises for all categories of healthcare waste, including infectious materials — a practice that creates dioxin exposure for facility staff and nearby communities. No monitored district had universal access to incinerators. In Sironko, three facilities contracted waste disposal

companies for highly infectious waste, but the majority relied on open burning. Color-coded waste bins were physically present in most facilities but were routinely misused — infectious waste was placed in general waste bins and vice versa — suggesting that the physical infrastructure exists but IPC behavior has not been established.

IPC committees, mandated at all levels of the health system, existed on paper in most facilities but were functionally inactive. In Kamwenge, no facility had a functional IPC committee despite IPC committees being listed as constituted in facility records. This illustrates the gap between paper compliance and functional compliance that characterizes governance across the health system: tools and structures exist but are not implemented with fidelity.

The neonatal sepsis epidemic documented in Kitagwenda represents the most extreme consequence of IPC failure. Sepsis in neonates — a directly preventable cause of death — was linked by district health workers to both poor IPC in labour suites (unsterilized equipment, dirty environments) and cultural practices (application of traditional substances to the cord stump). The failure of IPC education to reach both health workers and communities creates a double vulnerability for the most fragile patients.

## Conclusion

IPC failure in Uganda's health facilities is not primarily a resource problem — it is a behavior, training, and accountability problem. The majority of the most harmful IPC failures documented in FY 2023/24 — blood-stained delivery beds, unsterilized equipment, improper waste segregation — require no additional budget to correct. They require a commitment to and enforcement of professional standards of practice. However, resource constraints do compound the problem: when liquid soap is out of stock, even motivated health workers cannot comply with handwashing protocols; when water supply is unreliable, cleaning becomes impossible.

## Recommendations

- MOH to develop and distribute a mandatory IPC minimum standards checklist for all public health facilities, with monthly self-assessment and quarterly verification by DHT supervisors.
- All facility in-charges to institute daily inspection of the labour suite at the start of each shift: cleanliness verification, delivery set sterilization confirmation, and handwashing equipment check — with a signed daily log.
- All health facilities to reactivate IPC committees with monthly meetings, documented action plans, and quarterly reporting to DHO. CAO to include IPC committee functionality in facility performance assessments.
- NMS to include liquid soap, hand sanitizer, and bin liners as non-negotiable items in every delivery cycle, and to ensure their availability at OPD, labour suite, and laboratory in every facility.
- All health facilities to transition from open burning to contracted infectious waste disposal or functional incinerators within 24 months. MOH to fund incinerator construction at all General Hospitals and HCIVs.
- MOH to develop and disseminate an IPC education module for communities, targeting specifically the dangers of traditional birth practices and cord care, in all major local languages.
- DHOs to incorporate IPC compliance as a standard item in all support supervision visits, with photographic documentation and a written action log signed by the facility in-charge.
- All facilities handling deliveries to ensure color-coded waste bins are present at the bedside in the labour suite, with bin liners changed after every delivery.

## 7.8 HMIS, EMR, and Digitalization (EAFYA / eLMIS / eHMIS)

### Analysis

A robust health information system is the nervous system of the health system — it enables real-time monitoring of service delivery, evidence-based resource allocation, supply chain management, human resource tracking, and disease surveillance. In FY 2023/24, HMU found that Uganda's public health information systems at the facility level were operating predominantly on paper-based tools, with digital systems either absent, installed but unused, or partially functional without adequate maintenance or connectivity.

The three principal digital systems relevant to facility-level health information in Uganda — eHMIS (for patient and service delivery data), ELMIS/Rx-solution (for pharmaceutical logistics), and EMR systems (for patient clinical records) — were all found to be severely under implemented in the monitored districts. In Pader, no facility was using eHMIS or ELMIS of any kind. In Sironko, ELMIS was installed in only 4 of 8 monitored facilities, and none were up-to-date. In Namutumba, manual LMIS tools were the only record-keeping system available. In Wakiso, internet speeds at facilities that were connected averaged 5–10 minutes per patient record — rendering the system functionally unusable for busy OPDs.

The infrastructure prerequisites for digitalization are largely absent in lower-level facilities: computers (most HCIIIs and many HCIVs have none), reliable electricity (3 HCIIIs in Sironko lacked grid power and no generators), internet connectivity (few facilities have functional broadband), and Local Area Networks (LAN). Entebbe RRH — a facility of national strategic importance — received 25 desktop computers, 45 laptops, and 15 tablets from MoH in 2020 that remained entirely redundant at the time of the HMU visit five years later, with no utilization plan issued by MoH.

The consequences of this digital gap are system-wide and compound across functions. Without ELMIS, EMHS accountability relies on paper stock cards that are easily manipulated and difficult to audit — the primary enabler of medicine theft. Without eHMIS, service delivery data is compiled manually with all the attendant inaccuracies and delays that make it impossible for MOH to have real-time district performance visibility. Without EMR, patient clinical histories are not portable between facilities, referral notes are often incomplete or absent, and clinical research is impossible. The paper systems in place are not just slow — they are actively harmful to accountability.

Training gaps were universally cited as a barrier to ELMIS utilization. Store managers who had been delegated responsibility for EMHS management in HCIIIs could not navigate the Rx-solution system independently. CHOs and DHOs could not generate procurement orders through the NMS Client Self-Service Portal (CSSP). In-charges who had received a brief orientation to eHMIS years previously had not received refresher training and reverted to paper-based HMIS tools. The absence of an ICT officer at facility and district level — a role that does not exist in the current staffing norms — meant that there was no dedicated person responsible for maintaining and updating digital systems.

### Conclusion

The digitalization of Uganda's health information system is not a future aspiration — it is an immediate operational necessity. The financial losses documented in EMHS audits, the clinical information gaps that contribute to maternal deaths, and the absence of real-time performance data for MOH and district management are all direct consequences of the current paper-based system's failure. Digitalization at scale requires a coordinated investment in infrastructure (connectivity, devices, power), training (all relevant staff at all levels), technical support (ICT officers), and governance (mandated use and regular system audits).

The evidence also shows that digital systems installed without training, maintenance, and connectivity investment are a waste of resources. The Entebbe RRH experience — 85 devices installed in 2020 and never used — is a cautionary lesson for future health system digitalization investments. Effective implementation requires a complete package: hardware, software, connectivity, training, maintenance, and accountability for use.

## Recommendations

- MOH to develop and fund, within six months, a comprehensive national ICT infrastructure investment plan for all public health facilities above HCII level, covering: minimum device specifications (computers/tablets), LAN installation at all HCIVs and above, reliable internet connectivity (minimum 10Mbps at HCIVs, 4G connectivity at HCIIIs), and solar power backup for digital infrastructure.
- MOH to mandate ELMIS (Rx-solution) as the standard pharmaceutical management system and provide comprehensive training to all facility in-charges, store managers, and HMIS officers — with competency verification tests after training and annual refresher training.
- MOH to implement eHMIS at all public health facilities and mandate reporting by all health facilities through the digital system by July 2025. Paper-based reporting to be retained only as a backup in areas with no digital connectivity.
- MOH to develop a phased plan for national EMR rollout, beginning with General Hospitals and Regional Referral Hospitals. Each phase to include connectivity, training, and governance milestones.
- MOH to immediately audit all ICT equipment distributed to health facilities from 2019 to 2024, assess functionality, develop a utilization plan with accountability assignments, and replace non-functional items.
- MOH to create an ICT Officer post in the staffing norms for all General Hospitals and HCIVs, responsible for digital system maintenance, training, and reporting.
- DHOs to include HMIS/ELMIS compliance in monthly support supervision checklists and report ELMIS update rates quarterly to the MOH Director of Health Information.
- NMS to make the Client Self-Service Portal (CSSP) training mandatory for all new facility in-charges and store managers, and to verify CSSP competency annually as a condition for continued facility credit line access.

# 8.0 OVERALL CONCLUSIONS

The HMU monitoring activities in FY 2023/24 confirm that Uganda's public health sector is operating at a fraction of its potential, constrained by deeply intertwined challenges across the eight thematic domains assessed. The monitoring evidence from 16 districts and over 235 health facilities tell a consistent story: a health system under severe stress, where governance failures enable resource diversion, where resource diversion enables service delivery failures, and where service delivery failures erode community trust in a self-reinforcing cycle of decline.

Yet the evidence also demonstrates that positive change is possible and that HMU's dual mandate of monitoring and health systems strengthening is effective. In every monitored district, HMU interventions — arrests, administrative directives, capacity building, community dialogues, equipment repairs, and land titling support — produced measurable improvements within the monitoring cycle itself. A non-functional boiler at Entebbe RRH was operationalized. An illegal private wing at Iganga General Hospital was closed. A stolen vehicle in Manafwa was returned. Kakooge HCIII in Buyende was recognized as a center of excellence, demonstrating that high-quality health service delivery is achievable even within a resource-constrained system when leadership and governance are strong.

The total financial audit query of UGX 7.36 billion represents the visible tip of a much larger accountability iceberg. If even 50% of these funds were recovered and reinvested, they could fund the annual salaries of several hundred health workers, supply EMHS for dozens of facilities for a full financial year, or construct and equip multiple maternity wards. The fight against financial mismanagement in the health sector is therefore not only an ethical imperative — it is a direct investment in health outcomes.

Several cross-cutting themes emerge from the totality of FY 2023/24 monitoring evidence. First, leadership quality is the primary modifiable determinant of health system performance at every level. Second, community accountability mechanisms are underutilized but highly effective when properly empowered. Third, digitalization is not a luxury but a fundamental accountability tool whose absence enables and facilitates resource leakage. Fourth, the HRH crisis will not resolve without both structural reform (lifting the recruitment ban) and behavioral change (enforcing attendance and performance standards). Fifth, NMS's failure to adhere to delivery schedules is the single most frequently cited cause of stockouts and must be addressed as a governance and operational priority at the national level.

HMU remains firmly committed to its mandate of raising the bar in healthcare delivery. The findings and recommendations in this report are offered in the spirit of accountability, partnership, and improvement — with confidence that Uganda's health system can deliver better outcomes for every citizen when all actors fulfil their responsibilities with integrity and purpose.

# 9.0 NATIONAL RECOMMENDATIONS SUMMARY

The following consolidated national-level recommendations are directed at named responsible authorities for immediate action. They arise directly from the cross-cutting thematic analysis in Section 7 and the district findings in Section 4. Each recommendation is specific, measurable, and time-bound where appropriate.

### Ministry of Health (MoH)

- Increase EMHS budgets for all Regional Referral Hospitals to parity with comparable hospitals within the FY 2024/25 budget.
- Fast-track the national rollout of ELMIS (Rx-solution) and eHMIS; mandate digital reporting from all facilities above HCII level by July 2025.
- Develop and fund a national ICT infrastructure investment plan for all public health facilities.
- Develop and enforce a national IPC minimum standards package with quarterly compliance audits.
- Upgrade high-volume HCIIIs to HCIVs and high-volume HCIVs to General Hospitals based on HMIS utilization data.
- Reform the regional equipment maintenance workshop model with binding service level agreements.
- Constitute and operationalize Hospital Boards at all Regional Referral Hospitals within six months.
- Halt distribution of health infrastructure assets through Members of Parliament; require direct facility delivery.
- Commission an immediate clinical audit of C-section rates at Mukono GH and Kamwenge district.
- Develop a national Health Facility Infrastructure Database updated annually.

### Ministry of Finance, Planning and Economic Development (MoFPED)

- Increase health capital development budget and provide ring-fenced allocations for facility infrastructure, land titling, and EMHS.
- Adequately fund NMS to enable delivery of all six planned bimonthly EMHS cycles to all public health facilities.
- Ensure the health wage bill accommodates recruitment of all critical vacant positions and timely promotions.

### Ministry of Public Service (MoPS)

- Issue immediate targeted waivers to the health sector recruitment ban for midwives, anaesthetic officers, medical officers, pharmacists, and laboratory technicians.
- Fast-track promotion processing for health workers who have upgraded qualifications and meet eligibility criteria, with a target of 3-month processing time.

### Health Service Commission (HSC)

- Treat all substantive DHO vacancies as a national emergency; fill all positions within six months using accelerated processes including national-level secondment.
- Prohibit appointment of Acting DHOs who do not hold valid medical registration and have not completed internship.
- Conduct thorough qualification and track record vetting during all health sector recruitment.

### National Medical Stores (NMS)

- Strictly adhere to bimonthly delivery schedules; deliver no more than one cycle per facility per delivery.
- Cease all delivery of medicines with less than 6 months' shelf life to any public health facility.
- Cease deliveries after 7 pm to allow proper verification and recording.
- Emboss all sundries and laboratory kits with traceable government property codes.
- Make Client Self-Service Portal (CSSP) training mandatory for all facility store managers.
- Resolve the EMHS budget performance gaps documented in Iganga, Jinja, Manafwa, and Sironko districts immediately.

### District Local Governments — Chief Administrative Officers (CAOs)

- Process and secure land titles for all public health facilities within 1two months.
- Convene monthly accountability meetings with DHOs and document outcomes in written action logs.
- Enforce zero tolerance for patient extortion; prosecute all confirmed cases.
- Implement functional Rewards and Sanctions mechanisms consistently and equitably.
- Ensure monthly EMHS audits at all health facilities are conducted by the DHO/pharmacist.
- Deploy fully qualified, registered pharmacists at district level and at all HCIVs.
- Recover salary paid to health workers documented as absent without leave.

### District Health Officers (DHOs)

- Conduct monthly unannounced EMHS spot checks at all facilities in the district.
- Implement structured quarterly support supervision using standardized tools with written action plans.
- Report ELMIS update rates quarterly to MOH Director of Health Information.
- Coordinate collection of expired medicines from all facilities for NMS disposal within 30 days of expiry identification.
- Include IPC compliance as a standard item in all support supervision visits, with photographic documentation.

### Health Facility In-Charges

- Publicly display PHC fund receipts and expenditures within 30 days of receipt, as legally required.
- Conduct daily inspection of labour suite at start of each shift with a signed daily log.
- Constitute and operationalize IPC committees with monthly meetings and documented action plans.
- Restore all inpatient wards to their designated purpose; no ward to be used for storage.
- Ensure all staff maintain updated attendance registers and biometric records.

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# ANNUAL REPORT
## FINANCIAL YEAR 2023/24


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