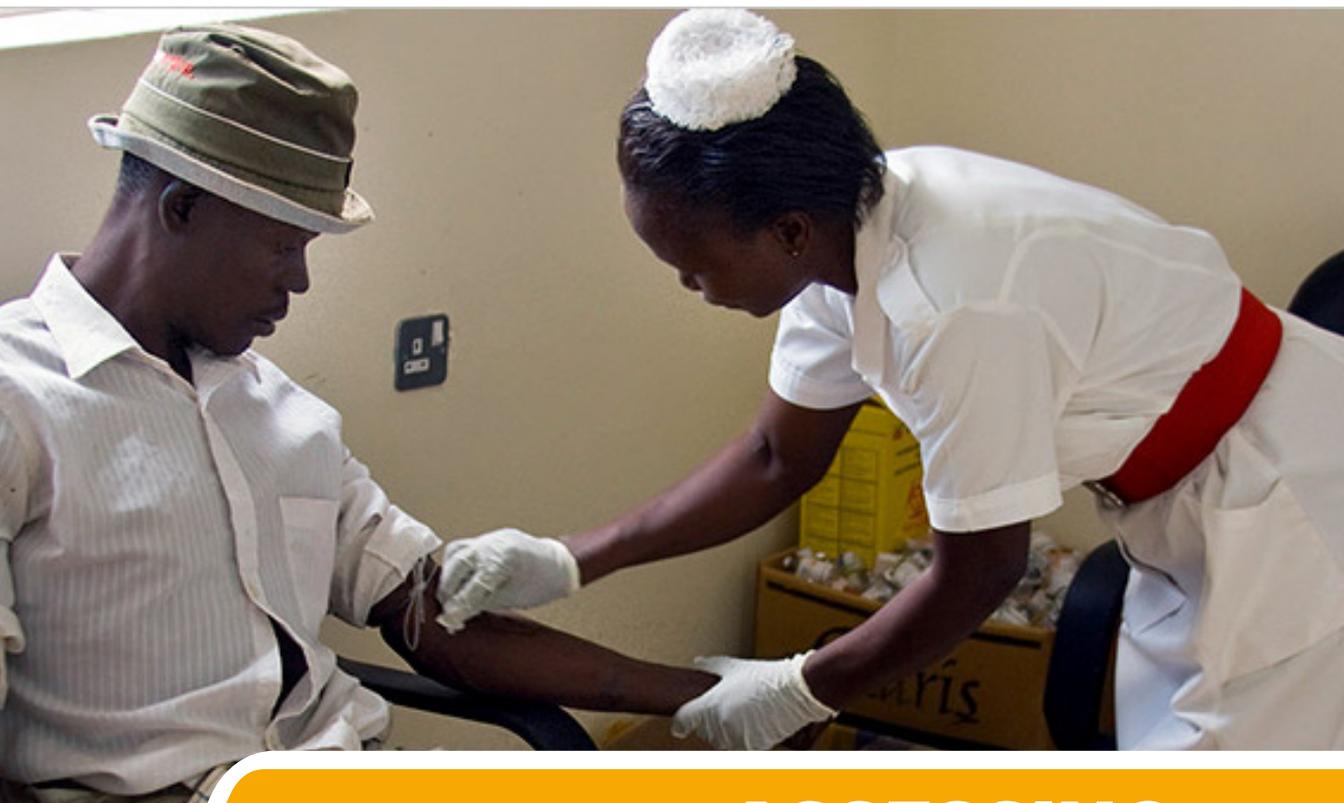




ADVOCATES COALITION FOR DEVELOPMENT AND ENVIRONMENT



ASSESSING PUBLIC EXPENDITURE GOVERNANCE OF THE PRIMARY HEALTH CARE PROGRAMME IN UGANDA

Emmanuel Keith Kisaame | Moses Mukundane | Ramathan Ggoobi | Richard Ayesigwa

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Emmanuel Keith Kisaame

Moses Mukundane

Ramathan Ggoobi

Richard Ayesigwa

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P.O Box 29836, Kampala

Email: acode@acode-u.org

Website: <http://www.acode-u.org>

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Acronyms

ACODE	Advocates Coalition For Development and Environment
CAO	Chief Administrative Officer
CHEWs	Community Health Extension Workers
DDHS	District Directorate of Health Services
DDP	District Development Plan
DHO	District Health Officer
DLGs	District Local Governments
FGDs	Focus Group Discussions
HDPs	Health Development Partners
HSD	Health Sub District
HUMCs	Health Unit Management Committees
KII	Key Informant Interviews
MoH	Ministry of Health
NDP II	National Development Plan II
NMHCP	National Minimum Health Care Package
NPA	National Planning Authority
PEG	Public Expenditure Governance
PHC	Primary Health Care
PNFPs	Private-Not-For-Profit Health Facilities
DGs	Sustainable Development Goals
TCMPs	Complementary Medicine Practitioners
UGX	Uganda Shillings
VHTs	Village Health Teams
WHO	World Health Organization

Executive Summary

The need to provide affordable and good quality healthcare is shared by Uganda and many other countries across the world. This is reflected in the third Sustainable Development Goal (SDG 3), which aims “to achieve universal health coverage, and provide access to safe and affordable medicines and vaccines for all.” In domesticating SDG 3, the overall goal of Uganda’s Health Sector Development Plan (HSDP 2015/16 – 2019/20) is *to accelerate movement towards Universal Health Coverage with essential health and related services needed for promotion of a healthy and productive life*. The provision of universal health coverage is what has come to be defined as Primary Health Care (PHC) in many countries globally.

Health policy literature indicates that provision of PHC was adopted to address weaknesses of health systems governance in meeting the health needs of people in the developing world. However, these challenges continue to characterise Uganda’s health system. The system is faced with governance challenges such as poor prioritisation of funds, limited human resource for health challenges and poor coordination. In addition, health policy literature indicates that good governance; especially in financing is needed universal health coverage to be effective. This is also necessary for the strengthening of Health Systems – an aim that Uganda has pursued along with its development partners over the last decade.

Given the strong links between financial governance and the effectiveness of universal health coverage, ACODE examined expenditure governance practices under the PHC programme at local government level to understand how and why they differ across districts. Specifically, ACODE sought to understand how districts placed on different scales of the MoH district league table differed in governing PHC funds.

Governance of PEG funds in this study is taken to refer to *the process of appropriating PHC funds and the interaction among actors in the utilisation of the funds*. The study was undertaken in eight of Uganda’s districts with four taken from among the best performing top 25 districts (Kamuli, Kabarole, Gulu and Luwero) and four from among the bottom 25 districts (Bududa, Buliisa, Moroto and Wakiso) on the Ministry of Health (MoH) district league table of Financial Year (FY) 2016/17).

The aim of the study was to understand how the expenditure governance practices and perceptions differed among the top and bottom performing districts on the FY 2016/17 MoH district league table.

The study is an indicator based assessment in design using the Public Expenditure Governance Framework. The practices and processes of the study districts were assessed based on nine PEG principles namely, strategic vision, accountability, equity, participation, transparency, responsiveness, control of corruption, effectiveness and efficiency, and coordination.

Overall, the top performing districts were found to perform better in most governance aspects especially, participation, accountability, coordination, control of corruption, responsiveness, equity, effectiveness, and efficiency.

Considering that PHC grants to local governments are conditional in nature, the existence of sector grant guidelines is critical to adherence to the sectoral and national priorities. There was however no consistency in the percentage breakdowns of the budgets spent on the respective items at health facility level. It was also noted that the persistent stock-outs of medicine stemmed from a resource allocation formula that appropriated the same amount of money for Essential Medicines and Health Supplies (EMHS) to facilities at the same level of care regardless of their differences in patient load (the population numbers they serve) – a challenge which also characterised the PHC non-wage funding. This then resulted into delivery of quantities that were not commensurate to the catchment areas that the health facilities served. In addition, it was noted that while coordination was seen to be effective among the public actors, challenges remained in the harmonisation with the Private-Not-For-Profit (PNFP) actors. These were coordinated through their medical bureaus at national levels yet they had no representation in most of the local governments.

Despite control of corruption mechanisms being put in place, corruption (mostly perceived theft of drugs and other medical supplies from public health centres) was reported to be prevalent across all the districts by the communities and some of the elected leaders. Reports of the corruption suspects victimising whistle-blowers were also reported to have weakened the fight against corruption.

On Participation, it was reported that the level of participation varied across stakeholders. In particular, the illiterate and semi illiterate community members felt they were not effectively participating in planning, budgeting, monitoring and evaluation processes of PHC service delivery. However, it was worth noting that avenues and mechanisms for receiving citizens' concerns and communicating feedback to the citizens were in place at different levels. For instance, the communities were represented on the Health Unit Management Committees (HUMCs). It was the level of utilisation of these avenues that was limited. In the case of the HUMCs, community members who were consulted reported that they had had limited interaction with their HUMC representatives. Health facility in-charges also reported constraints in responding to community feedback due to limited resources. Additionally, it was noted that there was limited feedback and action from the National Medical Stores (NMS) and Joint Medical Stores (JMS) in addressing discrepancies between what is demanded and what is delivered. This was mainly reported among the Health Centre III and II level facilities. These were under the push system of EMHS delivery while the Health Centre IV facilities which used the pull system had more discretion in the utilisation of their credit lines.

Against such findings, the study makes the following key recommendations:

1. MoH needs to ensure that the PHC Grant Utilisation guidelines are clear on how resources distribution at health facility levels. Currently, the health facilities claim to be following the guidelines in apportioning the PHC funds but the guidelines provide no such direction. In providing such guidance, the guidelines should, however, provide a proportion of the funding to be discretionarily allocated towards immediate needs.

2. MoH should consider revising the HUMC guidelines in line with the current National Health Policy and also provide for regular training. This will enhance the effectiveness of the HUMCs in providing oversight over PHC funds at health facility levels.
3. MoH in collaboration with the Uganda Communication Commission should consider providing a Toll free line for reporting drug theft and cases of corruption at health facility levels. This measure will mitigate cases of drug theft. The toll free line will provide the much needed anonymity for the whistle blowers.
4. MoH needs to ensure that health facility PHC non-wage funds and credit lines for essential medicines and medical supplies are planned on the basis of catchment areas. This will improve equity in the distribution of the PHC resources. Thus, MoH should also consider equipping transitional health facilities (up grading from one level to another (e.g. HC II to HC III) with the human and financial resources needed for the transition given that their catchment areas already necessitate these resources.
5. The NMS and JMS need to improve the responsiveness to the feedback received from health facilities on discrepancies in the delivery of medicines and supplies. However, given the costs associated with redistribution, it is also important that efforts are put in place to minimise or completely eradicate the sources of the discrepancies.
6. District Health Departments need to ensure that members of the HUMCs are oriented upon being elected and trained in their duties. This will make HUMC members more effective in exercising their oversight over the PHC funds at health facility levels. A third of the HUMCs consulted indicated not to have received any training or orientation on their roles and responsibilities.
7. District Health Departments also need to ensure that health facility officers-in-charge are trained in the fundamentals of financial management. This will improve accountability in the governance of PHC funds.

1.0 Introduction

Over the years, governments across the world but especially in developing countries have faced with the need to provide affordable, good quality healthcare and limit high expenditures on health by citizens. This need is reflected in Sustainable Development Goal 3 (SDG 3), that aims “to achieve universal health coverage, and provide access to safe and affordable medicines and vaccines for all.” In domesticating SDG 3, Uganda’s Health Sector Development Plan (HSDP 2015/16 – 2019/20) overall goal of is *to accelerate movement towards Universal Health Coverage with essential health and related services needed for promotion of a healthy and productive life*. Providing universal health coverage has in many countries come to be associated with provision of Primary Health Care (PHC).

The Alma Ata Declaration, article VI (1978) defines PHC as “essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination”. This definition underpins the need to have healthcare provided universally and at affordable costs.

Uganda, along with other developing countries, has been implementing the Primary Health Care (PHC) programme model since the Alma Ata conference. Provision of PHC is one of the major reforms that Uganda’s health care system has made in an attempt to improve health care service delivery in the country. Under Uganda’s Programme Based Budgeting Framework, PHC represents the second largest programme of Uganda’s health care budget – second only to the purchase of essential medicines and supplies which are also meant to facilitate the provision of PHC.

Provision of PHC was adopted in order to address weaknesses of health care systems governance in meeting the health care needs of people living in the developing world (Tashobya and Ogwal, 2004). However, these challenges continue to characterise Uganda’s health care system. The system is faced with poor prioritisation of funds, limited human resource for health challenges and poor coordination (Ministry of Health, 2017).

Health policy literature shows that improving the governance of universal health care coverage is critical to the strengthening of Health Care Systems – an aim that Uganda has pursued along with its development partners over the last decade. Good governance, especially in financing is considered essential to the effectiveness of universal health care coverage (WHO, 2014; Reis, 2016; WHO, 2017).

WHO (2017) posits that institutions and persons responsible for PHC in Uganda are weak in power and capacity. The report calls for strengthened regulation within the system to encourage capacity-building and to stimulate strategies for self-accreditation. There is also need to review the basic tenets of PHC as embedded within the current healthcare system as a means to revive and strengthen PHC strategy in Uganda.

The Ministry of Health annually produces a district league table that shows the performance of Uganda's districts in the provision of health care (mostly PHC). However, while the league table denotes performance outputs and outcomes, it doesn't provide insight into how the practices and processes differ across the performance divide, especially in the management of public funds. Given the strong link between financial governance and the performance of health facilities, ACODE examined how the governance of expenditure influences performance of health care facilities among the top most and poorest performing districts on the FY 2016/17 MoH district league table.

ACODE commissioned the study to understand how the governance of public expenditure in the provision of PHC in eight of Uganda's districts with four taken from among the best performing ones on the MoH district league table and another four from among those performing the poorest.

The study is an indicator based assessment in design by which ACODE assessed the PEG practices and processes of the study districts basing on nine governance principles, namely:- **strategic vision, accountability, equity, participation, transparency, responsiveness, control of corruption, effectiveness and efficiency, and coordination.**

1.1 Rationale for conducting the PEG Assessment

In providing healthcare to communities, Tashobya and Ogwal (2004) note that the PHC programme was adopted against five major principles namely: Emphasis on equity as a component of health; community participation in decision making; Multi-sectoral approach to health care service delivery; Adoption and use of appropriate technologies; and Emphasis on health care promotion activities. These PHC foundational principles resonate with seven of the nine principles under the Bogere and Makaanu (2016) PEG Assessment Framework stated above.

Using the PEG Assessment Framework is beneficial in the sense that it provides an understanding of the manner in which public resources are governed, by examining the interactions between the relevant actors (e.g. the distribution of power over public resources and how it is exercised), and how these interactions affect the outcomes of public expenditure. Additionally, by examining public expenditure processes, the framework identifies areas that need strengthening – an aspect which is useful in informing the on-going health systems' strengthening processes.

1.2 Objectives

The overall objective of the study was to understand how the PHC expenditure governance practices and perceptions differed among the top and bottom performing districts on the FY 2016/17 MoH district league table. Specifically, the study sought to:

1. Determine PEG practices under PHC at the Health Sub-district level
2. Document the perspectives of actors on PEG of PHCs at Health Sub-district levels
3. Highlight the importance of specific PEG practices to sector outputs.

The study informs the on-going debates on health care systems strengthening in Uganda. Focus for the study was placed on local governments as the main unit of analysis. This is because PHC services are provided at local government levels.

1.3 Structure and Public Expenditure in Uganda's PHC

Under the PEG framework, the assessment of prevailing expenditure governance principles and practices is underpinned by clear understanding of the institutional framework that governs the area of study. It is therefore important to assess the institutional set up of PHC in Uganda. This is vital for the understanding of the roles played by the various actors in the management of PHC funds, the reporting structures as well as the structure for the flow of funds.

1.3.1 Institutional framework of PHC in Uganda

Over the last three to four decades, Uganda's health system has been evolving to handle emerging concerns and challenges to the health situation in the country. PHC in Uganda is provided through public and private institutions with the support from both the government of Uganda and its development partners. The government dominates PHC provision, accounting for about 66 percent of health care service delivery outputs (MoH, 2012). The public PHC system constitutes of central government and the District Healthcare Services under the Local Government (LG) authorities. It is structured around a referral based system that is led by doctors and heavily supported by nurses and other medical workers, including clinical officers and community health workers (WHO, 2017). The Clinical Officers are especially important in the rural areas, where doctors and nurses are very few. Likewise, Community Health Workers are important in rural areas because nurses are very few.

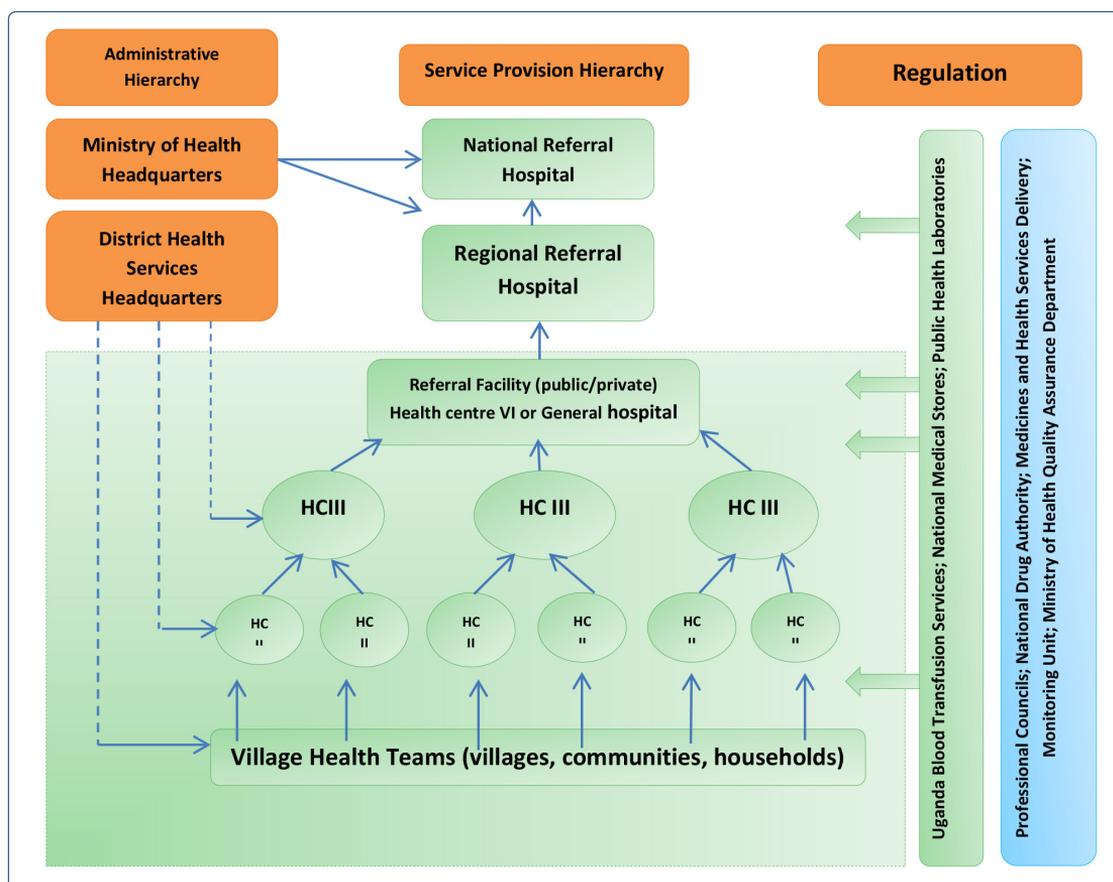
The private Primary Healthcare System is also provided for by doctor-led (urban) and clinical officer- or nurse-led (rural) facilities. However, its referral system is not as well defined as that in the public system. The private health sector consists of the private-not-for-profit health facilities (PNFPs), private health practitioners (PHPs) and the traditional and complementary medicine practitioners (TCMPs) such as herbal medicine, traditional birth attendants (TBAs), bone setters, and spiritual healers. PNFPs are subsidised by government and other donors. Seventy five (75) percent of the facility-based PNFP organisations exist under four umbrella organisations: the Uganda Catholic Medical Bureau (UCMB), the Uganda Protestant Medical Bureau (UPMB), the Uganda Orthodox Medical Bureau (UOMB), and the Uganda Muslim Medical Bureau (UMMB). In the field of TCMPs, there is recent emergence of non-indigenous traditional or complimentary practitioners such as the practitioners of Chinese and 'Ayurveda' medicine.

Recently, the country experienced persistence of high burden of communicable diseases, re-emergence of disease epidemic outbreaks of cholera caused partly by weak control measures and surveillance systems, HIV/AIDs pandemic and the growing incidence of non-communicable diseases (MoH, 2016). This prompted government to re-examine key health care strategies for improved health care services delivery. One of the proposed approaches to achieve this overarching objective was the expansion

of the PHC approach, from focusing on curative to basic preventive services through the Community Health Extension Workers (CHEWs) and Village Health Teams (VHTs). In addition, consolidation of Local Government (LG) Inter-Governmental Fiscal Transfers was implemented as a means for using the transfer system to provide incentives to improve institutional and service delivery performance.

In Uganda, PHC is provided through a National Minimum Health Care Package (NMHCP) with the help of a hierarchy of health care facilities in the Healthcare Sub District (HSD) – the primary providers of PHC in Uganda (See figure 1 for details of the hierarchy).

Figure 1: The Health Care System of Uganda Showing the Administrative, Service Delivery and Regulatory Arrangements



Source: Adopted from WHO (2017)

PHC at National Level

The administrative head of the health system in Uganda is the Ministry of Health (MoH), governing both the public and private sectors. The functions of the MoH include resource mobilisation and budgeting; policy formulation and policy dialogue with Health Development Partners (HDPs), strategic planning, regulation, advising other ministries on health matters, setting standards and quality assurance, capacity development and technical support, provision of nationally coordinated services such

as epidemic control, co-ordination of health research and monitoring and evaluation of the overall sector performance (MoH, 2010).

Several functions that were hitherto performed by MoH have over the years been delegated to national autonomous institutions with specialised clinical support functions such as Uganda Blood Transfusion Service (UBTS), National Medical Stores, and National Public Health Laboratories. Also, regulatory functions have been assigned to the professional councils (umbrella bodies for medical professionals), the National Drug Authority, and other regulatory bodies while research is coordinated by the Uganda National Health Research Organisation (UNHRO). All these are in place to support PHC service delivery. Apart from the professional councils which monitor and exercise general supervision over the healthcare system, the Medicines and Health Service Delivery Monitoring Unit was established by a presidential directive in 2009 to improve health services delivery in the country through monitoring the management of essential medicines and other health service delivery accountabilities (Lukwago & Achiro, 2013).

The MoH and other central level departments/agencies carry out periodic evaluations of the sector's performance such as the mid-term review of the HSSP. Challenges exist such as the inadequacy of human, logistical and financial resources for supervision, monitoring and evaluation, coordination of community/civil society organisations. Also, there are limited mechanisms to incorporate private sub-sector performance into overall sector performance (MoH, 2010). As far as inter-sectoral and inter-ministerial partnership is concerned, the MoH takes the principal role in advising, mobilising and collaborating with other government ministries, departments and agencies (MDAs) on healthcare matters.

The MoH also coordinates all HDPs. A Memorandum of Understanding exists between MoH and the HDPs whose goal is "to achieve improvement in people's health through a collaborative programme of work, with established structures and processes for negotiating policy, strategic and management issues, and reviewing sectoral performance against jointly agreed milestones and targets" (MoH, 2010). Apart from the above functions the MoH, with effect from FY 2015/16, took on specific roles in the implementation of PHC at the LG level, particularly PHC Grants (MoH, 2016).

PHC at Local Government Level

Uganda implements a decentralised hierarchy of the health system in line with the government's aim to provide healthcare services for all its citizens to enhance their quality of life and productivity¹. The decentralised policy gave the District Local Governments (DLGs) and lower level local governments central roles in the management of health service delivery. The district systems are under the leadership of the District Directorate of Health Services (DDHS) and are present in each district. The DDHS manages the health sub-district (HSD), which is made up of all health centres and Village Health Teams. As already state above, the HSD is the primary provider of PHC in Uganda.

¹ The Key thesis is that when those closest to where decisions are made are empowered to make decisions and given ownership of results, better decisions will be made (Birungi *et al*, 2000). The fundamental claim is that increased efficiencies should follow and the quality of services improved.

The creation of the HSD in 1999 aimed at enhancing effectiveness and efficiency in planning, provision and monitoring of health services at levels nearest to the population (in a hierarchical system). It is based on several principles, including integrated and better coordination and linkages between various types and levels of health care, and improving community involvement.

At its creation, the HSD was based on constituencies, which comprise the sub-county as the basic unit. However, because of limited resources at the sub-county level, it was deemed only administratively viable to create these HSDs at the county level until such a time when the country's economic circumstances would change. WHO (2017) asserts that this has compromised efficiency of service delivery due to the fact that most counties are very large, with populations of up to 400,000, whereas the HSD was meant to serve populations of up to 100,000 people.

Table 1: Hierarchy of PHC Provision within the District in Uganda

Level (Location)	Health Centre	Description	Target Population	Services Provided
Village	Village health team	A satellite health facility with no definite physical structure; it is where health facility outreach teams meet the community for immunization, health education and designated activities.	1,000	Community-based preventive healthcare services
Parish	Health Centre II	The closest structural health facility to the community; it delivers the Minimum Activity Package of the NMHCP. It is at parish level of the politico-administrative system.	5,000	Preventive and outpatient curative healthcare services, and outreach care
Sub-County	Health Centre III	The facility that delivers the Intermediate Referral Activity Package of the NMHCP. It handles referrals from HC (health centre) II level, as well as referring to HC IV level. It equates to the sub-county level of local government administration.	20,000	Preventive, outpatient curative, maternity and inpatient health services and laboratory services
County	Health Centre IV	The facility is a mini-hospital and delivers the Complimentary Activity Package. It heads the health sub-district, which equates to the county, equivalent to a parliamentary constituency.	100,000	Preventive, outpatient curative, maternity, inpatient health services, emergency surgery, blood transfusion and laboratory services

Source: Adopted from WHO, 2017

As Table 1 indicates, the district health system includes communities that work through Village Health Teams (VHTs) to provide community-based preventive and health promotion services that support the health centres II, III and IV at parish, sub-county, and county levels respectively.²

There are four clusters of the health sector interventions at LG level under the NMHCP. Cluster one includes health promotion, disease prevention and community health initiatives such as environmental health, control of diarrhoeal diseases, school health, epidemics and disaster preparedness and response, and occupational health. Cluster two encompasses maternal and child health elements such as sexual and reproductive health and rights, new-born health and child survival, management of common childhood illnesses, expanded programme on immunisation, as well as nutrition.

Cluster three comprises of prevention and control of communicable diseases such as STIs/HIV/AIDS, tuberculosis, malaria, and diseases that are targeted for eradication such as leprosy, guinea worm, sleeping sickness, among others. The fourth and last cluster includes prevention and control of non-communicable diseases, injuries, disabilities and rehabilitative health, sensitising communities about gender based violence as well as mental health and control of substance abuse.

1.3.2 PHC Funding

The Second Uganda National Health Policy (2010) is consistent with the decentralization policy framework that requires local governments (LGs) to provide primary healthcare services. With PHC has been the second largest programme in the health sector since Uganda adopted the Programme-based Budgeting (PBB) in FY 2017/18. In the 2017/18 national budget, PHC accounted for 18.3% of the health sector funding, second only to Pharmaceutical and Others Supplies which accounted for 40.6% of the sector budget³.

At local government level where PHC delivery is undertaken, it is publically funded through five major grants split between recurrent and development (capital) functions. The PHC Wage (also referred to as Conditional Wage Grant Health) and Non-wage grants funding the day-to-day service delivery activities as illustrated in Table 2.

² The district health structure is responsible for all structures in the district except the Regional Referral Hospitals where they exist.

³ For any currency conversions, readers are advised to use 1USD = UGX 3,528.3 for any FY 2016/17 budget figures and UGX 3,658.72 for FY 2017/18.

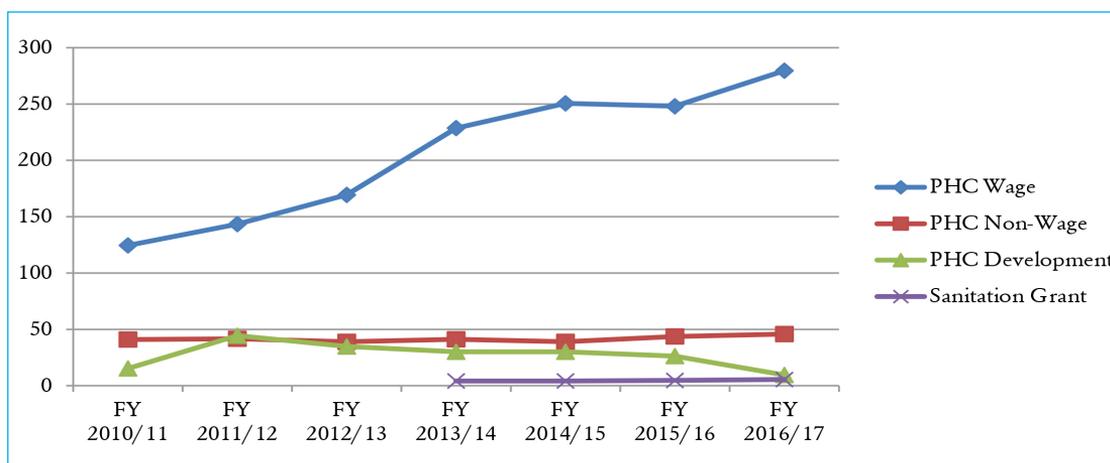
Table 2: Health Sector Grants to Local Governments in FY 2017/18

Function	Grant	Description	Amount (UGX)
Recurrent	<i>Conditional wage grant Health</i>	Paying salaries for all health workers in the district health service including health facilities and hospitals.	291,413,564,389
	<i>PHC - Non Wage Recurrent</i>	Funding service delivery operations by the health department, hospitals and health centres, both government and private non for profit - prevention, promotion, supervision, management, curative, epidemic preparedness	25,270,127,101
	<i>PHC - Hospital Non-Wage Recurrent</i>	Funding software activities such community sensitizations and advocacy work that contributing to the reduction of morbidity and mortality rates from sanitation-related diseases.	14,649,240,783
Development	<i>Transitional Development - Health Ad Hoc</i>	Funding hospital rehabilitation and other specified capital investments in selected LGs.	9,622,000,000
	<i>Transitional Development - Sanitation (Health)</i>	Funding hospital rehabilitation and other specified capital investments in selected LGs.	2,277,862,500

Source: Compilation from the MoFPED 2017

While the PHC grant has nominally been increasing over the last eight years, the non-wage components of the PHC funding have been fluctuating (relatively static in some years and declining in some).

Figure 2: Trends in PHC Grants to Local Governments (in UGX Billions)**



Source: Computations from the MoH Annual Health Sector Performance Report, FY 2016/17

** The sanitation grant was not available prior to FY 2013/14.

The implementation of the PHC programme has been faced with numerous funding challenges related to inadequacy in its management and governance (MoH, 2017). PHC funding has faced several governance challenges with allocations at the various Service Delivery Levels reported to be far below the levels required for effective service delivery (MoH, 2017).

Table 3: PHC Allocations by Service Delivery Level in FY 2016/17

Level of Health Service Delivery	Number of Units	Annual Average Allocation per level (UGX)	Annual Requirement (UGX)	Funding Gap	
				Absolute Amount	Percentage
District Health Offices	115	40,842,099	99,360,000	58,517,901	59%
Hospitals	102	166,574,356	366,650,000	200,075,644	55%
HC IVs	190	16,501,363	44,469,764	27,968,401	63%
HC IIIs	1,170	6,424,413	23,091,103	16,666,690	72%
HC IIs	1,954	3,680,694	12,690,163	9,009,469	71%

Source: Adopted from the Annual Health Sector Performance Report, FY 2016/17

In addition, the FY 2016/17 Health Sector Annual Performance report indicates major disparities in funding at individual health facility levels across the districts. These disparities have resulted into health facilities with similar challenges and service delivery requirements receiving different levels of funding. For instance, FY 2016/17 PHC Non-Wage grant allocations to the 115 District Health Offices ranged between UGX 10,647,282 and UGX 91,862,402. PHC Non-wage grant allocations to the Municipal Health Offices ranged between a minimum of UGX 2,598,440 to a maximum of UGX 40,936,268. These disparities remain largely unexplained and thus require assessment considering that the PHC requirements across most District and Municipal Health Offices are relatively similar.

Provision of PHC services also faces coordination challenges across levels of government and between the different actors involved. The provision of PHC services is complemented with private- not- for- profit (PNFP) health facilities, support from development partners (both through project and budget support), and NGOs. However, the pluralistic nature of the providers has created coordination challenges, especially, the failure to align project funding to PHC. These systemic and governance challenges have thus resulted into poor alignment of off budget funding to sector priorities, weak implementation of laws and policies, significant staffing gaps, and inadequate funding for PHC services (MoH, 2017). These challenges make it imperative to assess the governance of PHC funding.

2.0 Conceptual Framework

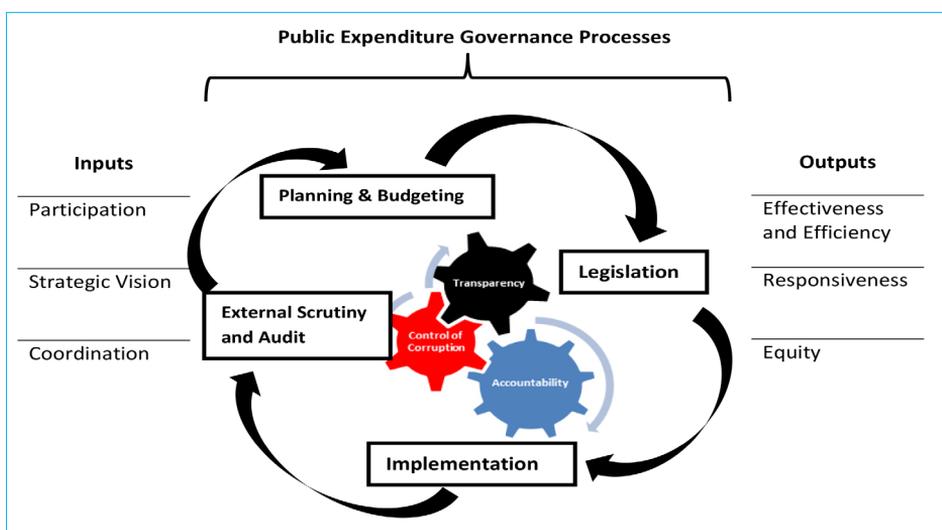
The study adopted the Public Expenditure Governance (PEG) assessment framework. The framework is based on the nine principles grouped into inputs, processes, and outcomes as explained by Bogere and Maakaru (2014). This Model, especially the principles of governance adopted builds on the work of Baez-Camargo & Jacobs (2011).

2.1 The Public Expenditure Governance Model

The PEG Assessment framework adopted by the study is based on an action research methodological framework. The assessment tool is designed not to place focus on scores but with a binary approach to indicate actionable gaps based on a select number of indicators under each principle. The tool is complemented by Key Informant Interviews and Focus Group Discussions which are designed both to solicit for information and produce actionable suggestions to some of the immediate challenges that policy makers and citizens face.

The Bogere and Makaaru (2016) framework uses qualitative indicators to assess public expenditure governance. In this framework, nine governance principles are categorized into three interrelated dimensions: inputs, processes and outcomes. The inputs include the strategic vision, participation and coordination aspects. The processes are defined as transparency and accountability, which should be promoted throughout the planning and budgeting, legislation, implementation, external scrutiny and audit stages of the budget cycle. Lastly, outcomes are broadly defined as the effectiveness and efficiency, responsiveness and equity of public expenditures.

This study adopted this framework to assess public expenditure governance in PHC. The governance principles under the PEG framework work together in guaranteeing effective delivery of Primary Health Care services. Control of corruption heavily



Source: Bogere and Makaaru (2016)

relies on the level of transparency and accountability. These are also related to the participation of service users in both decision making and monitoring processes of delivery of Primary Health Care services. In addition, it would be impossible to achieve effectiveness and efficiency in delivery of PHC services without clear set goals, objectives, vision and mission statement that are easy to understand.

The scoring against these indicators is binary in nature; designed to denote either existence or absence of evidence against a given indicator. The principles of governance and respective indicators used for the assessment of PEG in each district are presented in Annex 1.

3.0 Methodology

This study adopted the qualitative method of data collection and analysis. Qualitative data was collected by ACODE Field-based Researchers through Key Informant interviews (KIIs) and Focus Group Discussions (FGDs). The KIIs and FGDs were designed both to solicit for information and produce actionable suggestions to some of the immediate challenges that policy makers and citizens face. As already alluded to in the introductory section, the analysis of KIIs and FGDs was done basing on the PEG Assessment Framework (Bogere and Makaaru, 2014) which builds on the governance work of Baez-Camargo and Jacobs (2011). Atlas-ti qualitative data management software was used in the analysis of the data.

At the centre of the PEG framework was an assessment tool designed to evaluate the performance of the selected districts without putting emphasis on quantitative scores (such as a scale of 0 – 100) but with a binary approach (where 1 represents an indicator being met and 0 represents the indicator not being met). Ultimately, the assessment was designed to highlight actionable gaps based on a selected number of quantitative indicators under each of the principles of governance. The analysis of the data brought out various dimensions of governance of the PHC program at district level with emphasis on decision-making, effectiveness of the accountability framework in place and interaction between the actors in the PHC programme at local government level.

3.1 Study Design

The study collected and analyzed secondary and primary data using both the qualitative and quantitative approaches for purposes of assessing public expenditure governance in the selected districts and health sub-districts. The literature search for the secondary data was guided by the overall aim of assessing the extent to which governance principles are promoted in the design and implementation of the PHC program. Specifically, we reviewed local government and MoH documents for FY 2016/17 and FY 2017/18 (Q1 – Q3). On the other hand, the reference period for processes was strictly FY 2017/18.

For the case of qualitative analysis, we used three methods of data collection: (1) document review which involved identifying information on PHC in district reports related to the nine principles; (2) Key Informant Interviews (KIIs) with key stakeholders responsible for delivering, supervising and monitoring PHC in the selected districts; (3) Focus Group Discussions (FGDs) with communities, VHTs and Health Unit Management Committees at sub-county level. The assessment or document review was based on the nine principles of governance mentioned in the sub-section above and utilized specific indicators for each principle as illustrated in Annex 1.

In addition to the health facilities, we consulted the district headquarters, particularly the Chief Administrative Office (CAO), the Planning Office and the District Health Office. Therefore, at the district headquarters, we sought interviews with officials that included but were not necessarily limited to the CAO, Planning Officer, and District Health officer, LCV Chairperson, LCV Councillor and District Councillor for health. At the health centres, we conducted interviews with the chairperson of the Health Unit Management Committee and the Health Centre In-charge/ superintendent from the three levels (HC II –HC IV) in each district.

3.2 Study Scope and District Selection Criteria

The scope of this PEG study was restricted to Primary Health Care (PHC) at the Health Sub-District Level. Analysis of district documents in this assessment was limited to a reference period of two financial years that is; FY 2016/17 and FY 2016/17. The scores presented by the assessment tool on key indicators were based on the review of district documents from FY 2017/18 and quarter 4 FY 2016/17.

The study covered eight districts selected on the basis of health care service delivery ranking by the Ministry of Health (MoH, 2017) and regional representation. These districts were purposively selected from among the top performing ones namely; Kamuli, Kabarole, Gulu and Luwero and the poorly performing districts: Wakiso, Bududa, Moroto, and Buliisa. Selection of districts was further guided by ACODE's prominence in the district, time and the resource envelope. Furthermore, two sub counties were purposively selected from each district based on distance from the district headquarters that is; an urban sub county (Near the district headquarters) and a rural sub county (the furthest from the district headquarters). The selection of the sub-counties also considered presence of HC II, HC III, HC IV and Private Not-for-Profit (PNFP) Health centre as key.

3.3 Data Collection Process

Data were collected by use of Key Informant Interviews (KII) both at district and Sub County levels. These were supplemented by Focus Group Discussions (FGDs) and review of government documents.

Key Informant Interviews (KIIs)

At the district level, one key political leader was selected, that is, the District Chairperson of Local Council (LCV). The LCVs were selected because they are the

highest ranking elected politicians responsible for service delivery in the district under the decentralised system. However, owing to scheduling challenges, only 4 LCV chairmen were interviewed for the study. In addition, from the technical arm of the governments, the District Administrative Officer (CAO), District Planner, and the District Health Officer (DHO) were interviewed. At the sub county level, health centre in-charges were interviewed.

Focus Group Discussions (FGDs)

In total, 8 FGDs were conducted in each district with a minimum of 8 and a maximum of 10 participants. Of the 8 FGDs, 4 were community FGDs for women and men from both urban and rural sub counties while the other 4 were for VHTs and HUMCs both in urban and rural sub counties. In total 14 HUMCs and 12 VHTs focus group discussions were conducted comprising 112 and 133 HUMCs and VHTs respectively in the 8 districts. Community level FGDs comprised of youth, religious leaders, Elderly persons, People with Disabilities (PWDs), women leaders and Expectant mothers.

Content Analysis of Government Documents

The district documents reviewed included: the current five years District Development Plan, District performance Reports, Annual work plans, Annual budget, Council Minutes (most recent), Minutes for the Technical Planning Committee, Minutes for the Health sector review meeting, and Minutes for the Health departmental meeting. It also took into account 2017/18 Internal audit reports, PAC reports, Budget Conference reports, Quarterly inspection reports submitted to the DHO's office, Quarterly inspection reports submitted to central government, Auditor General's reports, Annual performance reports and Sector progress reports.

ACODE researchers were required to use authentic and up-to-date documents accessed legally to score each district on each indicator. A tick symbols (✓) was used to denote availability of document and presence of evidence, (✗) to represent presence of document but no evidence and an empty box (□) for documents not available or not accessed. Prior to the scoring, researchers were practically trained at the ACODE secretariat on how to effectively complete the assessment tool.

Quality Assurance

A number of measures were put in place to ensure consistence and validity of the research. The process included constituting of a task group of experts in the health sector to critique and input into the methodology, consulting with a wide range of stake holders in order to make valid conclusions about the findings, review of district documents to provide documented contexts for the perspectives generated through interviews and ensuring that the enumerators are trained on the key concepts and data quality measures before data collection started.

The KIIs and FGDs were conducted by ACODE field based researchers to ensure consistence, validity, credibility and reliability of the data collected. These researchers were already well versed with the area and were in good working relationships with the

communities and the district leadership due to their constant engagements through other ACODE interventions in these districts. These researchers had also participated in various studies of a similar nature in these districts including Public Expenditure Governance assessment of the Universal Primary Education (Kavuma et al, 2017) and Public Expenditure Governance in Uganda's Agricultural Extension System (Kuteesa et al, 2018). With a goal of leaving no room for errors, the researchers though already familiar with the PEG framework had to be re-trained.

The researchers were also trained in research ethics, methods of conducting effective and highly organized KIIs and FGDs including how to transcribe interview notes. The researchers were also supervised by a team from ACODE during the process of conducting KIIs and FGDs which also reviewed the transcribed notes to ensure consistence. The notes that were found not to meet the minimum required standards were sent back to the researchers with comments for improvement. Photocopies of district documents were obtained from the researchers and vilification of the scores on indicators in the assessment tool was done at the ACODE secretariat.

3.4 Data Management and Analysis

The main data for this study was derived from the assessment tool which provided results against the indicators in Annex 1. The data from the assessment tool was limited in the sense that it only documented existence or inexistence of evidence sought by the indicator. It was thus complemented by the findings from the KIIs and the FGDs to provide the context and insight into the existences and inexistences identified. During the data collection process, the KIIs and FGDs were recorded and subsequently transcribed. The qualitative data obtained from these KIIs and FGDs was then coded and analysed using the Atlas.ti. In Atlas.ti, each of the transcripts constituted a "primary document" which was then combined with other primary documents to make up the database for the analysis.

The data analysis process commenced with developing a set of codes. The codes emerged from the data themselves, derived along the principles, definitions and indicators described in the narrative of the conceptual framework. Once the list of codes and accompanying codebook containing definitions were finalized, the research team subjected the codes to a thorough process of establishing inter-coder reliability. This entailed the entire team coding the same document in order to identify codes and coding practices that could be applied inconsistently. The result of this was the refining and clarifying of the definitions of each code in order to ensure that the entire team uses the same principles for coding the documents. A second layer of reliability was added when each document underwent secondary coding by another researcher as a check on the coding of the primary coder.

The analysis of the data mostly involved content analysis. Using Atlas.ti, the research team retrieved segments of the documents ("quotes") coded with the similar codes, and analysed the retrieved data for themes and patterns. In order to understand the perspectives and practices of the different stakeholders, retrievals were done for specific "families" of documents classified along the types of respondents, for instance, KII interviews with CAOs, FGDs with Health Unit Management Committees, and FGDs with VHTs etc. In order to limit subjectivity of the responses, Quotes from

one set of stakeholders were to the extent possible compared to those from another set of stakeholders to understand the ways that perspectives and practices of these various groups varied and/or were consistent across stakeholder groups and across districts.

3.5 Limitations of the Assessment

Assessing public expenditure governance in primary health care study was faced by a number of challenges. First, retrieving of documents that were needed to score the indicators in the assessment tool was complex. In some districts, the responsible persons told the research team that the documents were stored in soft copy on one of the computers which had since stopped working and could not be accessed. In some other districts, the officials were reluctant to avail the documents which left the research teams unsure of whether such information existed or not.

To mitigate the limited access to documents in some of the districts, multiple visits were made to even after the data collection period had ended as well as consulting alternative offices at the district headquarters. Where these failed to yield any documents, they were marked with an empty box (□) in the assessment to denote documents not available or not accessed.

Additionally, the research teams sought to access documents already submitted to ministries, departments and agencies of government such as the National Planning Authority (NPA) and the Ministry of Finance, Planning and Economic Development (MoFPED) published on the budget website (www.budget.go.ug). This helped the research team to mitigate the limitations imposed on the study due to the poor record keeping practices found at several of the local governments.

Additionally, the research team was faced with a challenge of accessing documents that were out dated in their implementation period. For instance, while the research team accessed Kabarole's District Development Plan, its implementation period was between FY 2011/12 and FY 2015/16. This was equally treated as a missing document and assigned an empty box (□) in the assessment because the assessment was restricted to documents that are currently guiding the implementation of the PHC programme.

4.0 Findings

This section presents the findings from the study organised along the nine governance principles that we assessed. To the extent possible, the findings have been reconciled with available literature which provides a policy context for the governance concepts that were assessed. In addition, we have made every attempt to compare practices and perceptions across the better and poorly performing districts included in the study. This comparison was however constrained by the limited access to some relevant documents during the data collection process. This limitation has been accordingly taken into account in the analysis.

4.1 Strategic Vision

Assessing strategic vision in the expenditure governance of PHC mainly seeks to establish alignment of local government planning and resource allocation with national policy objectives and priorities. Therefore, work plans and budgets were assessed for consistency with key policy guiding documents in the sector including the National Development Plan (NDP II), the National Health Policy, the HSDP 2015/16 – 2019/20 and the PHC Grant guidelines for FY 2016/17 and 2017/18. The assessment covered local government budgets and health facility budgets. At facility level, the assessment took into account consistency between the public health facilities and the Private but Not-for-Profit (PNFP) facilities that received public funds.

Table 4 presents the specific indicators against which the strategic vision in the governance of PHC was assessed. The indicators sought to capture evidence of district work plans providing for the major tenets of PHC which included equity, community participation, coordination (multi-sectoral approach), and adoption of technology and health promotion.

Table 4: Evidence of Strategic Vision in the Governance of PHF Funds

Strategic Vision Assessment Indicators	Good Performers on MoH District League Table				Poor Performers on MoH District League Table			
	Gulu	Kabarole	Kamuli	Luwero	Bududa	Buliisa	Moroto	Wakiso
Evidence of progressively improving targets on provision of PHC	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Evidence of progressively improving targets on equity as a component of health	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Evidence of progressively improving targets on community participation in decision making	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Evidence of progressively improving targets on multi-sectoral approach to health service delivery	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Evidence of progressively improving targets on adoption and use of appropriate technologies.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Evidence of progressively improving targets on emphasis on health promotion activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Key: *evidence seen* *No evidence seen.* *Documents not accessed.*

The provision of PHC is a national priority that is espoused in the National Health Policy (MoH, 2010). PHC is highlighted in the policy as a core measure for providing health services. Prioritization is assessed on the existence of improving targets on the various components of PHC. Emphasis is placed on targets because they operationalize the priorities. It is therefore not enough for a district to plan for the provision of PHC as per the National Health Policy; the district ought to state its targets in implementing PHC.

As depicted in Table 4 most of the districts had evidence of prioritizing PHC with specific targets with the exception of Kamuli and Kabarole. What is peculiar is that these two districts were among the best performing districts on the MoH District League Table. Review of the district development plans and work plans of the two districts revealed a common pattern. In both districts the research teams did not obtain access to the current DDP. In the case of Kabarole the DDP obtained was for an implementation period ending in FY 2015/16 (the same was available on the National Planning Authority-NPA Website). Thus information from the plan could not be considered given the implementation period. In the case of Kamuli, the research team was availed with drafts of the would-be current DDP which also lacked evidence of PHC targets in it. These findings are consistent with the NPA's FY 2016/17 Certificate of Compliance to the NDP II in which both districts scored poorly (Kabarole 12.2% and Kamuli 31.7%).

The unavailability of approved and current DDPs was also consistent with findings of the FY 2016/17 Certificate of Compliance to the NDP II. Among the 133 local governments that NPA assessed; only 26 had their plans approved by the local authorities and cleared by NPA. Majority of the local governments (96) had their plans only in draft form (approved, reviewed by NPA but not finalised). The remaining 11 local governments completely had no DDPs.

Overall, the performance across all the Strategic Vision assessment indicators was mixed without clear distinctions between the good and poor performing districts on the MoH district league table. As shown in Table 4, the adoption and use of appropriate technologies scored the lowest on the assessment.

Strategic Direction in Planning and Resource Allocation

Planning and resource allocation processes in PHC similar to other services were not linear in nature but rather “characterized by circular loops – going back and forth between demands and needs identified at local level and priorities and targets identified at national level” (Rohrer, 2016). It is for this reason that planning and resource allocation at local government level ought to be consistent with sector and national priorities.

Overall, it was found that priority setting during resource allocation both at local government headquarter and facility level was guided by the Annual Sector Grant and Budget Guidelines which have come to commonly be known as PHC guidelines. In addition to communicating how the PHC funds should be allocated, the guidelines also served the purpose of communicating the national and sector priorities for the planning and budgeting period. Overall, the use of the guidelines was found to be consistent at both local government headquarter and health facility level. All the plans and budgets for PHC funds strictly followed the guidelines. Deviations from the guidelines were reported to be sources of audit queries – this compelled the officers in charge of planning and budgeting to strictly adhere to the guidelines.

*We have guidelines... For example they can tell you immunization should take between 40-60% of the PHC fund, this and this should be for this percentage. So you cannot say that I have 2 million, 1 million is going for administration, much as that activity is part of PHC it will not be acceptable by the auditors so we have guidelines that direct the allocations that we pass... **DHO Respondent***

The nature and shape of relationship between national and subnational budgets has been found to be dependent on the degree of autonomy experienced at each level of a given health system (Rohrer, 2016). Therefore the existence and pre-eminence of the PHC guidelines which limit the room for discretion at the various levels of the PHC delivery system explains the consistency between the national, sectoral and sub-national priorities absent in the governance of public expenditure under other government programmes such as Universal Primary Education (Kavuma et al, 2017) and Agricultural Extension (Kutesa et al, 2018). This consistency extends to the PFNP facilities that receive PHC funding.

Strategic Vision Challenges in Governing PHC Funds

The key informant discussions indicated some challenges with abiding by the guidelines that arose out of inconsistency between immediate community health needs and the sectoral priorities. The pre-set percentage allocations to the various PHC components/services had at times not been consistent with the health needs of the communities. While dealing with insufficient funds, health facilities had difficult decisions to make as trade-offs between meeting immediate needs and sticking to the guidelines. With majority of the funding going towards community outreaches and preventive care, many immediate needs at the facilities were not adequately dealt with.

*You also realize that no health facility can exist without water and electricity because we conduct deliveries and many other activities which requires a lot of water to clean the blood etc. equally electricity is important...so we also pay for utilities although we have an outstanding debt of over 5 million shillings (Five million shillings) for UMEME which has stayed for over a decade now... **Health Centre IV In-charge Respondent***

Health unit in-charges therefore reported a need for more discretion in how PHC funds were to be apportioned at health facility level. However, while the percentage breakdowns of the budget were reported by health facility in-charges across all the districts visited, it was notable that these percentages were not found in the PHC guidelines for both FY 2016/17 and FY 2017/18. The guidelines provided for the items to be planned for under the PHC Non-Wage grants which included employee costs (other than wage), administrative expenses, food supply, medical and office equipment, operation and maintenance, utilities, cleaning services, material supplies and manufactured goods, training costs, payment of interns, outreaches, property costs, monitoring, supervision and reporting. However, there were no percentage breakdowns on what needed to be allocated to the respective items at health facility level. The only percentage breakdowns in the guidelines applied to the PHC development grants. The percentage breakdowns of the PHC Non-Wage grant were analysed in great detail in the section 4.2 on Effectiveness and Efficiency.

Summary

Overall, it is notable from the assessment indicators that PHC is highly prioritized in line with the national and sectoral priorities among most of the study districts; with no distinction between the top performing and poorly performing districts on the MoH district league table of FY 2016/17. In the two districts where evidence of improving targets on PHC were not found, it was due to the absence of current DDPs – a finding that is consistent with the conclusions of the Certificate of Compliance issued by the NPA on the FY 2016/17 local government budgets.

This consistency in priorities across the different levels of government must however be reconciled with the fact that PHC funding at the Health Sub-District is conditional in nature and there are guidelines in place which are instructional in the resource allocation process. We therefore conclude that, the existence of the sector grant guidelines is critical to the adherence to sectoral and national priorities at the local government and health facility level. There is however a great need for discretion, especially, at health facility level, to ensure that health facilities are able to address the immediate needs they are faced with.

4.2. Effectiveness and Efficiency

Public spending on primary health care has been characterized as inadequate given the numerous health needs that communities face (MoH, 2017). Given the limited funds available, it is therefore vital that every shilling spent on PHC yields the intended target outcomes and there is value for money. PHC resources such as funds, medicines and supplies ought to be optimally utilized to meet the set targets. Assessment of effectiveness and efficiency in the governance of PHC expenditure is mainly aimed at establishing the appropriateness of the practices and processes that characterize resource allocation and utilization.

Table 5: Evidence of Effectiveness and Efficiency in Primary Health Care (PHC)

Effectiveness and Efficiency Assessment Indicators	Good Performers on MoH District League Table				Poor Performers on MoH District League Table			
	Gulu	Kabarole	Kamuli	Luwero	Bududa	Buliisa	Moroto	Wakiso
Evidence of district review of PHC services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Evidence of at least two council meetings discussing PHC services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Level of utilisation of the PHC grants transferred to the district	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

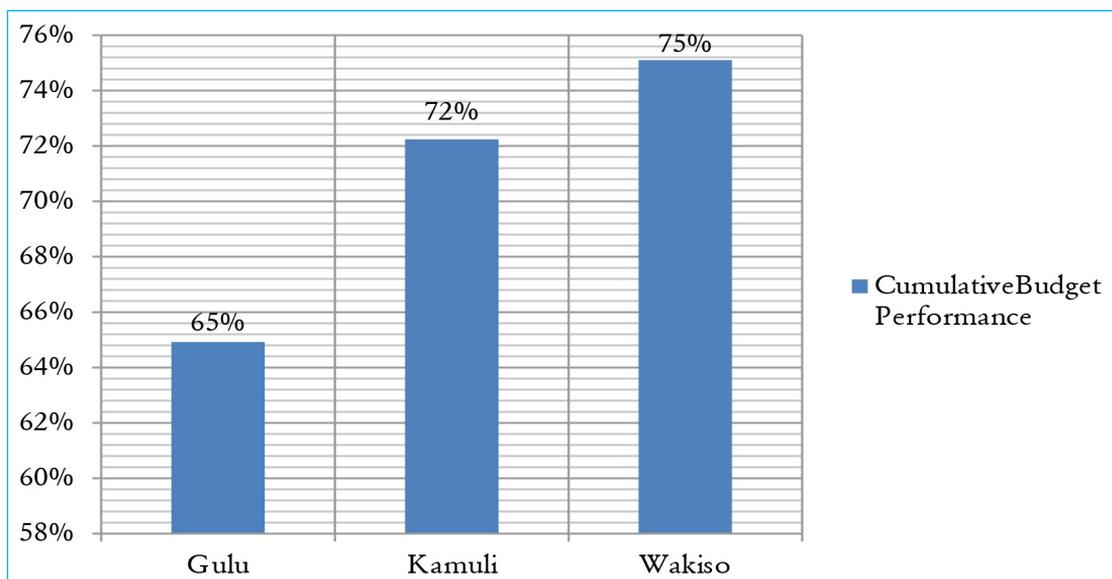
Key: evidence seen No evidence seen. Documents not accessed.

Across all the indicators used to assess effectiveness and efficiency, a contrast emerged between the districts that performed well and those that performed poorly on the MoH district league table. The research team had a limited level of access to documents and evidence among districts that performed poorly on the MOH district league table of FY 2016/17. Overall, majority (6 out of 8) of the study districts demonstrated evidence of processes in which PHC services were reviewed. The exceptions were found in Bududa and Buliisa where documents were not accessed⁴. From Table 5, it can also be noted that absence of documents and evidence of District Council discussions on PHC issues were found among the poor performing districts on the Bududa and Buliisa.

During the assessment, there were limited levels of access to documents such as quarterly and annual progress reports that contain evidence on the utilization levels of the PHC grant. It is however notable that three of the four districts that demonstrated this evidence were among the best performing districts on the MoH district league table of FY 2016/17. The availability and access to this evidence was also consistent with the documents that were available on Uganda’s Budget Website⁵.

Among the districts where information was available, the levels of PHC Grants utilization were high thereby demonstrating high levels of absorption capacity and effectiveness. By the end of the third quarter of FY 2017/18 when the research was undertaken, most of the annually budgeted funds had been utilised, as illustrated in Figure 3.

Figure 3: Cumulative Quarter three PHC Grants Performance FY 2017/18



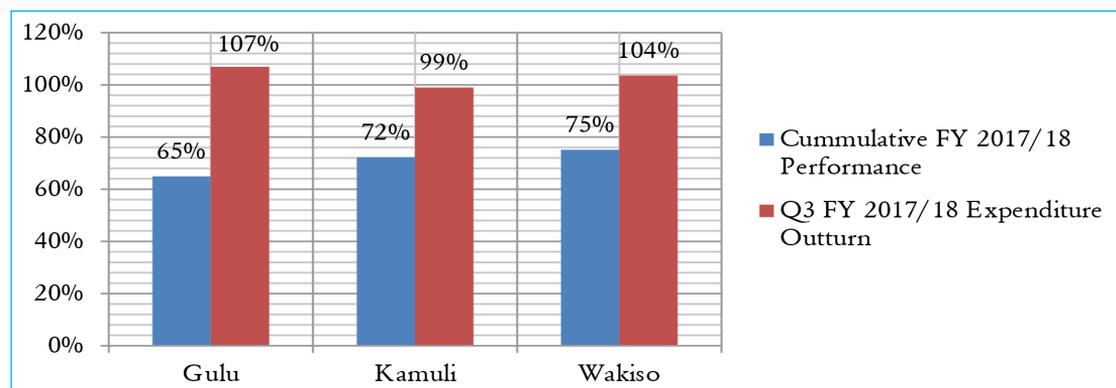
Source: Computations from Local Government Quarterly Performance Report - Quarter 3 FY 2017/18

⁴ The failure to access the documents could be interpreted to indicate poor record keeping or a limited level of access to information of this kind.

⁵ The research team triangulated the information obtained on utilization of PHC grants in the data collection process with what is available on Uganda’s budget website; www.budget.go.ug and found both sources to be consistent?

Considering the funds allocated for only the third quarter, Gulu and Wakiso's budget performance was higher than 100%. This suggests that both districts did not fully absorb PHC funds meant to have been spent in Quarter two. A comparison between the third quarter and the cumulative financial year performance as illustrated in Figure 4, posits, that the high levels of cumulative budget performance were mostly due to the high performance in quarter 3.

Figure 4: Budget Performance in the Utilization of PHC Grants



Source: Computations from Local Government Quarterly Performance Report - Quarter 3 FY 2017/18

This could imply that the budget performance within the first and second quarters was poor. The research team was unable to access quarterly progress reports for the respective quarters to conduct a quarter-by-quarter analysis.

Effectiveness in Resource Allocation

Allocation of PHC funds at local government level is guided by the Annual Sector Grant and Budget Guidelines already alluded to in the findings under the Strategic Vision principle. It was however noted that the level of specificity of the guidelines varied across the implementation levels. The grant guidelines were very specific with percentage allocations of the Non-Wage and Development grants at district head quarter (departmental) level but not at facility level. For instance the FY 2017/18 guidelines specify the PHC development grants to be broken down into at least 85% for transitional development (e.g. upgrading HC III to HC IVs); at most 5% to finance investment service costs (e.g. bills of quantities or economic impact assessments) and at most 10% to finance monitoring and evaluation. Still at departmental level, the grant utilization guidelines directed that an amount equivalent to 30% of the salary of staff leaving in hard to reach areas (outside town councils and headquarters) be taken from Non-Wage PHC grant as hard-to-reach allowance.

The grant utilisation guidelines also indicated the funding non-wage recurrent budget ceilings for health facilities at the various levels. In FY 2017/18, the levels of funding did not change relative to the previous financial year with adjustments only noted at

HC IV and HC IIIs. Public Health Centre IVs were appropriated an additional UGX 7,540,107 while each public HC III was allocated an additional 2,865,854. It was notable that allocations to HCIIIs were maintained at FY 2016/17 level. However, the rationale behind the decision to maintain the allocation levels for HC IIIs while marking up the funding at HC III and IV was not stated in the sector budgets.

Consultations at health facility levels revealed that the PHC funds were inadequate in dealing with the needs of the communities served. Some of the health facility In-charges attributed the inadequacy to health facilities at the same level receiving same levels of funding irrespective of their catchment areas. Additionally, it was observed that while Health IIIs in transition (being upgraded to HC IVs), had received some additional funding, they had the same staff structure despite their growing services demands after being designated as HC IV in FY 2017/18. This greatly affected their effectiveness in providing PHC services.

*We were supposed to have 19 staff as a HC III but have only 13 and the number has not changed despite being upgraded to a HC IV. These staffing gaps have persisted and we have been told there will be no recruitment in the coming financial year 2018/19. We will not be accredited as a HC IV until the theatre being built is operational. It was expected to be completed in April 2018 but it has delayed and we are being told it will be completed in July 2018. So we expect to continue the same way for another financial year unless we get a miracle... **HC IV In-charge in Bududa***

At Health facility level, it was noted across all the health facilities and districts visited, that immunization and community outreach was the top most funding priority. However, there were no clear guidelines on how the PHC non-wage grant ought to be utilized across the different priorities despite all health facility in-charges reporting that allocation of funds was guided by the PHC guidelines. As a result, the health unit in-charges interviewed all had varying responses to the question on the percentage breakdown of the PHC non-wage grant in their resource allocation and utilization. These variations were noted within and across study districts; across health facility levels (HC II, III and IV) as well as types (public and PNFP).

*There are also fixed expenses that must appear. One that must appear is immunization... Now we know the percentages that were designed. I think the people who designed had problems because if you get like 40% and give it to one activity, you cannot do other activities... So like 40% for immunization is around 600,000/- if you put all that money on immunization, other things will be done.... - **Health Center III In-Charge Kabarole***

*We prioritize the PHC imprest/petty cash in accordance with spending guidelines attached to the funds, according to the Ministry of Health. For example; 50% of the funds could be allocated to immunization and community outreaches, 30% water and electricity and 20% for maintenance of cleanliness and support staff welfare... - **HC IV In-charge Wakiso***

*PHC allocations depend on the guidelines set by the Ministry of Health. 50% for outreaches, 30% for health maintenance, 10% Office maintenance and 10% transportation of blood samples... **HC II In-charge Wakiso***

*We prioritize PHC services in accordance with the guidelines set by policy makers. For example, 50% is allocated for drugs, 30% for outreaches and 20% for administration and support staff purposes..... **PNFP HC III In-charge Wakiso***

As can be seen in the quotations above, there were variations on the percentage allocations to immunization and outreach. In Wakiso, 50% of the funding at health facilities was directed towards immunization and outreach while 40% was being allocated for the same activities in Kabarole. Further interactions with health unit in-charges revealed that there were often no induction or orientation for the health unit in-charges especially on how to handle the resource allocation, utilization and accountability. They usually learnt on the job which could explain these variations.

However, it is also notable that these percentage breakdowns had not been published in the PHC grant utilization guidelines for over a decade. They were last published in the PHC grant utilization guidelines of FY 2002/03, an exception of which is presented in Annex 2.

There was a clear discrepancy between what was provided for in these guidelines and what was being implemented. Given the 16 years that had passed since the guidelines were published, it was important for MoH to review these in light of prevailing contexts of health service provision. After such a review, it was important that they be widely disseminated to provide clarity across all levels of health service provision.

Receipt and Utilisation of PHC Funds

Interactions with study respondents on effectiveness and efficiency practices in the utilization of funds were informed by the timeliness in receipt of funds, availability of health facility staff or levels of absenteeism and practices in expenditure.

In FY 2014/15, MoFPED effected the transfer of PHC Non-Wage grants directly to health facilities' accounts, a reform that was made to reduce bureaucratic delays in the transfer of funds to local governments. Data from ACODE's budget monitoring exercise of the third quarter FY 2017/18 revealed that the PHC non-wage grant was received between mid-January and early February (see Image 1). The reported timelines revealed slight variations between the best performing and poor performing districts as per the selection criteria of the study districts. Overall, majority of the study districts reported to have received the PHC non-wage grant in the third and fourth week of January. Only two districts of Luwero and Bududa received the grant in the first week of February 2018.

However, while improvements had been registered in the timeliness of the transfer of funds to districts/local government headquarters, challenges remained with timeliness in the receipt of grants at health facility level. Health facilities reported delays in the receipt of funds despite the funds being transferred directly onto the facility accounts.

The delays in the receipt of the PHC Non-wage grant were reported among both the

public and the PNFP facilities. In Gulu for instance, the research team encountered reports from both PNFP and public health facilities indicating receipt of funds in the second month of the quarter, which to them was considered to be timely.

It (PHC Non-Wage Grant) comes timely. We normally receive the money in the second month of a quarter... PNFP HC III In-charge Gulu.

...Normally this money comes a little late at the end of the second month of every quarter... HC III In-charge Gulu

Some of the delays could be attributed to the delays in the warranting process (approval before funds are withdrawn from the consolidated fund). As per the current expenditure governance practices, funds that were transferred directly onto the health facility accounts had to be warranted (validated and approved) before they are transferred to the health facilities' accounts – a process that is informed by the local government health departments. However, the process of warranting had been reported to have delays (MoFPED, 2017). The Budget Monitoring and Accountability Unit (BMAU) in MoFPED reported that warrants took three (3) working days on average to process in FY 2016/17.

It was also noted that bank charges remained a challenge for some health facilities in spite of the FY 2014/15 public financial management reforms instituted by MoFPED which had been reported to have reduced bank charges (MoFPED, 2017b).

Another challenge is bank charges which are high in Stanbic bank, they charge us around 500,000 shillings annually on the already little funds. In fact, we are in the process of transferring our account from Stanbic to Equity bank and CAO has already recommended for the transfer... HC III In-charge Bududa

Given the inadequate nature of the PHC funds, it is inefficient for health facilities to be losing up-to UGX 500,000 annually in bank charges. Health Facilities were observed to lose funds to account management charges to a tune of UGX 30,000 monthly. These losses were further compounded by excise duty charges levied on each transaction among other charges. Annex 3 explicitly illustrates this issue and shows a health facility incurring UGX 44,000 as the bank charges/fees in October 2017. Given the routine nature of the transactions charged, it is likely that the facility incurs these costs on a monthly basis which brings the annual cost to UGX 528,000. Given the facility's FY 2017/18 PHC Non-Wage budget, bank charges/fees would therefore be accounting for about 4.3% of the funding. There is room for improvement here by switching to Banks with lower charges. However, government (MoFPED in particular) could also enter into memoranda of understanding with the commercial banks for them to offer banking products with an element of corporate social responsibility.

Functionality of the HUMCs and VHTs

The HUMCs played a significant role in exercising oversight over the PHC funds and being liaisons between the communities and the health facilities. Across all the districts visited, HUMCs were found to be in place at all health facilities visited and were functional. It was reported that the majority of HUMCs across all the districts met on a quarterly basis. In some instances, the HUMCs reported meeting on monthly

basis. The monthly and quarterly timelines were consistent with the MoH guidelines⁶ for HUMCs. However, there were two cases in Gulu and Moroto where the HUMCs reported meeting once a year which did not go well for effective management of PHC resources. HUMCs ought to meet at least once every quarter in order to ensure service delivery needs of the communities they serve were reflected in resource planning and budgeting at the health facilities.

The limited functionality of the HUMCs also affected the utilization of funds. In some instances, it was reported that delays in the utilization of funds was due to the unavailability of other signatories to the facility accounts such as the HUMC chairperson and Senior Assistant Secretaries at Sub-county level. These are needed to approve or sign on the cheques to withdraw funds from the facility accounts.

*The challenge comes if one of the signatory to accounts goes for study leave or event; there is a likelihood of spending money late which may be questioned during the audits... **HC III In-charge Gulu***

However, without specific guidelines in place, it was also noted that there was no standard criterion for deciding who to take on the role of signatory to the account of the health facility. In some instances, HUMC chairpersons were signatories to the account while in some instances they were not.

In instances where none of the HUMC members were signatories to the accounts, they reported having limited information on the PHC funds which constrained their ability to provide oversight.

*Those health workers don't have time to listen to us. If you want the information, you can go to the Senior Assistant Secretary and the In-charge who are signatories to the PHC account so he knows the releases and not us. We actually don't know how much is released... **HUMC Member Bududa***

Consultations with the HUMCs also revealed infrequency in the training and retraining of the members of the HUMCs. The MoH Guidelines on HUMC did not provide for their training (and its frequency thereof). These guidelines had not been revised since 2003 and mostly provide for only the composition of HUMCs. The study team also profiled some of the HUMCs serving the health facilities that were visited. It was noted from the resultant data that **as of April 2018, majority of the HUMCs reported to had been trained by either government MDA (56.7% of the HUMCs consulted) or by Non-Governmental Organization (43.3%)**. The years in which the training was given ranged from as far back as 2009 for some HUMC members to as recent as March 2018. Majority of those reporting training were trained between 2016 and 2017. In observing for patterns, it was also noted that the years of receiving training were similar across all the districts.

On the other hand, **one third of the HUMC members consulted reported having received neither training nor orientation since they were appointed⁷**. Among the HUMC members reporting no training or orientation, 18% of them were newly appointed (less than a year on the committee), nearly half of them (48.5%) had spent a year on the HUMC, while another 18% had spent two years on the HUMC. An

6 The research team was only able to access the 2003 MoH Guidelines for HUMCs at HC III

7 These estimations are based on data from seven of the study districts (excludes Kabarole) with a total of 102 HUMCs consulted.

additional 12% of the HUMC members reported having spent 3 years or more on the HUMC without training or orientation. Some of these reported to have spent 6 to 7 years on the committee – an equivalent of two terms on the HUMC without training.

This lack of training and orientation consequently limited the effectiveness of the HUMCs in providing oversight over the governance of PHC funds at the health facilities. This left them at the mercy of the health facility in-charges who then decided what kind of information to share with them.

We don't have any guiding documents in relation to our roles so we just use our knowledge especially when we are in the meetings, the meetings tend to be more less clan meetings than Health Unit Management Committee meetings. Instead of advising, planning etc, we are the ones to be educated by the person we're supposed to oversee... **HUMC Member Bududa**

Given the numerous public expenditure and health governance reforms that had been undertaken over past five years, it is important that the HUMCs were frequently trained to keep abreast with the resultant changes in PEG practices at health facility level. It was also notable that some of the HUMCs had members that had exceeded the legally prescribed length of time on the committee as per the HUMC guidelines. The guidelines forbid HUMC members from holding office for more than two consecutive terms of three years each. However, 9% of the HUMC members consulted reported to have exceeded these years on the committees.

In addition to HUMCs, the Village Health Teams were seen as vital to the effective functionality of the PHC delivery system. In the absence of a Health Center I, the VHTs were the first point of call in the delivery of PHC. Consultations with VHTs revealed that the VHTs met regularly and most of them had received training. It was noted that one in four (25%) of the VHTs that reported being trained were trained in calendar year 2017. However, it was also noted that more than one third (36%) of the VHTs were last trained in calendar year 2010. Contrary to the HUMCs, it was observed that training of the VHTs was mostly undertaken by NGOs with 71% of the VHT reporting the training to have been provided NGOs.

However, the effectiveness of the VHTs was greatly constrained by the limited amount of facilitation. Owing to inadequate funding received at health facilities, the VHTs hardly got any facilitation. As a result, many reported difficulty in getting to the community members that needed their services in time or at all.

We really find it difficult, I would have moved to Bukolwa and move there fast but you can't because you do not have a means of transport... **VHT Member Wakiso**

In instances where a few bicycles had been provided, the types of bicycles supplied were not common in the areas and there were no spare parts available upon breakdown. In addition, the funding received at health facilities was also inadequate to provide for the routine maintenance of the bicycles.

Remember that those bicycles had no spares...some of us hang them a long time ago...Whatever got spoilt on the bicycle you would just count it as a loss... **VHT Members Wakiso**

There is no routine funds for the maintenance of the bicycles for the VHTs hence this retards the efforts of VHTs in doing their roles... VHT member

Buliisa

The voluntary nature of the VHTs implied that the VHTs were at times compelled to decide between earning a living for their households and attending to the community health needs. In the absence of any allowances, bicycle repairs were definitely not a priority on individual resources. As MoH plans to replace VHTs with Community Health Extension Workers (CHEWs) gains traction, the challenges that had limited the effectiveness of the VHTs worth taking into account.

Allocation and Utilisation of Medicines and Supplies

Health facilities in Uganda do not directly purchase or procure medicines and supplies but have them delivered by the National Medical Stores (NMS) and the Joint Medical Stores (in the case of PNFPs). Thus health facilities have credit lines with the NMS/JMS which vary across the levels of health facilities. The MoH's PHC guidelines provide detailed instructions on the procurement of medicines and supplies as well as the respective budget ceilings for the health facilities. As per the FY 2016/17 guidelines, HC IIs had an average credit line allocation of UGX 6.3 Million, HC IIIs had an average credit line allocation of UGX 19.2 Million and HC IVs had an average credit line of UGX 44.6 Million.

There is joint planning and budgeting meeting conducted at the DHOs office with the District Health Team. A representative from NMS regional office in Hoima attends this meeting. The budget is guided by IPFs sent from the centre for the different levels of health facilities. The NMS representative guides in the types of drugs and supplies recommended for each level of health facility... HC IV In-Charge, Buliisa

It was reported that the procedures for requesting the medicines functioned effectively and medicines were delivered on time. However, challenges remained with the quantities supplied with the respondents reporting some discrepancies between the quantities requisitioned for and what was received. The discrepancies were reported as occurring frequently. As a result, health facilities were reported to have resorted to ordering for medicines and supplies worth more than their quarterly credit lines to compensate for what had not been delivered.

Discrepancies are common. They occur almost in every delivery of the quarter. There are many issues. In the quarter, they may ask you to order for medicines and other medical supplies worth 10 million shillings and they deliver supplies worth 9 million shillings. In another quarter you order and they deliver commodities for 8.5 million shillings. At the end you find you have very many balances. Actually we have been ordering for more than actual for the last two quarters. If it is like ten million for this quarter, we order for supplies worth 14 million to compensate for undelivered supplies in the previous quarters and utilize the balances... HCIV In-charge Kabarole

It was reported that NMS sometimes delivers medicines and supplies to health facilities that were meant for other facilities. The Health facility in-charges consulted reported existence of redress mechanisms which involved notifying the NMS/JMS of the discrepancies. The in-charges utilises NMS' toll free line to register complaints or sent emails to register their complaints. However it was noted that there was limited feedback and in many instances the discrepancies had not been dealt addressed in the subsequent delivery of the medicines and supplies.

Health facility in-charges reported drug stock-outs as a major challenge to PHC delivery to the communities. These stock-outs could be attributed partly to delivery of inadequate medicines and supplies and the discrepancies already alluded to. The stock-outs had as a result affected the delivery of PHC services including essential ones such as immunisation.

On the recent vaccination we were told that the vaccines were few because the medicine was not there but they promised to bring more and vaccinate the children but till now they haven't brought... **VHT Member
Kamuli District**

Community members reported buying the medicine from private clinics and drug stores due to stock-outs of medicines and supplies. In Gulu, for instance, community members reported pregnant women not being attended to due to absence of gloves.

First of all we have a problem of medicine. We have inadequate medicine. We go to health Centre for help but instead we are given name of the medicine we should buy from clinics. We are even told the buy gloves for us to be worked on...

We mothers who go to maternity ward to deliver, this happened to me when they told me to go back home if I don't have gloves. They rejected my gloves and said I should buy the glove which fit their hands... **Female
Community Members, Awach Sub-County, Gulu District**

Therefore, the limited availability of essential medicines and supplies consequently limited the effective delivery of PHC services. As a coping mechanism, health facilities in collaboration with district health offices had instituted redistribution mechanisms for the medicines and supplies. In Bududa district, it was reported that health facility in-charges met quarterly to share information on stock-outs and surpluses which then informed the redistribution. Thus, surpluses of particular medicines and supplies in any given health facility were redistributed to facilities with stock-outs.

Summary

These reported practices and experiences point to some ineffectiveness in the delivery of medicines and supplies. It is important that the deliveries made are consistent with the requests of the health facilities especially since the medicines are often not adequate/ commensurate to the catchment areas that the health facilities serve.

While health facilities electronically file weekly and monthly stock reports to the MoH, a measure meant to improve on the effective management of medicines and supplies, stock-outs persist. This could be attributed to the planning which sees health facilities

at similar level being given the same credit lines despite the variances in their catchment areas – a challenge which also characterised the PHC non-wage funding.

4.3 Accountability

In developing countries where health systems are characterised by service delivery challenges, proponents of increased accountability have done so with understanding that it plays a vital role in ensuring greater responsiveness, sustainability and efficiency in service delivery – thereby recognising the potential of accountability in improving PHC service delivery (Atela, 2013). This understanding is consistent with the PEG Framework which considers accountability as a gear/wheel for improved expenditure outcomes. In assessing accountability in the governance of PHC expenditure, three key concepts were considered namely; reporting, participation of non-state actors in expenditure governance, and accountability monitoring. The study districts were therefore assessed against these parameters with the research team taking keen observation for patterns across the best and poorly performing divide of the study districts based on the FY 2016/17 MoH District League Table. The results of this assessment are summarised in table 6.

Table 6: Evidence of Accountability in Primary Health Care (PHC)

Accountability	Good Performers on MoH District League Table				Poor Performers on MoH District League Table			
	Gulu	Kabarole	Kamuli	Luwero	Bududa	Buliisa	Moroto	Wakiso
Evidence of district reporting on performance in provision of PHC services in a public forum	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Evidence of at least one quarterly monitoring and supervision visit by the District Health Team	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Evidence of submission of quarterly progress report to MoH and MoFPED	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of sanctions enforced against any office bearer for non-compliance with accountability guidelines for providing PHC services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Evidence of stakeholders witnessing delivery of medicines	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Key: *evidence seen* *No evidence seen.* *Documents not accessed.*

Overall, the assessment of accountability was greatly constrained by a lack of access to district documents from which the evidence was expected to be obtained. Thus, deductions from the patterns observed could not be significantly conclusive. Nonetheless, even with the limited access to documents taken into account, the best

performing districts on the MoH district league table performed better than their poorly performing counterparts against most of the indicators. More of the best performing districts on the MoH District League Table demonstrated evidence of accounting to citizens by reporting on PHC performance at a public forum. Additionally, only Kamuli which was among the best performing districts demonstrated evidence of submitting quarterly progress reports to MoH and MoFPED. The evidence, therefore, suggests better book keeping practices and adherence to reporting requirements among the districts that performed well on the MoH district league table.

Results from the assessment of accountability monitoring which is often undertaken by District Health Teams demonstrated a clearer distinction between the best performing districts and the poorly performing ones on the MoH district league table. While all the best performing districts demonstrated evidence of quarterly monitoring visits undertaken by the District Health Teams, only one of the poorly performing ones demonstrated evidence of such monitoring. In three of the poorly performing ones, the research team did not obtain access to the necessary documents and in one where the documents were obtained; there was no evidence of the monitoring visits.

Accountability monitoring provided an opportunity for the district health team to provide better oversight and identify issues that needed urgent attention. The findings on accountability monitoring in Wakiso were consistent with what the Health Monitoring Unit found when it monitored 16 health facilities in Wakiso district in August 2016. It was observed that there was no evidence of quality supervision from the district. A number of additional issues affecting the governance of PHC funds were identified. These included but were not limited to lack of prioritisation in budgeting, staff absenteeism, sale of medicine, closure of health facilities on weekends, poor inventory management and utilisation of equipment, non-engraving of equipment, and limited evidence of quality supervision from the District. Thus, upon receiving a copy of the monitoring report, the CAO's office directed the Health Department to conduct monitoring once every two months in July 2017. Nonetheless, the ACODE study team did not come across any of the bi-monthly monitoring reports.

The patterns in citizens or their representatives witnessing delivery of medicines and supplies were similar across the well and poorly performing districts on the MoH District League Table. Only two of the districts in each of the categories had evidence on the citizens witnessing the delivery of the medicines. In both categories of the districts, the team had no access to the required documents in the remaining two districts.

Accountability also involved the enforcement of sanctions where office bearers failed to adhere to public finance regulations. In all the study districts, only three districts of Luweero, Moroto and Wakiso had evidence of sanctions being enforced on an office bearer for non-compliance with regulations in the provision of PHC services. In Wakiso district, for instance, a nursing assistant and an enrolled nurse were interdicted by the CAO's office for absenteeism and put on half pay for the duration of the interdiction.

Overall, based on the available evidence, it was observed that the districts from the best performing category on the MoH district league table performed better in accountability compared to their poor performing counterparts.

Financial Accountability Mechanisms

In this section, we address the mechanisms in place to ensure accountability for PHC funds. In order to ensure accountability of the PHC funds, the local government financial and accounting regulations had to be adhered to by duty bearers across all levels of PHC service delivery. Many aspects of these regulations, such as reporting and sanctions, have already been addressed in the preceding sub-section.

Effective FY 2014/15 health facilities now receive their funds directly onto the facility accounts. Health facility in-charges are required to write to CAO's office acknowledging receipt of the PHC funds on their respective health facility bank accounts, a mechanism which greatly fostered accountability. This mechanism was found to be in place at both public and PNFP health facilities. As an additional accountability requirement, health facilities submitted work-plans to the district administration based on money is spent.

*Basically, once funds are disbursed on their accounts, they have to write the acknowledgment letter to the Chief Administrative Officer, and give copies to DHO, Planner, Audit, HUMCs Chairperson, and Senior Assistant Secretary of the Sub County. But these acknowledgements must be accompanied by the work plan to show how you intend to use the funds disbursed to you. Also as you implement, you should give us the reports about the progress and finally you submit your financial statements together with your reports on how you spent the money... **DHO Bududa District***

These mechanisms of accountability were also found to be working well in both the best performing and poorly performing districts on the MoH district league table as illustrated in the Image 3. However, it was also observed that there was a time lag between when the funds were received and when the letters of acknowledgement were received at the CAO's office. In the case illustrated in Image 10, the health facility indicated receiving the PHC non-wage funds on 2nd November, 2017. It dispatched the acknowledgement letter on 10th December and it was received in the CAO's office on 18th December, 2017. This delay in accountability was attributed to heavy workload.

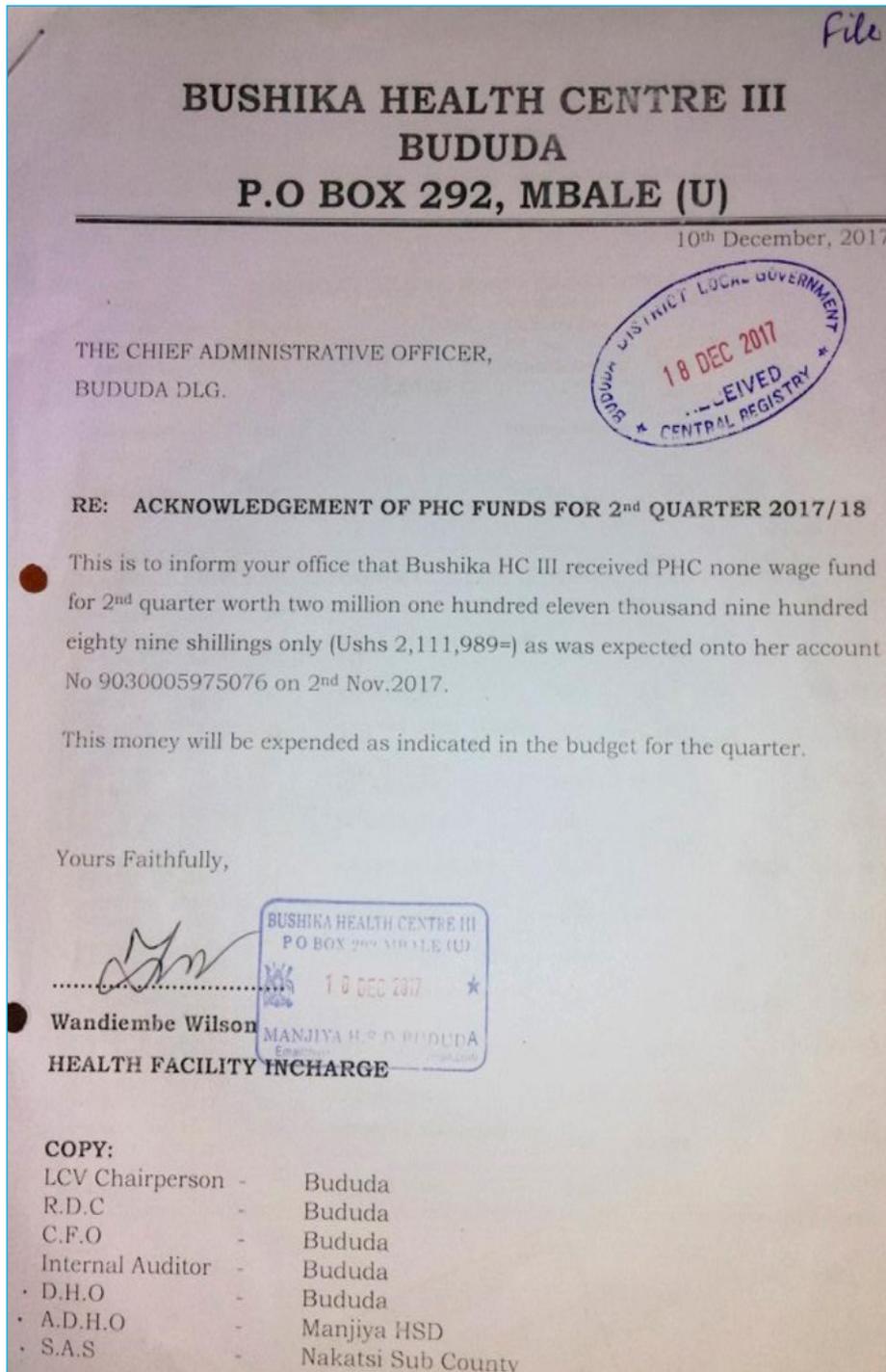
(See Image 1)

The Health facility in-charges treated patients and undertook administrative duties in addition to being the accounting officers. Additionally, many of the health facility in-charges had not received any training in financial management despite being appointed accounting officers for their respective health facilities.

It was also reported that health facilities underwent internal audits to ensure effective accountability for how the funds were being spent. Consultations with the health facility in-charges revealed that the existence of the annual audits ensured that the PHC guidelines were adhered to in the utilisation of the PHC funds. Deviation from the PHC guidelines was said to be grounds for audit queries.

We have the audit department that audits every transaction or every investment that the district makes. If the audit department finds out any evidence of mismanagement, we have a disciplinary committee before which we summon the implicated officer. Once the allegation is proved, we either ask the person to refund the money or they are interdicted. There

Image 1: Copy of Letter Acknowledging Receipt of Funds at a HC III



Credit: ACODE Images Captured during Data Collection.

are cases that go beyond the disciplinary committee. In those cases we involve the IGG or the Police to investigate and culprits are always prosecuted... **CAO Gulu District**

Accountability in Medicines and Supplies

At health facilities level, expenditure on Essential Medicines and Health Supplies (EMHS) was in form of credit lines rather than expending of finances directly. Thus the accountability loop for medicines and supplies also involved the National Medical Stores (NMS) which supplied the public health facilities and the Joint Medical Stores (JMS) which supply the PNFP health facilities. These were expected to supply medicines and supplies to health facilities as per their respective requests.

During consultations with health facility in-charges, it was reported that delivery notes and invoices were sent by the NMS along with the medicines and supplies. These were signed upon delivery to verify quantities and categories of medicines and supplies delivered. Signing of these delivery notes served as an acknowledgment of receipt for the delivered medicines and supplies.

There is the delivery note and the invoice which comes along with the medicine. We cross check and then we sign to verify all is well. If there are any errors, we let them know always. It is the in-charge and the store keeper... **PNFP HC III In-charge Gulu**

The receipt of the medicines and supplies was also reported to be witnessed by members of the community (often represented by the HUMCs) and some of the community leaders at sub-county level. This added an additional layer of accountability. The community members however could only attest to quantities of the medicines and supplies as opposed to content of what was delivered. The content delivered was often reconciled with copies of what was ordered and the record on the stock cards, after which, health facility in-charges filled in a discrepancy form in case of variations between what was ordered and what was delivered.

In instances, where discrepancies between what was ordered and what was delivered were experienced, feedback mechanisms existed for the health facilities to communicate the discrepancies. The in-charges utilise NMS' toll free line or sent emails to register the complaints as discussed in the effectiveness and efficiency section. However, it was noted that the feedback loop was incomplete when it came to the NMS and JMS. While the health facilities provided feedback via the discrepancy forms, email and a toll free telephone line, the NMS seldom acted on the feedback received.

But once we realize these discrepancies, we complain by calling their Toll free line or email. But the challenge is that they don't compensate and once a mistake has been made, you just communicate to show them that they have made a mistake but helping you out is not easy... **HC III In-charge Bududa District**

The same was reported about the JMS during the consultations with the PNFP health facilities. It was therefore observed that there was limited accountability (redress of complaints) on the part of the NMS and JMS concerning wrongful deliveries.

Summary

Overall, it was noted that the best performing districts performed better than the poor performing ones on the MoH district league table in most of the accountability indicators. Notably, the best performing districts were better at accountability reporting and monitoring. It was further noted that accountability mechanisms were in place and function similarly well across the study district divide on the MoH district league table and the public and the PNFP divide. However, accountability delays were noted in reporting especially regarding health facilities acknowledging receipt of funds. These delays were attributed to workload and absence of training in financial accountability for health facility in-charges whose only training is medical in nature. Finally, accountability was significantly associated with feedback and it was noted that there was limited feedback and action from the NMS and JMS in addressing discrepancies between what was demanded and what was delivered.

4.4 Control of Corruption

This section presents findings obtained from document review and responses from respondents on control of corruption practices in the delivery of PHC services. The document review focused on evidence of bureaucratic and administrative systems and practices in place to safeguard against corruption. In particular, the review looked for evidence of the PHC grants being captured in quarterly internal auditing exercises by district; evidence of the district PAC/DEC discussing issues related to PHC Services from either the Internal Audit or Auditor General's report; evidence of a Council meeting discussing a PAC report raising issues related to PHC; and evidence of administrative actions taken (e.g. introduction of new rules/procedures) in response to queries raised by the Office of the Auditor General/District PAC. The documents reviewed under the control of corruption in PHC activities majorly included minutes of Council meetings as well as reports by Council and DHO's office on actions taken in response to queries raised by the citizens on PHC services both to Council and DHO's office. Table 7 summarises the findings of the review.

Table 7: Evidence of Control of Corruption in Primary Health Care

Control of Corruption	Bududa	Buliisa	Gulu	Kabarole	Kamuli	Luwero	Moroto	Wakiso
Evidence of the PHC grants being captured in quarterly internal auditing exercises by district	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of the district PAC/DEC discussing issues related to PHC Services from either the Internal Audit or Auditor General's report.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of a Council meeting discussing a PAC report raising issues related to PHC.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Evidence of administrative actions taken (e.g. introduction of new rules/procedures) in response to queries raised by the Office of the Auditor General/District PAC.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Key: Evidence seen No evidence seen. Documents not accessed.

Evidence of control of corruption in the delivery of PHC services at district level was very scanty. Only one district (Kabarole), of the eight districts involved in this study, had evidence on all the four best practices of corruption control. Documents on all the four practices could not be accessed in two of the districts (Moroto and Wakiso), showing evidence that control of corruption is not given enough attention otherwise such information would be public and easily accessible. In all other districts where the documents were accessed, there was no evidence of adherence to most of the best practices of controlling corruption except in Kabarole. For example, Gulu District had no evidence of the district PAC/DEC discussing issues related to PHC Services from either the Internal Audit or Auditor General's report; no evidence of a Council meeting discussing a PAC report raising issues related to PHC; and no evidence of administrative actions taken in response to queries raised by the Office of the Auditor General/District PAC. This poor performance in corruption control in Gulu (and Kamuli District) was consistent with findings in the PEG in agricultural extension (see Kuteesa *et al*, 2018).

Only one district had evidence of district PAC/DEC discussing issues related to PHC Services from either the Internal Audit or Auditor General's report, and also the same district had evidence of a Council meeting discussing a PAC report raising issues related to PHC and evidence of administrative actions taken in response to queries raised by the Office of the Auditor General/District PAC. In only three of the eight districts in the sample were documents containing evidence of control of corruption in PHC grants captured in quarterly internal auditing by the district.

Information obtained from key informant interviews and focus group discussions with government and non-government actors provided further evidence on the prevalence and control of corruption in relation to PHC services in Uganda.

Mechanisms for Dealing with Corruption

A number of mechanisms were found to be in place designed to ensure that PHC funds were put to their intended use. The mainstream public service processes such as procurement, audits, sanctions and accountability reporting mechanisms were in place to ensure funds were put to intended use. It was also reported that functional disciplinary committees as well as District Public Accounts Committees are in place to deal with errant office bearers at all local government levels. Some of the processes and practices reported were recurrent in nature like use of inventory books and stock cards to hold to account those in charge in the event of any misuses.

The health sector has a disciplinary committee in place which disciplines officers who misuse these funds. We also report to police grave issues that are beyond our control and disciplinary procedures are instituted and investigated. --- Chief Administrative Officer, Bududa District.

We have given different departments inventory books and we emphasise daily handover of items. These days we give out things to individuals and not departments, and they are signed for by an individual. If we are to give out a BP [blood pressure] machine we give it to a head of department and he/she signs for it. So when the inventory person is

*taking an inventory he asks that particular person who took the item. So individuals are responsible unlike in the past when we used to give items to departments and no one was personally held responsible. --- **HC IV In-Charge, Luwero District.***

Despite the existence of these mechanisms, reports on the prevalence of corruption remain.

Prevalence of Corruption in PHC

The main form of corruption reported in almost all the districts PHC activities is the theft of drugs and other supplies from public health centres. The stolen medicine and supplies are often sold to unsuspecting and/or none vigilant public in private clinics and/or drug shops. Others reported forms of corruption in form of embezzlement of PHC funds, sale of blood for transfusion to patients, absenteeism, and late coming by health workers.

*Yes drugs are stolen. One time the health staff of this health centre was arrested by police, taken to court and got imprisoned. This was case was reported by one of the community members. --- **Male Respondent, Kabarole District.***

*The big problem here is blood. They ask for money yet someone may not have or even if one had, blood is supposed to be free. They claim that the money is for buying the bag that carries the blood. --- **Female Respondent, Kamuli District***

However, it was observed that the views on the prevalence of corruption varied across the categories of respondents. The prevalence of corruption was denied or downplayed by the health workers and other actors at the district administration level. Additionally, reports on the prevalence of corruption also varied across and within districts. Respondents in a sub-county in Luwero reported corruption to be minimal.

*No corruption case has ever been recorded in the district.
--- **CAO Respondent***

*Stealing of drugs is minimal and we haven't yet seen it here. We used to have it the past but it has since stopped. Most of the corruption [related to theft of drugs and embezzlement] has been dealt with. The kind of corruption we have here is laziness and late coming [by health workers]. The worst form of corruption we have here is the theft of our time. --- **Male Respondent, Luwero District.***

Some of the respondents indicated not reporting corruption cases for fear of mistreatment at the health facilities when seeking treatment. This could partly explain why few cases of drug theft are prosecuted despite theft of drugs being widely reported in media outlets.

We have never dealt with any cases of corruption in the health services, although we are aware of government drugs being sold in most clinics owned by the health workers. We fear being mistreated at the health facility.

Communities here fear to be earmarked [as the ones who reported the corrupt] and suffer the consequences. --- Female Respondent, Buliisa District.

The research team observed that the level of participation of citizens in controlling corruption varied greatly without any discernable patterns distinguishing districts or urban and rural areas within the districts. While some reported a lot of apathy in holding health workers accountable for PHC funds, reports from others suggested an empowered citizenry that reported cases and action was taken on errant officers.

The most significant factor influencing the corruption control behaviour among citizens was the availability of information among those that reported cases or the lack thereof among those that reported apathy. Some respondents at community level were not aware that there were primary health care funds remitted to the health centres in their areas including members of the VHTs.

That one is news to our ears. The In-charge and the HUMC may be able to understand it. What have you called it again? "It's the primary health care fund." We do not know that one. We have never heard about it. We suggest they pin it at the health centre's Notice Board just like the UPE funds are displayed. Let them show the community how much funds they receive and if possible the accountability for those funds. --- VHT

Member, Luwero District

During interviews and FGDs, it was evident that the actors who were supposed to report the corruption were resigned while those that were supposed to act on it were noncommittal. In line with the findings in Kuteesa *et al* (2018) about corruption in agricultural extension services, findings of this study clearly showed that if corruption escaped the institutional mechanisms, the average consumer of PHC services had little to do about it. Ugandan citizens, particularly those in rural areas, had not been empowered to report corruption. Asked about the challenges they faced while reporting corruption, several respondents said:

The problem is when we report, nothing is done to suspects. Instead, you who reported may not receive even a mere Panadol from the person you reported; or if they help you, you will always be the last person to receive treatment. --- Male Respondents, Gulu District.

We apprehended a health worker in possession of stolen drugs. We handed her over to the doctor who was available. She was eventually taken to Kamuli Police Station. But now the person is back. --- HUMC

Members, Kamuli District.

Respondents at Community level reported that measures to safeguard anonymity of the whistle blowers would go far in increasing the number of cases reported. Respondents suggested that if they were provided with telephone numbers to report graft or drugs theft, they would report such cases. However, they still expressed fear that the persons they reported to (even on telephone) could be part of the corruption cartel.

*When you go to police to report, they may end up imprisoning you instead.
So we decided that since government hates us this much, let us die free.*

--- Male Respondent, Kamuli District.

The apathy reported among community members suggested limited functionality of HUMC in respect to interacting with the communities they represented – consistent with the effectiveness and efficiency discussed around their functionality in section 4.2. It also pointed to limited transparency at health facility level which limited the flow of information to the citizens.

Summary

Overall, reports on the prevalence of corruption did not vary significantly between the top performing and poorly performing districts on the FY 2016/17 MoH district league table. This mixed performance in the perceptions is consistent with what the research team found among the practices and perceptions reported across all the districts. There were no discernable practices and mechanisms that particularly distinguished any of the districts. The most frequently reported forms of corruption included theft of drugs by health workers, extortion of money from patients by health workers, embezzlement of PHC funds, and absenteeism and/or late coming by health workers. Although mechanisms to deal with corruption in PHC services have been put in place in most districts ranging from standing orders and laws against corruption to disciplinary committees that were supposed to punish the culprits, there was no evidence of implementing these mechanisms. Instead reports of the corruption suspects victimising whistle-blowers had instilled fear in the latter thereby weakening the fight against corruption. Citizens needed empowerment to fight corruption, by ensuring proper and safe channels of reporting corruption cases, sensitisation and enforcement of anti-corruption laws.

4.5 Coordination

This section presents the findings obtained from the content analysis of government documents, interviews, and focus group discussions on coordination practices and perspectives. The coordination principle looked at effective communication and coordinated actions between the key stakeholders involved in funding, planning, delivery, monitoring and evaluation of primary health care (PHC). The review and analysis of relevant documents focused on identifying evidence of at least one quarterly Technical Planning Committee (TPC) meeting where PHC issues were discussed; evidence of meetings between District Health Officers (DHO), District Health Inspectors (DHI), Village Health Teams (VHTs) and the Chief Administrative Officer (CAO) to discuss PHC issues; and evidence of an annual Joint Sector Review (JSR) meeting between district officials and other stakeholders on PHC services. Table 9 summarises the findings of the review.

Table 8: Evidence of Coordination in Primary Health Care at District Level

Coordination	Bududa	Bulisa	Gulu	Kabarole	Kamuli	Luwero	Moroto	Wakiso
Evidence of at least one TPC meeting where PHC issues are discussed every quarter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Evidence of meetings /communication between DHO, District Health Inspectors, VHTs and CAO to discuss PHC Issues	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Evidence of an annual Joint Sector Review meeting (between district officials and other stake holders) on PHC	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Key: *evidence seen* *No evidence seen.* *Documents not accessed.*

Evidence in Table 8 shows that only one district (Kabarole) out of eight districts in the sample, presented evidence of all the three best practices of coordination. In Kamuli and Wakiso, documents were not accessed. In total, eleven (11) of the twenty four (24) documents needed to assess evidence of coordination at district level, were not accessed despite efforts by the research team to access them. Of the thirteen (13) documents that were accessed, only one did not have evidence of coordination. This shows that unlike other services such as agriculture extension where most districts lacked evidence of coordination (see Kuteesa *et al*, 2018), the PHC services are well coordinated at district level in Uganda. Only Moroto was found without evidence of one of the practices of coordination – formal communication between DHO, DHIs, VHTs and CAO related to PHC issues.

Intra-Sectoral Coordination of PHC

Evidence from interviews and FGDs conducted among different actors at district level, showed that health services in particular, PHC services, were well coordinated at sectoral level. The roles of different actors were well defined and by and large understood right from the administrative head of the system—the Ministry of Health (MoH)—to the national autonomous institutions and the health sub-district (HSD)—the primary provider of PHC services in Uganda. It was evident from the data (both primary and secondary) that apart from a few weaknesses, such as weak coordination of non-state actors involved in health service delivery, the health sector was better coordinated, at least compared with the agriculture extension (*ibid*). Many actors in charge of implementation appreciate the significance of coordination. Asked how they related with the MoH and whether they found it relevant under decentralisation, district health officers had this to say:

MoH carries out supervision, coordination, planning and funding altogether. It also involves us in the budgeting process, sends us guidelines, train us and our staff, and we also have a toll-free line that can be used by both the community and us the staff to communicate with the Ministry.

--- District Health Officer.

When it comes to PHC, the Ministry [of Health] is very reliable. We get support from them, including our salaries. --- Assistant District Health Officer.

Respondents reported that the Ministry of Health offered their districts and health facilities the support supervision, monitoring and capacity building needed. It also issues guidelines followed at lower levels to provide PHC services. However, some respondents reported that levels of communication between the MoH Headquarters and the districts had deteriorated.

In the past, communication was okay but these days it is lagging. [The past leaders at Headquarters] could send communications in time. They could call the DHO directly and they would have our emails and communicate with us directly. This is no longer the case. Recently, we had a forum where we engaged the PS [Permanent Secretary] and shared with her about the challenges in communication. We have been receiving information on 'Whatsapp' purportedly from the PS and we wonder whether it is information that is authentic or not. Sometimes we just ignore and all of a sudden someone calls you questioning why you haven't submitted a particular document. There is a communication gap around there.

--- Assistant District Health Officer from Eastern Uganda

Findings also indicate that underfunding and 'agencification' of the health sector could have deprived the Ministry Headquarters of the one of the most effective enablers of coordination – funds. One respondent said:

At times we can go [to the MoH headquarters] and tell them that we want this or that, and they tell you 'we don't have;' or 'our budget does not allow that.' Much as they are receptive [of our demands], they don't have the budget. For example, I have gone there many times to ask for patients' files because we want to keep the medical records but they keep saying they cannot help much because they don't have the funds. They tell us 'go to National Medical Stores' but when we reach there they also tell you they don't have that budget. So our poor 'father' cannot provide much but has remained our father all the same (laughs). -- District Health Officer

Coordination of PHC under the Health Sub-District

At district level, the focal point of this study given that PHC was a highly decentralised service, data showed that actors in the public health facilities—which made up 55 percent of the total health care facilities in Uganda ((MoH, 2014)—were well coordinated. Right from Village Health Teams (VHTs) that act was the first contact for someone living in a rural area, through the chain of health centres II, III and IV, the actors exhibited satisfactory levels of awareness and practice of coordination.

Weaknesses in coordination emerged when the private-not-for-profit (PNFP) and private-for-profit (PFP) organisations came into play.

Structures such as District Health Team, Technical Planning Committee, management meetings, sectoral committee, and the Executive that reported to Council provided platforms for coordination among the different actors. In all the districts, it was reported that the non-state actors have got to seek collaboration from the Chief Administrative Office before implementing any of their activities in the districts. The collaboration among all the implementing partners at times involved the signing of Memoranda of Understanding (MoU) before implementation to begin.

We sign MoUs [memoranda of understanding] with the PHC implementing partners in the district. The CAO signs the MoUs on behalf of the district while my office signs as witness. --- District Health Officer.

All PHC implementing partners have one entry point, that is, the Chief Administrative Officer's office and District Health Officer. There after we enter into a Memorandum of Understanding after looking at what they will offer, how long they will take, what changes are expected, and the outcomes. We also conduct meetings to discuss issues arising and evaluate performance. We also share information." --- District Health Officer.

In order to enhance coordination, some of the activities such as supervision and monitoring were reported to be jointly undertaken by the district health teams. These undertook coordinated planning and monitoring activities. Most of the respondents said supervision and monitoring of health centres (HCs) by the District Health Teams (DHTs) was done on a quarterly basis. The supervision involved review of books and moving to the field to track progress, especially, on the targets (like safe deliveries). After the review, the HCs got feedback and developed joint action plans.

At lower levels, several In-Charges of Health Centres at different levels (II, III and IV) confirmed participation in planning meetings at the districts, when they were asked how their health facilities related with the DHT. In was hard-to-reach districts such as Moroto, who said, coordination was mainly done electronically using telephones. In comparison, easy-to-reach districts such as those in Central Uganda reported physical visits to the health units by the DHT where supervision, reviews, monitoring, capacity building and provision of feedback and redistribution of drugs in case of shortages and transfer of health workers were done. In other districts, they mixed the coordination mechanisms.

As In-Charge of the health facility I participate in health sub-sector planning meetings at the district. These are multi-sectoral meetings including Chairpersons of HUMCs [Health Unit Management Committee].

--- In-Charge of HC II

We coordinate through phone calls where we share weekly and monthly reports. --- In Charge HC III, Moroto District.

Coordination of Non-Governmental actors

Asked to report on the ways non-state actors were involved in the planning, budgeting, monitoring and evaluation of health service delivery and utilisation, several respondents reported that this is one area where coordination was weak. Although a mechanism had been devised to coordinate them through MoUs with the districts upon which they were allowed to take part in the Budget Conference where their plans and activities were absorbed and harmonised by the district technical planning committees, evidence from responses showed that a lot needed to be done to effectively coordinate the Non-Governmental actors in the health sector.

We have a challenge with our partners from the faith-based health centres – the PNFPs [private-not-for-profit] who do not want to give us information. We do not have enough information to guide decision making. --- Chief Administrative Officer.

We don't have direct involvement [with non-government actors]. We involve the HUMC [health unit management committees] which represent the interests of the community members. We send the facility's work plan and budget to the chairperson HUMC for approval. If he/she signs he/she represents the community. But we don't involve them directly in the planning process. --- In-Charge HC IV

Respondents suggested that involvement of non-governmental actors could be improved and/or strengthened by encouraging sharing of work plans and budgets and jointly monitoring and supervising the work. In particular, they suggested that the non-state actors should be encouraged to involve state-actors in the initial stages of their programs to bridge knowledge and trust gaps. In addition, they should train local citizens to work with government on their behalf instead of bringing 'expatriates' who sometimes failed to adapt to the environment the locals were used to working in.

Another key finding was on the role of media in the delivery of PHC services in Uganda. Most respondents perceived media more as a challenge than a useful non-state actor. Similar perceptions were reported about politicians, consistent with what other health policy literature has found in the past about a chaotic political-technical interface in Uganda (OPM, 2008).

They come to pick [bad] information and take it to the radios instead of helping to solve the problem. I am interested in someone who finds out [something that is not going on well] and tell us instead of running to radio. This is more helpful. I have realised that media is more of talking than helping. If you come here and [and find that] clients are not attended to and you go to the radio, how does that help? I expect the media to come and find a challenge, share it with us and we find a solution. They give one-sided information, and usually the negative side. If you do not consult the people concerned, have you solved the problem? --- In-Charge HC III

Nonetheless, evidence from interviews showed that technical personnel in PHC system across districts work with the District Councils to implement lawful resolutions on PHC made by the councils. In many districts the CAO's office facilitates the council to monitor PHC, provides reports to council on PHC upon which the councils based to make decisions and approved plans and budgets.

When it came to involvement of citizens in the PHC activities, they mostly came in through monitoring. Responses indicated citizens often petitioned the District Health Office and their local governments about issues such as absenteeism of health workers, poor attitude of PHC staff, and drug-related issues, particularly theft of drugs (see Section 4.5).

Summary

Proper coordination requires effective communication and coordinated actions between the key stakeholders involved in funding, planning, delivery, monitoring and evaluation of the PHC services. Evidence from government documents at local government level and responses to key informant interviews, suggests that the PHC activities are well coordinated especially among the public actors. The best practices of coordination are being practiced by most of the local governments where evidence was accessed in the delivery PHC services. However, coordination of non-government actors such as the private-not-for-profit (PNFP) and private-for-profit (PFP) organisations needed improvement by devising ways of involving the public actors and sector regulators early enough in programs of non-state actors to bridge knowledge and trust gaps.

4.6 Participation

Democratic decentralization provides that local governments and rural and urban communities are put in the 'driver's seat', and are given new sets of powers, rights and obligations. These include the right to be treated as people with capabilities, not objects of pity, the power to plan, implement, monitor, evaluate, and maintain programmes and projects to serve their felt needs, the obligation to be accountable to local people, not just central governments or donors, and the obligation to enable stakeholders and beneficiaries, most especially, the women, ethnic minorities, the poorest, and other long excluded groups, to participate fully and influence the decisions that affect them (Gills et al, 2001; World Bank, 2000).

In the context of the health sector, the government of Uganda through the Ministry of Health Policy documents has over the years emphasized participatory approaches in the programmes that intend to improve the population's health outcomes. This is expected to change the terrain of civic engagement by creating more spaces to maximize people's involvement in health service delivery and utilization processes.

In this study, we intended to explore the ways in which a spectrum of key stakeholders participated in PHC service delivery at different levels of the district local government. Particular focus was on the involvement of development partners, implementing partners, state actors at different levels, citizens, and civil society in planning, budgeting, monitoring and evaluation of PHC service delivery. Table 10 summarizes the findings of the document review on participation at the district level.

Table 9: Evidence of participation in PHC service delivery

Participation	Good Performers on MoH District League Table				Poor Performers on MoH District League Table			
	Gulu	Kabarole	Kamuli	Luwero	Bududa	Buliisa	Moroto	Wakiso
Evidence of district meetings held at least once a year to solicit views of non-government actors (e.g. NGOs, PNFP Health facilities, etc.) on the planning and evaluation of PHC.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Evidence of discussions of views from citizens on PHC in the district meetings	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Allocation of resources in the annual district budget for holding meetings with citizen groups, NGOs, PNFP Health facilities and other non-government stakeholders to discuss PHC issues	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Evidence of expenditure on meetings with citizen groups, NGOs, PNFP Health facilities and other non-government stakeholders to discuss PHC issues	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Key: *evidence seen* *No evidence seen.* *Documents not accessed.*

Results in Table 9 shows that four study districts (Gulu, Kabarole, Luwero, and Moroto) produced documented evidence of having held meetings at least once a year that solicited views of non-government actors - NGOs, PNFP Health facilities, and Citizens, on the planning, budgeting and evaluation of PHC. The rest of the study districts (Bududa, Buliisa, Kamuli, and Wakiso) lacked documented evidence of holding such as meetings i.e. no documents were available for review in order to verify the evidence.

Results in Table 9 above also show that only three districts of Kabarole Luwero, and Moroto had documented evidence of discussing the views from citizens on PHC in the district meetings. On the hand, four districts of Gulu, Bududa, Bullisa, and Kamuli lacked evidence on the same subject matter in the available documents that were reviewed. The district of Wakiso lacked evidence on the same subject due to unavailability of documents to review so as to verify the evidence.

Results in Table 9 above further show that only one district of Bududa dad documented evidence of having allocated financial resources in the annual district budget for holding meetings with a spectrum of key stakeholders – the citizen groups, NGOs, PNFP Health facilities among others to discuss PHC issues. The rest of the districts (Gulu, Kabarole, Kamuli, Luwero, Buliisa and Wakiso) lacked evidence on the same subject matter in the available documents that were reviewed.

Last but not least, results in Table 9 above show that only one district (Kabarole) presented documented evidence of having spent resources on meetings with citizen groups, NGOs, PNFP Health facilities and other non-government stakeholders to discuss PHC issues.

It is generally observed that the districts of Kabarole and Luwero, and Moroto performed relatively better on most of the participation indicators outlined in this PHC governance study. The districts of Bududa, Buliisa, Wakiso, Kamuli seemed not to perform well on most of the outlined participation indicators. With the exception of Moroto and Kamuli this performance is consistent with the criterion that guided the selection of these study districts based on the district league table data per region. Whereas Kamuli district appeared among the best performing districts on the district league table, in this study, it performs poorly on most participation indicators. Similarly, whereas Moroto district appears on the poor performing districts on the district league table, it performs relatively better on most participation indicators outlined in this study.

Perhaps, the striking observation is that poor records keeping in most districts jeopardized empirical evidence on the performance and practices. The implication is that even when some activities that involved stakeholders could have been carried out, without documented evidence, it was as if it had not been done. There were some discrepancies between documents reviewed, results, and key informant interviews. For example, despite the absence of documented evidence in most study districts regarding holding district meetings with NGOs, PNFP Health facilities, citizens, etc for planning, budgeting, and evaluation of PHC, the district leaders consulted confidently reported to be doing so. But as said earlier, without documented evidence, one could not differentiate the facts from fictions, hearsays and mere rhetoric. Best practices and performance must be scientifically evidenced through proper documentation. The panacea is therefore to encourage and build the capacity of district personnel in proper records keeping.

Participation in planning and decision making for PHC services

Under the democratic decentralization policy framework in Uganda, sector planning and prioritization, resource allocation and expenditure requires effective participation from all key stakeholders, transparency, and a great deal of responsiveness from duty bearers to meet the various, competitive, and ever-changing needs and interests of all the stakeholders - community members and / or their leaders, community health workforce (village health teams), health facility workforce, sub-county and district leaders, civil society organizations including NGOs and CBOs, and private sector (Republic of Uganda, 2016; Republic of Uganda 2001). This is done under the guidance of the designated national priority programme areas (NPPAs) - education, healthcare, agriculture, roads and water (Nsubuga 2002; Kukkiriza, 2007; Katono, 2007).

In addition, the Uganda government's planning guidelines calls for participatory, bottom-up, and inclusive planning process that involves all stakeholders including communities, local councils, civil society organizations including NGOs and CBOs, and private sector (Republic of Uganda, 2001). The planning process offers a form of direct and indirect citizen participation. This process begins with each village or community producing a Community Action Plan. These plans are incorporated into two strands of planning process; either the decentralized local government administrative structure or the health facility structure (Republic of Uganda, 2016; Republic of Uganda 2001).

Following the path of decentralized local government administrative structure, village action plans are meant to be incorporated by the Parish Development Committees into a Parish Plan which is then passed on to the sub-county level. The resulting sub-county plan may be implemented at sub-county level if resources are available; sub-county plans are also passed up to the district, where the District Technical Planning Committee then produces an integrated plan based on the recommendations of the committee which convenes the district budget conference (Kukkiriza, 2007). District budget conferences provide yet another avenue for direct form of participation which directly solicits citizen input into the district budget and development plans. The conferences are attended by not only the councilors, but also departmental heads, sub-county chiefs and councilors, members of civil society, Area members of parliament, and other members of the public. Finally, this process is ratified by the district council. Budget plans and expenditure need to be publicly displayed as a provision for ensuring accountability, and transparency (ibid).

On the other hand, the path of health facility structure planning involves a structure for planning through levels of health service delivery at the district level- HC-II, HC-III, HC-IV, HC-IV and general hospitals. The work plans for HC-IIs, HC-IIIs, and HC-IVs are consolidated to form a health sub-district plan. Consolidated plans from different Health Sub-district form a district health plan (Republic of Uganda 2016).

Consistent with the above, the study findings revealed that indeed, district local governments had put in place several avenues for stakeholders to participate as required by the law and guidelines.

*As the district, we have empowered the local citizens to participate in Sub county planning process where most of these views are generated from. They discuss from a Sub county level and we get copies of these proceedings which are then integrated in the district budget and work plans. May be another thing that I would say is that we conduct public Baraza's where the citizens come and ask questions regarding PHC service delivery, we note and capture these issues for inclusion in our plans for proceeding FY. We also have access to radio talk shows where citizens call in and ask questions which we then send to the health sector committee --- **CAO Respondent.***

Citizen participation in decision making in health processes

One of the critical elements of the conventional Primary Health Care strategy as crafted at the 1978 Alma Ata Conference was community participation- "the population should be made active in promoting health rather than acting as receivers of services" (Lindstrand et al., 2006). The philosophy behind is that popular participation entrenches 'substantive citizenship' (Mundial, 2004; Mayo and Craig, 1995; UNDP, 1993) with a focus on "placing social agency at the centre of things" (World Bank, 2000). 'Substantive citizenship' also provides that those who enjoy the formal legal status of citizenship should actually claim the rights that they have been formally accorded (Bukonya, 2012). To this end, popular participation is regarded as primarily a right of citizenship and its level of engagement is at citizens, civil society, state agencies and institutions (ibid). The focus is on convergence of social and

political participation, scaling up of participatory methods, state-civic partnership, decentralization, participatory budgeting, and citizens' hearings, among others (Hickey and Mohan, 2004).

Generally, popular participation is viewed as a mechanism to empower local communities, capture indigenous people's knowledge, and ensure sustainability and efficiency of interventions (Hickey and Mohan, 2004). It ensures that citizens influence and share control over development initiatives, decisions and resources that affect their lives (Long, 2001; Muhangi, 2007; Mukundane, 2012). The interface between the community members (service users) and the health facilities/health workers, sub-county and district level authorities (service providers) though various is believed to generate a shared action plan on what needs to be done to improve health service delivery and utilization (Mukundane et al, 2016; Martin et al, 2014; Bjorkman and Svensson, 2009). Community participation in the planning and decision-making process is also critical to strengthening local accountability and demand-responsiveness (Björkman and Svensson 2010; Svensson and Björkman 2009).

This study revealed that, in all the study districts, several opportunities have been created for citizen's participation in community development issues. These range from community meetings, community dialogues, barazas, constituency health assemblies council meetings, and budget conferences. These gatherings provided the community members with a platform to interact and discuss with various state and non-state actors regarding health-related issues, among other things.

At the sub-county level, we have a barazas where citizens are invited to participate in meetings to discuss issues concerning health service delivery. At the district level, citizens are allowed to go to council sessions to listen to the debates about service delivery of which health forms part of the discussion. --- Male FGD Respondent, Wakiso District

...at sub county level, women are also invited for barazas while at the district level, we are invited to participate in budget conferences.

--- Female FGD Respondent, Wakiso District

It is worth noting that citizens' participation seems largely confined to meetings purposely meant for health information sharing and not necessarily to plan and make decisions on health issues that affect them. Community meetings are convened by VHTs, leaders from sub-county or district levels or local community leaders, and CBOs / NGOs to discuss community development issues, seek citizen's views and share information. However, some respondents reported that, very often, community meetings discussed a mix of issues and health issues were not given much and particular attention they deserved.

They do meetings but they don't talk about health, they normally talk about security and youth things --- Female FGD Respondent, Wakiso District

*There are no meetings conducted in the community to discuss health issues. Most of the meetings that are organized in the community discuss issues of security and other services but there are no specific meetings called for the issues of the health--- FGD_Women Mugusu Rural
Community Kabarole*

Besides, other respondents noted that there was an increasing disinterest of community participation in community meetings in terms of attendance and sharing views. The reason was that whenever they attend the meetings, they got the information on health and development issues, shared their views as a way of influencing decision making but they felt their views were never considered because they did not yield any changes in the short terms such as increase in drug stocks or number of health workers at the facility. They therefore find no reason of keeping attending the meetings whose outcomes did not reflect their views.

The truth is that the meetings are always there but sometimes they call us and we don't go because we don't find the reason ... if you can even go and complain of rampant drug stock-outs at the health facility but nothing change only to deny you drugs ... so for us men we hardly go ... they invite us for those meetings but we don't go --- **Male FGD Respondent, Kamuli District**

The issue of increasing disinterest of community members in attending community meetings was echoed by some district leadership but blamed it on the “spoilt system”.

...the participation of the citizens in the budget conferences or let us say in the entire planning process is still far since the citizens and the system has been spoilt by you the civil society who bring huge amounts of money without which the community can never attend the budget conferences or other community meetings. At district level we have tried but the attendance of local community members is still poor, it is only the majority elites who attend... I don't know what comment you are going to put but just know that there is less grass root involvement. --- **KII_ Planner Kabarole District.**

This kind of attitude among some community members towards community meetings was consistent with critics of popular participation who challenged the populist assumption that attention to ‘local knowledge’ through participatory learning redefined the relationship between local communities and authorities. To them, local knowledge far from determining planning processes and outcomes, was often structured by external actors, and what in one case was expressed as a local need was actually shaped by local perceptions of what the agency in question would legitimately and realistically be expected to deliver (ibid). Participatory planning may more accurately be viewed as the acquisition and manipulation of a new ‘planning knowledge’ rather than the incorporation of ‘people’s knowledge’ by projects (Golooba, 2004; Mosse, 2001).

In some districts, respondents expressed a high degree of disengagement to the extent that they felt they had lost their social agency and the driver’s seat which proponents of popular participation tended to emphasize. Respondents reported that they were neither community meetings, nor consultations on health-related issues that affected them in their community or that affected their local health facility.

Some respondents felt that decision making on issues of health was a preserve of a distant authority at a sub-county or district and thus the locus of community’s input was largely considered superfluous.

*We are never invited, we just see people doing things but we have no right to question about anything...most of the major decisions are made by higher authorities at the national or district levels and for us our role is to wait for what they decide for us. We don't have any control over decisions they make. ---- **Male FGD Respondent, Bududa District.***

It is worth noting that, key informant interviews seem to refute the allegations of the citizen disengagement. Several interviews actually show that most districts periodically engage the citizens and the views of the citizens are incorporated into the decision making processes as DHO Kabarole said:

*...last year we received a lot of petitions on the staff absenteeism, failure of staff to report at the facility and so many things in staffing, we did a massive recruitment together with the district chairperson and recruited a lot of staff which put our staffing targets to 87% better than any other district in Uganda. Another one is the citizens' concerns have also influenced the level of monitoring and tracking of late coming, for instance I have just received a call from one of the community members telling me that the health facility has not yet open and I take action by calling the in charge to establish his whereabouts ---**DHO Kabarole district***

Equally so, the DHO Gulu district said:

*There are several avenues we have created to allow stakeholder participation and their views are incorporated in some of the following ways- during the community Barazas/meetings, parish development committees meetings, LCIs and VHTs meetings, and through other community structures like HUMCs and population champions ---**DHO Gulu district***

These contradicting views can largely be attributed to uncoordinated feedback mechanisms. Lots of things seem to be happening at the sub-county, district, and health facilities but the community members are not well informed. This however, confirms that the community –based structures such as the HUMCs, VHTs, local community leaders and representatives which are supposed to mediate feedback mechanism between the community and higher authorities in the district, are perhaps not playing this role effectively. The section of responsiveness and feedback mechanisms provides details of this phenomenon in the subsequent part of this report.

Monitoring and evaluation of PHC service delivery

Community members reported that they don't directly participate in the monitoring and evaluation of PHC service delivery. They however, said this is done through representative participation mechanisms. Representative participation through health unit management committees (HUMCs) and elected leaders mostly the councilors was mentioned across all the districts. Consistent with HUMCs guidelines (Republic of Uganda, 2003), respondents reported that HUMCs are charged with the responsibility of representing communities to higher level meetings particularly at the health facility level to discuss health related issues. HUMCs are also expected

to monitor and evaluate PHC service delivery and influence decision making at the health facility level on behalf of the community. Similarly, consistent with the local governments Act (1997, as amended), citizens reported that the elected councilors to sub-county and district level councils are expected to play their oversight role through periodic supervision, inspection and monitoring of social service delivery. Councilors are also expected to represent the views of the community members in the council sessions and make decisions that reflect community's views.

However, some citizens expressed concerns that representative participation is not effectively representing their views. They felt that both the HUMCs and the councilors were not performing to their expectations. They both rarely consult the community and seek for their views nor do they provide feedback to the community regarding developments in the health sector either at the health facility, sub-county or district levels. Most respondents accused the political leaders they elected for having neglected them and only appear during election campaign period.

*Our leaders never consult us on health issues. Ever since we elected our councillors, they have never come back to consult us and seek our views regarding development issues in this community including health issues. We don't see them in the community --- **Female FGD Respondent, Kabarole District***

In this area, I have not seen citizens being invited to discuss health issues or to be involved in health sector planning meetings. Our sub-county and district leaders and leaders have not consulted us on health issues

*--- **Male FGD Respondent, Buliisa District***

Some members of HUMCs admitted that they are not functioning well because they have not undergone any induction training and thus not well conversant with their scope of work.

*... we do not know what takes place because we are all new. We were appointed in January and now this is May but no one of us has been oriented at the facility --- **FGD HUMC - Kabarole***

*As health management unit, we don't know the delivery schedule of the drugs such that we are able to witness the drug delivery at the facility. We are not aware of what else we are supposed to do --- **FGD HUMC - Kabarole***

It should be noted that in such circumstances when the community members lose on options for direct and representative participation in decision making on health issues, their substantive citizenship and social agency become susceptible to erosion.

Challenges to effective participation

Civic incompetence and elite dominancy: Most community members feel that participation in decision making for health is meant for a certain elite group. Other than community-based meetings, when they are invited to high level meetings at the health facility, sub-county or district, they feel unworthy to attend and think after all the elites (the most educated, technical and political leaders etc.) will attend instead and make decisions on their behalf.

Relatedly, there is ineffective representative participation. Local citizens feel they have representatives (VHTs, HUMCs and elected leaders) who would ideally solicit their views and represent them to the higher authorities for consideration during decision making processes. However, citizens feel that the duty bearers seem not playing their role to the expectations of the community (electorates). For that matter, citizens feel they don't participate at all in influencing decisions that affect their lives.

Lastly, monetized participation is slowly killing community participation. Citizens expect allowances (transport or sitting allowance) whenever they are invited to participate in consultative meetings. In the event that allowances are not provided, the attendance at the meetings keep declining over time.

Summary

Several opportunities exist to enhance popular participation in PHC service delivery. Guided by national policies and guidelines, the district local governments have created spaces for stakeholder participation in planning, budgeting, monitoring and evaluation of social and health service delivery. These include community meetings, barazas, community dialogues, sectoral stakeholder performance review meetings, constituency health assemblies, budget conferences, and council sessions among others. Some districts have documented evidence of this phenomenon which was verified in the available documents that were reviewed while others do not have the evidence either because the documents reviewed don't capture this evidence or there are no documents available at all to verify the evidence. Records keeping is such an important aspect that districts need to seriously consider.

The level of participation is felt differently by different stakeholders. In particular, the illiterate and semi illiterate community members feel they are not effectively participating in planning, budgeting, and monitoring and evaluation processes of health service delivery. They feel that these consultative meetings are usually held for compliance reasons and less for genuine consultations and are not necessarily connected to decision-making. As a result, citizens are often informed about the decisions already taken. Even when they feel that at some level, their representatives (elites) should consult them, solicit their views and present them at high authorities, it is not adequately done. They are not regularly consulted, and once they are consulted, they don't receive feedback. Some elites admitted that the participation of local citizens remains wanting. Much effort is therefore needed to empower local citizens and build their civic competence to be able to effectively participate in health service delivery process. Representative participation also needs to be reinvigorated such that it meets the expectations of the represented. Emphasis needs to be placed on the importance of wider community consultations and providing timely feedback.

4.7 Transparency

Transparency is another basic principle of good governance that focuses on involving insights of the state and non-state actors in public administration. It is connected to other governance principles including mainly participation and accountability. Access to information by non-state actors is necessary to enable them pro-actively participate in Primary Health Care processes. For example, non-state actors equipped with the right information can effectively monitor and participate in necessary reforms aimed at improving delivery of PHC services.

In this study, we sought to explore the ways in which PHC service provision process is honest and open including how accurate, timely and fully the information flows through right channels between service providers or managers (duty bearers) and various key stake holders including service users at the local government level.

Evidence in table 10 reveals that display of information about PHC grants is adhered to by most of the study districts. It is only two districts of Bududa and Luwero which did not have any information on PHC displayed at designated places. On the other hand, the districts of Buliisa and Kamuli did not have documented evidence on clear guidelines for the Chief Administrative officer (CAO) and District Health Officer (DHO) to communicate to the Health facility In-charges of the information on PHC funds.

Table 10: Evidence of Transparency in Primary Health Care (PHC)

Transparency	Bududa	Buliisa	Gulu	Kabarole	Kamuli	Luwero	Moroto	Wakiso
Display of up to date (Q1 – Q2 FY 2017/18) information on the PHC grants at district head quarters	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>				
Display of up to date (Q1 – Q2 FY 2017/18) information on the PHC grants at noticeboard of Health Centres	<input checked="" type="checkbox"/>							
Existence of clear procedures for requesting information on PHC services by citizens.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Evidence of communication from the CAO/DHO to Health Unit In-charges on guidelines for public display of information on PHC funds and services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Key: evidence seen No evidence seen. Documents not accessed.

The absence of information displayed at the notice boards could be as a result of lack of clear guidelines on display of information at district and other service delivery centres. It could also mean that the district did not receive instructions on display of information or received instructions but remains reluctant to comply. Limited/ absence of publicly displayed information hamper transparency in service delivery of primary Health Care Services. Consequently the public cannot demand effectively for better services from un-informed point of view.

With the exception of Buliisa, Gulu and Wakiso, the rest of the study districts did not provide evidence of clear procedures for citizens to request information on Primary Health Care services. This frustrates citizen's efforts for participation and holding their

leaders accountable. Stakeholders cannot access information due to lack of clear channels of communication and as a result their participation in PHC is limited due to information gap. When citizens are unable to access information on funding of PHC, it also becomes hard for them to hold their leaders accountable.

Despite its ranking among poor performing districts on the 2016/17 district league table for central region, Wakiso district, appears to perform well on most transparency indicators outlined in this study compared to Citizen Participation in the Local Public Service Provision and Quality Improvement its counterpart Luwero district. Similarly, Buliisa district ranked among the poor performing districts in the western regions appears to outperform Kabarole district categorized among the best performing districts on most of transparency indicators of this study.

Access to information at the sub-county and community level

Just like the districts, sub counties as well as Health facilities were also required to display up-to-date information on PHC including funds. Where information was displayed, citizens claimed to have accessed it while others said they have visited the notice board a number of times but information on PHC funds is never displayed. All they find are health education charts, duty Rota and outreach plans.

*At Bugoigo health centre II, information on PHC funds received and expenditures are well displayed on the noticeboard... **Female FGD Respondent –Buliisa***

*I have taken time whenever I go for antenatal services to pass by the notice board. It has been my habit to look at the notice board because all the things are put there. But for the number of times I have gone for antenatal services, I have not seen such information on money received all you find is duty Rota and outreach plans... **Female FGD Respondent- Kamuli***

In some instances, citizens had been empowered by non-stake actors to demand for budget information and as a result, they have always forcefully demanded from the responsible persons to have the information displayed. This could undermine effectiveness in delivery of primary health care services as it creates a rift between stake holders and service providers. Also some of the citizens claimed that they had not cared to know anything concerning PHC because of ignorance while others reported that they were not aware of the fact that they were entitled to any kind of information regarding PHC.

*.....we were trained by Uganda Debt Network about the budget, we went to the health centre and we wanted to know about our budget allocation but it was nowhere to be seen. We had to quarrel with the in charge before she could start to display the information on the notice board... **Female respondent- Moroto***

Some citizens reported that they access information through radio; health centres in-charges, Health Unit Management Committees (HUMCs), and notice boards at health facility and Sub County headquarters. The citizens also added that they get information through meetings, potable public address systems and home visits that are all carried out by VHTs.

The VHT team move door to door telling us what is taking place. Even in the times when there is mass immunization, they always give the health workers a hand. They really care; when the drugs are brought, they even move through schools to treat children. For that issue they are doing excellently. They also have a portable public address system which they endeavor to use while moving around the community disseminating information... **Female FGD Respondent– Luwero**

However, in some places people do not have access to information and they cannot request for it for fear of being marginalized leaders. This hampers participation of the citizens in PHC work and frustrates their efforts to hold their leaders accountable.

I want to tell you for us the village women who are not on health care committees, just seeing the chairperson you want to run away how can you go to the DHO, health assistant or VHT to ask for information, he will begin to ask you for your position on the committee before chasing you away. Even some time we don't know them and we see people but we don't know who they are or what position they hold at a health centre...

Female FGD Respondent - Kamuli

Transparency Mechanisms

At health facility level, health centre in-charges reported a number of avenues through which they receive information and disseminate feedback to citizens. These ranged from adhoc ones such as communicating to citizens through patients who come for treatment, LCI chairmen, and politicians, to structured ones such as using HUMCs and VHTs.

It depends on the information that you really want to give to them. If it is about the drugs which have come, we actually inform the LCI chair who comes to sign. It is one of his roles to inform the community that drugs have come. Then another way is when we want to tell people let say about the meetings we usually pass through the HUMC. We inform them about the new updates and happenings at the health facility and then they take this information to the community. We also hold health education talks and in those talks if there are specific things like change of vaccines or campaigns we pass the information through the health education talks. If it is about health workers coming to give family planning, we usually use radio announcements. Sometimes when those come, they have a van which goes through the community... **In-charge – Kabarole District**

The district health offices consulted also highlighted a number of mechanisms used to solicit views from the citizens and give feedback which include district wide monitoring visits and public hearings. They also alluded to the use of councillors to communicate to their electorate. However they continued to note that feedback mechanisms are not fully developed and need strengthening. Councillors represent the citizens and they are supposed to solicit their views and present them in the district council and take feedback to the citizens. This channel being poorly developed is a bottleneck to information flow and limits the citizens from holding their councillors accountable.

Challenges to Transparency in PHC Service Delivery

Some of the officials at the health centres such as the in-charges expressed concerns about the citizens fearing them and as result they are not consulted for any information that they may need. This same concern was raised by one of the FGD participants from Kamuli district who expressed their fears of the Leaders.

*The community has a way it looks at health workers. One time it was Easter holiday, they called me something had happened. I went and I explained to the speaker. Most times I have seen it through their leaders. Rarely do the community members come to us. They fear us. At least that is the experience. **Health facility In-Charge –Kabarole***

Other health facility in-charges expressed challenges in regards to dissemination of information due to lack of funds to facilitate the process. They reported that when the communities are invited to provide their views or give feedback, they expect lunch and transport refund which they can't provide. As a result they do not conduct such meetings, a practice which jeopardizes the willingness to promote transparency at the health facility level. In addition, the lack of authenticity in some of the information disseminated especially by the media and some of the community leaders was reported as a challenge. However, citizens also provide false information that is sometimes picked by the media. Leaders also expressed a challenge of receiving wrong information from the community members.

*NO! We do not hold meetings at the facility to give information because of limited facilitation, you call people and they expect transport refund and lunch which we do not have as a HUMC. We also have a challenge of false information running from the community to the media houses especially the radio. For instance there is a time they talked about the mother who delivered from the compound and it was all over the news yet it didn't happen at the facility. **HUMC Member – Kabarole***

Summary

Public display of up-to-date information on PHC funds and other related information regarding PHC services is paramount in promoting transparency in PHC delivery. There is need for districts, sub-counties and health facilities to priorities regular display of PHC information on their notice boards. In addition, there is need of an ordinance that stipulates clear mechanisms for disseminating and accessing information at the district to improve transparency, foster accountability and at the same time, empowering citizens to demand and receive better quality of PHC services.

4.8 Responsiveness

Responsiveness is a process that entails the means and the extent to which duty bearers react to the issues raised by citizens. A good public service is one that is responsive to the needs and wants of its users. Indeed, responsiveness of this kind is arguably an essential element of what constitutes quality in public service (Le Grand, 2007). The principle of equal autonomy provides responsiveness a solid philosophical justification:

all persons are entitled to respect as deliberative and purposive agents capable of formulating their own projects, and that as part of this respect there is a governmental obligation to bring into being or preserve the conditions in which this autonomy can be realized – Albert Weale (1983).

Being responsive to the needs and wants of users could be viewed as an essential element of according the respect to ‘deliberative and purposive service users (ibid).

This study intended to explore the ways duty bearers at community, health facility, sub-county, and district levels solicit from, react to, and provide feedback to health users. Table 11 below summarizes the findings of the document review on responsiveness in PHC service delivery at the district level.

Table 11: Evidence of Responsiveness in PHC service delivery at district level

Responsiveness	Good Performers on MoH District League Table				Poor Performers on MoH District League Table			
	Gulu	Kabarole	Kamuli	Luwero	Bududa	Buliisa	Moroto	Wakiso
Evidence of resolutions taken by Council on issues raised by citizens on PHC services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Evidence of the implementation of resolutions on PHC services passed by Council	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Evidence of the DHO's Office receiving complaints from Citizens on PHC services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Evidence of DHO's Office responding to the complaints received from citizens on PHC services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Key: *evidence seen* *No evidence seen.* *Documents not accessed.*

Results in Table 11 show that majority (5 out of 8) of the study districts- Gulu, Kamuli, Luwero, Moroto and Wakiso) produced documented evidence of resolutions taken by Council on issues raised by citizens on PHC services. The districts of Bududa and Buliisa lacked documented evidence of this subject matter i.e the available documents could not capture this evidence. On the other hand, Kabarole district had no document at all available to verify this evidence.

Results in Table 11 also show that only two districts of Gulu and Wakiso had documented evidence of implementing resolutions passed by District Council on PHC services. On the hand, Bududa district lacked evidence on the same subject matter in the available documents that were reviewed. The rest of the study districts (Kabarole, Kamuli, Luwero, Buliisa, and Moroto) did not have any document available to verify this evidence.

Results in Table 11 above further show that only three districts of Gulu, Kabarole and Wakiso had documented evidence of District Health Officer (DHO's) office receiving complaints from citizens on PHC services. On the other hand, majority of the districts (Bududa, Buliisa, Kamuli, Luwero, and Moroto) did not have any document available to verify this evidence.

Lastly, results in Table 11 above show that only one district (Kabarole) had documented evidence of DHO's office responding to the complaints received from citizens on PHC services. The rest of the districts (Gulu, Luwero, Kamuli, Wakiso, Moroto, Buliisa, Bududa) did not have any document available to verify this evidence.

The absence of documents to verify evidence on responsiveness in PHC service delivery at district level was rampant in this study. Whereas most interviews and FGDs captured evidence of this responsiveness, few districts had this evidence documented. Majority of the study districts did not either capture this evidence in the available documents that were reviewed or have any document available to verify this evidence. The implication is that either these documents did not exist at all or they existed but could not be traced due to poor records keeping.

Different sets of key informant interviews and FGDs revealed that there are several avenues through which citizen's views are solicited, discussed, and feedback provided to the citizens regarding PHC services. These include meetings, face-to-face interaction, person-to-person telephone calls, suggestion boxes, and radio talk shows and associated callers-in. Solicitation of citizens' views from, and returning feedback to, the community is also done through established community structures such as VHTs, HUMCs, and elected political leaders.

Perspectives of duty bearers on Responsiveness and Feedback mechanisms

Duty bearers consulted indicated that they were doing enough to establish avenues to respond to citizens' views and provide feedback in accordance with the existing policies and guidelines and using the established structures.

"We hold several meetings according to the guidelines given to us by the Ministry...All health facilities have Health Unit Management Committees which solicits views from the community about health issues, discuss them at health facilities and reports submitted to us to follow their recommendations after scrutiny... we also have Standing committee of Council on health where their elected representatives sit and discusses all matters on health and decisions are arrived at for implementation... We also have suggestion boxes at the health facilities where people raise issues concerning health workers, their community health, and many other things. So we pick and discuss them at health facility meetings, District Health Team and District Technical Planning Committee meetings

---DHO Bududa district

Citizens have submitted petitions to us and they raised issues of absenteeism and late coming of health workers which we have intensified inspection. For instance there is a healthy worker in Karambi that I have transferred because of neglect of duty as the community continuously

complained about her...some of the community members actually call me on my mobile phone that DHO, my wife wants to give birth and there are no midwives. I sometimes drive there myself and sometimes I call the staff attached to that facility to find a solution --- DHO Kabarole District

Some duty bearers however, noted that not all responses from the citizens are worth considering. That very often they receive complaints, allegations and rumours about health service delivery which do not have evidence. Attempts are done to investigate such allegations only to find they are baseless. In such circumstances, no feedback may be provided to the complainants even when the latter expects it.

...so at times we value feedback depending on how someone would have packaged his or message...but at times some one can say anything either because they don't want the health worker or the government or maybe they have personal interests like politics just to get political mileage and then tend to exaggerate things only to investigate and find they are just baseless. So the way one reports, is the way we react ---DHO Luwero District.

Responsiveness and feedback mechanisms: User Perspectives

Citizens attested using various avenues to present their health concerns and getting feedback. However, there are mixed reactions among the citizens regarding responsiveness and feedback mechanisms on PHC services within and across districts. Striking variations are mostly on feedback mechanisms which ranged from channelling grievances through VHTs, radio and Resident District Commissioners (RDCs) to solicit responses from the President of Uganda.

"We raise our concerns about health matters through the VHTs. And even the feedback is also accessed through the same channels... sometimes we raise our concerns through the political leaders and feedback is still through them... However it takes long to get the feedback because the political leaders only wait for burials or even during marriage ceremonies to get back to us...we also use local FM radio station like Biiso FM to present our concerns and also receive some feedback, but this is not very common --- Male FGD Respondent BULISA

Yes the concerns we raised are acted upon. However, the response depends on the political leader's discretion. It can take 2 weeks or 3 weeks to get the necessary changes. For example, we had burning issues like extortion of money from patients by midwives and absenteeism of health workers, the RDC got to know about it through some concerned citizens. It took 2 weeks to attract Presidential intervention which resulted into dismissal of some health workers, and recruitment of other health workers --- Male FGD Respondent Wakiso

There were however, some responses from FGDs which challenged the degree of responsiveness and feedback mechanisms from duty bearers. Despite acknowledging the fact that they have avenues and opportunities for presenting their health concerns, citizens expressed discontent with the way feedback is communicated.

...we have raised several issues not only on health and we have even reached the district but I have not seen any change. In most cases, when the issue has just reached, it can “boil” as if there will be change but in two three days the issue goes to silence and you see the same style --- **Male FGD Respondent Gulu**

We don't get any feedback from concerned authorities... there are even no suggestion boxes where our concerns and feedback could be channelled through -- **Male FGD Respondent Bududa**

In some cases it appears that responsiveness and feedback from the duty bearers is kind of forced or sparked off by citizen's threats and demonstrations.

One day we peacefully demonstrate at the health centre and district officials came and we got results. This was so because Health workers were not doing their work well. You could come to the health centre and the health workers just look at you. It did not even take a week before the district transferred the errant health workers and gave us others and even the drugs became a little sufficient --- **Male FGD Respondent Luwero District**

Challenges to Effective Responsiveness

Citizens were reported to have very high expectations for immediate feedback from authorities yet some of the issues raised require formal procedures involving consultations with stakeholders and formal budgeting cycle. This is compounded by the limited resources mainly funds to meet the diverse needs of the community: Citizens present their concerns that require colossal sums of money that is hardly available in the district or sub-county budgets.

Some citizens raised concerns like construction of a new health facility in their community and yet funding may not be available --- **KII_District Planner Kamuli.**

The communities have provided petitions on drug stock-outs, absenteeism and they need immediate action but of course not all the issues are within our mandate but we handle what we can and we tell them what cannot be done now or may be in future” – **KII_DHO Kabalore**

In addition, there were challenges of mal-functional channels of communicating feedback to the communities such as HUMCs and political leaders. Much as these are common structures for obtaining views from and providing feedback to citizens, evidence obtained is that some are not functioning as expected and therefore create gaps the information flow.

Summary

From the finding of the study, there exist avenues and mechanisms established by duty bearers at different levels for receiving citizens' concerns and communicating feedback to the citizens. The major challenge remains on the feedback mechanism characterized by delayed communication of the feedback or even failure to

communicate the feedback due to weakness in the common channels expected to play this role. Much attention is needed to address the bottlenecks in the transmission of feedback whenever final decisions are made in response to the citizens' concerns.

4.9 Equity Considerations in PHC Service Delivery

Equity is a key element in any good public service. Indeed, for many people, it is the reason why services such as health are in the public domain at all (Le Grand, 2007). "If by virtue of their income, their social class, their gender, or their ethnicity, some categories of people (patients) have preferential access to healthcare, then this is widely regarded as unfair or inequitable." (Le Grand, 2007: 13). Health equity is regarded as central to the understanding of social justice (Sen, 2004; Fabienne, 2004), and in fact, the justice of a society can be measured by how much equity is considered in the social arrangements (Brock, 2004). According to Sen (2004) what is particularly serious as an injustice is the lack of opportunity that some categories of people may have to achieve good health because of inadequate social arrangements.

It is vital to place importance on identifying and addressing constraints, needs and opportunities in structured and equitable manner that is inclusive of all vulnerable groups such as women, youth, elderly, under five children, and persons with disabilities (PWDs). Investigating intergroup inequities and inequalities in health allows identifying of groups that are at high risk of or suffer particularly poor health. It also allows to uncover those inequities and inequalities in health that we regard as particularly unjust. Public policy and public health policy may thus be able to target them directly to effect health improvements (Anand, 2004). Distributive justice requires some special concern for those who are most disadvantaged or vulnerable. Ethical justification for giving such priority is to avoid increasing the already unjustified disadvantage or inequality they suffer relative to those better off (Brock, 2004).

A critical analysis of Uganda's policy and development documents indicates that equity concerns in service delivery are comprehensively considered. Equity considerations with regard to gender, age, vulnerability are evident in National Development Plans (2010, 2015), National health policies (1999; 2010); the framework for Uganda National Minimum Health Care Package (UNMHCP); the Health Sector Strategic Plans (HSSP) I, II and III (2000/1-2004/5; 2005/06-2009/10; 2010/11-2014/15), the Health Sector Quality Improvement Framework and the Strategic Plan (2010/11-2014/15), the Health Sector Strategic Investment Plan (HSSIP) (2010/11-2014/15), the Health Sector Development Plans (HSDP) I and II (2010/11 – 2014/15; 2015/16 - 2019/20); Uganda Gender Policy (2007), and Uganda National Policy on Disability (2006). The ultimate goal of this broader framework has always been to improve equity in health care. It is expected that these equity considerations in national policy documents transcend all sectors at local government levels such that they guide planning, resource allocation and implementation of equity-related interventions.

An assessment of equity considerations would capture the extent to which there is equal and equitable access to services and inclusiveness among citizens in the developmental activities (Hoof, 2011). In this study, we intended to explore the ways primary health care service delivery is equitable with particular focus to vulnerable social groups such as vulnerable groups such as the pregnant mothers, children,

elderly, and people with disabilities. Table 13 summarizes the findings of the document review on equity considerations in PHC service delivery at the district level.

Table 12: Evidence of Equity considerations in PHC service delivery at district level

Equity	Good Performers on MoH District League Table				Poor Performers on MoH District League Table			
	Gulu	Kabarole	Kamuli	Luwero	Bududa	Buliisa	Moroto	Wakiso
Evidence of disaggregation of health outreach beneficiaries by gender	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Evidence of disaggregation of health outreach beneficiaries by age category (youth/elderly)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Evidence of strategies and plans to improve equity in provision of PHC services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Evidence of implementation of strategies and plans to improve equity in the provision of PHC services.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Key: *evidence seen* *No evidence seen.* *Documents not accessed.*

Results in Table 12 show that half of the study districts - Kabarole, Luwero, Moroto and Wakiso produced documented evidence of disaggregating health outreach beneficiaries by gender. On the other hand, the districts of Gulu, Bududa, and Kamuli lacked documented evidence of this subject matter i.e. the available documents could not capture this evidence. Buliisa district had no document at all available to verify this evidence.

Results in Table 12 also show that majority (5 out of 8) of the study districts (Bududa, Gulu, Kabarole, Luwero, and Wakiso) had documented evidence disaggregating health outreach beneficiaries by age category (mostly youth/elderly). On the other hand, two districts of Kamuli and Moroto lacked evidence on the same subject matter in the available documents that were reviewed. Buliisa district did not have any document available to verify this evidence.

Results in Table 12 above further show that majority of the study districts (Gulu, Kabarole, Kamuli, Luwero, Moroto, Bududa, Buliisa) had documented evidence of existing strategies and plans to improve equity in provision of PHC services. It is only Wakiso district that lacked evidence on the same subject matter in the available documents that were reviewed.

However, results in Table 12 above show that only three districts of Buliisa, Kabarole, and Gulu had documented evidence of implementing the above mentioned strategies and plans to improve equity in the provision of PHC services. Whereas the districts

of Bududa, Kamuli, Luwero, and Moroto had documented evidence of strategies and plans to improve equity in provision of PHC services, they lacked evidence of implementing them.

In addition to the already observed weakness in poor records keeping, the document review findings in this section clearly demonstrate that in most of the districts, there is a discrepancy between what is planned and what is eventually implemented. It appears that most of the strategies and plans that districts laydown to improve equity in the provision of PHC services are not implemented. Perhaps, this explains the dissatisfaction most citizens expressed during the FGDs regarding the way health equity concerns were considered by the duty bearers in the course of providing PHC services in their respective communities, as mentioned in the latter part of this section.

It can also be observed that the districts of Kabarole, Gulu and Luwero were comparatively consistent on documenting evidence of equity issues in the provision of PHC services according to the equity indicators outlined for document review. This performance is consistent with our criterion for their selection in this study as one of the best performing districts in their regions according to the Ministry of Health District League Table 2016/2017. On the other hand, the districts of Kamuli and Bududa were not consistent in documenting evidence of equity issues in the provision of PHC services according to the equity indicators outlined for document review. They consistently lacked documented evidence on most of the health equity indicators outlined for document review. This performance is also consistent with our criterion for its selection for this study as one of the poor performing districts according to the Ministry of Health District League Table 2016/2017.

Perceptions of health equity among the duty bearers

Various duty bearers at health facility and district levels acknowledged the fact that there were disadvantaged / vulnerable groups of people that need fair treatment and attention in PHC service delivery. The commonly mentioned groups were pregnant mothers, elderly, youth, adolescents, children under five, the poor, people with disability and people living with HIV/AIDS. Apart from conventional equity considerations on the basis of demographical characteristics such as gender and age, some respondents also mentioned ill-health (especially HIV/ AIDS) and geographical locations (“hard-to reach”) as bases of vulnerability. They noted that vulnerability among the above social groups becomes dire when they come from the underserved or “hard to reach” geographical locations.

It is worth noting that the health equity concerns regarding vulnerability on the basis of geographical locations are consistent with the study in Windhoek, Namibia about the utilization of government health facilities (Bell et al, 2002). The survey revealed disparities between patterns of utilization of the services whereby the poorer localities were relatively underprovided with health facilities and staff. On the basis of the results of the study, a more equitable allocation of primary health care services between localities was developed. The regional health management team redistributed nursing and medical staff and argued for a shift in the allocation of capital expenditure towards the poorer communities (Bell et al. 2002). The study demonstrated the potential for regional and provincial health management teams to make effective assessments of

the needs of their populations and to promote the equitable delivery of primary health care services. In order to achieve this they needed not only to become effective managers, but also to develop population-based planning skills and the confidence and authority to influence the allocation of resources between and within their regions and provinces (ibid).

In this study, our key informant interviews captured some responsive equity considerations/interventions from district authorities regarding attempts to consider health equity and also lessen vulnerability based on citizens' underserved geographical locations. Specialist services are provided to pregnant women who also do not cue up to receive medical attention. In addition, special attention was reported to be provided to people leaving with HIV/AIDS who receive counselling services in addition to the free Anti-retroviral treatment. Health facilities also sensitise communities in a bid to eradicate stigma against persons with HIV/AIDS. The wide spectrum of services offered aims at ensuring all categories of people are taken care of.

Let me begin with pregnant mothers. Of course we offer medical attention to the pregnant mothers like antenatal, and all the packages that they need in pregnancy. We offer maternity services when they deliver and postnatal services. There is a wide variety of services that we also offer to children. For example, immunization we have static and outreaches. We also offer special attention for the adolescents to the extent that we have an adolescent HIV clinic with a focal person --- **KII_Health In-Charge Mugusu HCIII Urban Kabarole**

"The district has come up with age friendly services for instance the elderly are served faster at the health units and has also built structures that are user friendly for instance put structures that have provisions for older persons to support themselves. In addition, development partners have also supported other groups of pregnant and lactating mothers through nutritional supplementary feeding programmes --- **KII_District Planner, Moroto**

In addition, districts utilising the PHC Development Grant have ensured that health facility infrastructure reduces discrimination based on geographical limitations by constructing health facilities in sub-counties without any as well as upgrading some health facilities to improve the range of services provided to the communities. In some instances, health workers such as midwives have been recruited in hard to reach areas to reduce the distances travelled by expectant mothers to receive treatment.

Well, one best example is Nabweya HC II. Nabweya Sub County had no health centre and they could travel all the way to Bulucheke HC III in Buluchke Sub county or to Bushiyi HC III in Bushiyi sub county. Citizens used to complain a lot but through the constituency assemblies (Baraza), they requested that a health facility be constructed and now we put a health centre II which we are soon upgrading to a Health Centre III-- **District Planner Bududa District**

However, as has already been noted in literature, there are usually discrepancies between what is planned and what is actually implemented (Ggoobi, 2016). Indeed,

where as some duty bearers reported that they consider equity issues in the planning and budgeting processes as well as daily PHC service delivery operations, others frankly reported that they don't take it seriously. Some committed themselves to do more and consider equity in health planning and budgeting seriously. It was also reported that equity issues are largely handled by the implementing partners whose operations focus on special interest groups such as pregnant mothers, under five children, the elderly, people with Disabilities, children with special needs, Orphans and other vulnerable children (OVC).

*Unfortunately, for some groups we don't have special attention. The only groups we give attention are pregnant women and the adolescents... we have special days for them ... But others like the elderly, no no! It is still a challenge. Sometimes we rely on our partners like the one which looks after people with disabilities. For the orphans we also rely on our partner [SOS] which deals with the orphans at our facility but as a facility we really don't have a special attention for them...our current plans captures some equity issues but they are not comprehensive. I think since we are still working on our five year strategic plan, it is something that we should put emphasis on. We have already written something small about these vulnerable groups in the draft plan but it is not yet well developed --- HC
IV In-Charge Kabarole.*

Summary

Equity in health carries a trio importance as a component of health rights, ethics, and social justice. Because of this importance, it is a requirement that both national and district level planning and budgeting processes incorporate equity considerations. Evidence from this study (document review, key informant interviews and focus group discussions) indicates that whereas some districts incorporate aspects of health equity in the planning and budgeting processes as well as implement equity-related interventions, issues of health equity are not comprehensive enough in most districts. This is to the extent that evidence of budget allocations to address equity concerns are not so explicit both at the health facility and the district levels and evidence of implementing most of these plans is not readily available. For most districts, it appears that equity issues are not viewed as core tasks but more of a social welfare issue. For that matter, most of equity-related interventions have been left largely in the hands of charity organizations (NGOs). It is no wonder that citizens (service users) perceive health equity consideration at government health service points- health facilities as unsatisfactory. It is thus recommended that health equity issues be accorded serious considerations not only in the planning but also budgeting and implementation processes at all levels of service delivery points. In so doing, the principle of "equal autonomy" would be upheld.

5.0 Conclusion

The study set out to understand the differences in public expenditure governance practices and perceptions in the delivery of PHC, between the best performing and the poorly performing districts on the MoH district league table of FY 2016/17. Overall, based on the PEG Assessment Framework indicators, the best performing districts were found to be better in most governance aspects namely, participation, accountability, coordination, control of corruption, responsiveness, equity, effectiveness and efficiency. On the other hand, the category of the poorly performing districts on the MoH district League table performed better in strategic vision in the governance of PHC funds. The specific conclusions against the respective governance principles are summarised below;

Strategic Vision: Overall, it was noted that the existence of the sector grant guidelines is critical to the adherence to sectoral and national priorities at all local government and health facility level. However, there is no consistency in the percentage breakdowns of the budgets spent on the respective items. This stems from the fact that despite the PHC grant utilisation guidelines being in place, the percentage breakdowns of how the non-wage grant should be allocated at health facility level were last provided in FY 2002/03.

Effectiveness and Efficiency: The reported PHC funds governance practices and experiences pointed to ineffectiveness in the delivery of medicines and supplies. The inefficiencies were mostly reflected in delivery of fewer quantities of medicine and supplies than those requisitioned by the health facilities as well as a few tendencies of mismatching health facilities during delivery (some health facilities end up with medicines and supplies belonging to other health facilities). It was also noted that the persistent stock-outs of medicine stems from delivery of quantities that are not commensurate to the catchment areas that the health facilities serve. This could be attributed to the allocation criteria for EMHS (Essential Medicines and health supplies) whereby facilities at the same level of care receive same budgets despite differences in their patient load (number of people they serve, resulting in inequitable allocations – a challenge which also characterises the PHC non-wage funding).

Accountability: It was noted that accountability mechanisms were in place and function similarly well across the study district performance divide on the MoH district league table as well as the public and the PNFP divide. However, accountability delays were noted in reporting especially regarding health facilities acknowledging receipt of funds. These delays were attributed to workload and absence of training in financial accountability for health facility in-charges whose only training is medical in nature. Finally, accountability is significantly associated with feedback and it was noted that there is limited feedback and action from the NMS and JMS in addressing discrepancies between what is demanded and what is delivered.

Coordination: Proper coordination required effective communication and coordinated actions between the key stakeholders involved in funding, planning, delivery, monitoring and evaluation of the PHC services. Evidence from government documents at local government level as well as responses to key informant interviews, suggests that the

PHC activities are well coordinated especially among the public actors. However, coordination of non-government actors such as the private-not-for-profit (PNFP) and private-for-profit (PFP) organisations needed improvement by devising a mechanism of involving the public actors and sector regulators early enough in programs of non-state actors to bridge knowledge and trust gaps.

Control of Corruption: The prevalence of corruption related to PHC services was widely reported across all districts, the main form being theft of drugs and other medical supplies from public health centres. Although mechanisms to deal with corruption in PHC services have been put in place in most districts, there was no evidence of implementing these mechanisms. Instead reports of the corruption suspects victimising whistle-blowers have instilled fear in the latter thereby weakening the fight against corruption.

Participation: Several opportunities exist to enhance popular participation in PHC service delivery. The level of participation however varied across stakeholders. In particular, the illiterate and semi illiterate community members felt they were not effectively participating in planning, budgeting, and monitoring and evaluation processes of health service delivery. They feel that these consultative meetings are usually held for compliance reasons and less for genuine consultations and are not necessarily connected to decision-making. As a result, citizens are often informed about the decisions already taken. Much effort is therefore needed to empower local citizens and build their civic competence to be able to effectively participate in health service delivery process.

Transparency: Public display of up-to-date information on PHC funds and other related information regarding PHC services is paramount in promoting transparency in PHC delivery. There is need for districts, sub-counties and health facilities to priorities regular display of PHC information on their notice boards. Also there is need of an ordinance that stipulates clear mechanisms for disseminating and accessing information at the district to improve transparency, foster accountability and at the same time, empowering citizens to demand and receive better quality of PHC services.

Responsiveness: It was noted that avenues and mechanisms are in place at different levels for receiving citizens' concerns and communicating feedback to the citizens. The major challenge that remains is delayed communication of the feedback or even failure to communicate the feedback to citizens due to weakness in the common channels expected to play this role. Much attention is therefore needed to address the bottlenecks in the transmission of feedback whenever final decisions are made in response to the citizens' concerns.

Equity: Equity in health carried a three tier importance as a component of health rights, ethics, and social justice. Because of this importance, it is a requirement that both national and district level planning and budgeting processes incorporate equity considerations. Evidence from this study indicated that whereas some districts incorporate aspects of health equity in the planning and budgeting processes as well as implement equity-related interventions, issues of health equity are not comprehensive enough in most districts. This is to the extent that evidence of budget allocations to address equity concerns are not so explicit both at the health facility and the district levels and evidence of implementing most of these plans is not readily

available. For most districts, it appears that equity issues are not viewed as core tasks but more of a social welfare issue. For that matter, most of equity-related interventions have been left largely in the hands of charity organizations (NGOs). It is no wonder that citizens (service users) perceive health equity consideration at government health service points- health facilities as unsatisfactory.

6.0 Recommendations

Against the conclusions made in the preceding section, this section presents key recommendations for various actors at both local government and central government level. While the study was undertaken at local government level, deductions made herein have applications at central government level as well. This is due to the structure of public expenditure in PHC which sees government play a central role in its governance and decision making. For instance, the PHC grant utilisation guidelines are set at central government level. It is for this reason that some of the recommendations presented hereunder are addressed to MDAs at central government level.

Central Government

- MoH needs to ensure that the PHC Grant Utilisation guidelines provide clarity on how resources ought to be distributed at health facility level. Currently, health facilities claim to be following the guidelines in apportioning the PHC funds but the guidelines provide no such direction. In providing such guidance, the guidelines should however provide a proportion of the funding to be discretionarily allocated towards immediate needs.
- MoH should consider revising the HUMC guidelines in line with the current National Health Policy and also provide for regular training. We envisage this will enhance the effectiveness of the HUMCs in providing oversight over PHC funds at health facility level.
- MoH in collaboration with the Uganda Communication Commission should consider providing a Toll free line for reporting drug theft and cases of corruption at health facility level as a measure to mitigate cases of drug theft. The toll free line will provide a much needed anonymity for the whistle blowers.
- MoH needs to also ensure that health facility PHC non-wage funds and credit lines for essential medicines and medical supplies are planned on the basis of catchment areas. This will improve equity in the distribution of the PHC resources. Thus, MoH should also consider equipping transitional health facilities (up grading from one level to another e.g. HC II to HC III) with the human and financial resources needed for the transition given that their catchment areas already necessitate these resources.

- The NMS and JMS need to improve the responsiveness to the feedback received from health facilities on discrepancies in the delivery of medicines and supplies. However, given the costs associated with redistribution, it is also important that efforts are put in place to minimise or completely eradicate the sources of the discrepancies.

Local Government Level

- Local government administrations should ensure that their DDPs are up to date with progressive targets on Primary Health Care. Local government could consider obtaining capacity development support from the National Planning Authority to work on their development plans and Development Partners/Implementing Partners for the Departmental level plans.
- District Health Departments need to ensure that members of the HUMCs are oriented upon being elected and trained in their duties. This will make them more effective in exercising oversight over the PHC funds at health facility level. A third of the HUMCs consulted indicated not to have received any training or orientation on their roles and responsibilities.
- District Health Departments also need to ensure that health facility in-charges are trained in the fundamentals of financial management. This will improve accountability in the governance of PHC funds.

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Annex 1: Principle, Definition and Indicators

Principle	Definition	Critical Assumption (Desired outcome)	Indicators
1. Participation	The interactions of individuals or organized groups in the process of formulation and implementation of public policies within a governance arena (Graham et al., 2003). Participation takes different forms, ranging from information sharing and consultation methods, to mechanisms for collaboration and empowerment that give stakeholders more influence and control (World Bank, 1996).	Opportunities exist for non-state actors (e.g. PNFP Health facilities, NGOs, Communities etc.) to participate in planning, monitoring and evaluation of PHC services and their views are taken into account in decision making	<ol style="list-style-type: none"> Evidence of district meetings held at least once a year to solicit views of non-government actors (e.g. NGOs, PNFP Health facilities, etc.) on the planning and evaluation of PHC. Evidence of discussions of views from citizens (including patients) on PHC in the district meetings Allocation of resources in the annual district budget for holding meetings with citizen groups, NGOs, PNFP Health facilities and other non-government stakeholders to discuss PHC issues Evidence of expenditure on meetings with citizen groups, NGOs, PNFP Health facilities and other non-government stakeholders to discuss PHC issues
2. Strategic Vision	Strategic vision establishes a direction for the organization on achieving its objectives. Schoemaker (1992) defines strategic vision as the rules for acting opportunistically or incrementally. It determines the strategies, plans and budgets of the organization	Consistency of district PHC plans with national, and sectoral plans as well as the health needs of the communities	<ol style="list-style-type: none"> Evidence of progressively improving targets on provision of PHC Evidence of progressively improving targets on equity as a component of health Evidence of progressively improving targets on community participation in decision making, Evidence of progressively improving targets on multi-sectoral approach to health service delivery, Evidence of progressively improving targets on adoption and use of appropriate technologies, Evidence of progressively improving targets on emphasis on health promotion activities

Principle	Definition	Critical Assumption (Desired outcome)	Indicators
3. Coordination	<p>“Coordination is a way of bringing together disparate agencies to make their efforts more compatible, in the interests of equity, effectiveness and efficiency” (Panday and Jamil, 2011). Inter-sectoral coordination reconciles policies and programmes across sectors while intra-sectoral coordination refers to linking policies and programmes in the same sector (Matei and Dogaru, 2013).</p> <p>Transparency offers the promise of accountability and better governance, which may lead to the efficient allocation of capital and resources (Choi et al., 2012:4). The free flow/accessibility of information encompasses “mechanisms for keeping the stakeholders and public fully informed of the decision making process, implementation and results.” Decisions made and information provided by public officials are clear and open to scrutiny by citizens (Hyden and Mease, 2002; Kosack and Fung, 2014).</p>	<p><i>Coherence between plans and activities of various actors involved in the delivery of PHC</i></p>	<ol style="list-style-type: none"> 11. Evidence of at least one TPC meeting where PHC issues are discussed every quarter 12. Evidence of meetings between DHO, District Health Inspectors, VHTs and CAO to discuss PHC Issues 13. Evidence of an annual joint sector review meeting (between district officials and other stake holders) on PHC
4. Transparency		<p><i>Communities have access to information on PHC resources (e.g. funds, medicines and supplies etc.) disbursed to districts, sub-counties and health facilities</i></p>	<ol style="list-style-type: none"> 14. Display of up to date (Q1 – Q2 FY 2017/18) information on the PHC grants at district head quarters 15. Display of up to date (Q1 – Q2 FY 2017/18) information on the PHC grants at Health Centres 16. Existence of clear procedures for requesting information on PHC services by citizens. 17. Evidence of communication from the CAO/DHO to Health Unit In-charges on guidelines for public display of information on PHC funds and services

Principle	Definition	Critical Assumption (Desired outcome)	Indicators
5. Control of Corruption	Aims at understanding the extent to which power is exercised to avoid private gain, and includes both petty and grand forms of corruption, as well as 'capture' of the state by elites.	<i>Administrative systems including sanctions and practices are in place that prohibit office bearers from using their PHC resources (e.g. funds, medicines and supplies etc.) for private gain</i>	<p>18. Evidence of the PHC grants being captured in quarterly internal auditing exercises by district</p> <p>19. Evidence of the district PAC discussing issues related to PHC Services from either the Internal Audit or Auditor General's report.</p> <p>20. Evidence of a Council meeting discussing a PAC report raising issues related to PHC.</p> <p>21. Evidence of administrative actions taken (e.g. introduction of new rules/procedures) in response to queries raised by the Office of the Auditor General/district PAC.</p>
6. Accountability	Bovens (2007) looks at accountability as a relationship between an actor and a forum, in which the actor has an obligation to explain and justify his or her conduct, while the forum can pose questions and pass judgment, and the actor can be sanctioned.	<i>Mechanisms are in place to ensure that PHC duty bearers give account for their work and sanctions are applied where needed</i>	<p>22. Evidence of district reporting on performance in provision of PHC services in a public forum e.g. Barazas, District Budget Conference, Community meetings/dialogues/ radio</p> <p>23. Evidence of at least one quarterly monitoring and supervision visit by the DHO</p> <p>24. Evidence of submission of quarterly monitoring and supervision report to MoH and MoFPED</p> <p>25. Evidence of sanctions enforced against any office bearer for non-compliance with accountability guidelines for providing PHC services e.g. dismissal, suspension, disciplinary action, refund etc.</p> <p>26. Evidence of stakeholders witnessing delivery of medicines</p>

Principle	Definition	Critical Assumption (Desired outcome)	Indicators
7. Effectiveness and Efficiency	<p>Effectiveness of a program's general focus on measuring the changes in outcomes that reflect the objectives of the programme. According to Ulrike et al (2008), when measuring efficiency, a distinction can be made between technical and allocative efficiency. Technical efficiency measures the pure relation between inputs and outputs taking the production possibility frontier into account. Technical efficiency gains are a movement towards "best practice." Allocative efficiency reflects the link between the optimal combination of inputs taking into account costs and benefits and the output achieved.</p>	<p><i>PHC resources such as funds, medicines and supplies are optimally utilized to meet set targets</i></p>	<p>27. Evidence of district review of PHC services 28. Evidence of at least two council meetings discussing PHC services 29. Level of utilisation of the PHC grants transferred to the district</p>
8. Responsiveness	<p>Best (2008) defines responsiveness as "effective planning, evaluation and feedback with regard to particular actions, as well as the conduct of regular review processes to ensure that programmes reflect the needs and preferences of stakeholders". Vigoda (2000) examines three variables by which responsiveness can be measured: speed and accuracy of responding to public needs and citizens' attitudes and feelings about public services using satisfaction surveys.</p>	<p><i>Providers of PHC services solicit and respond to feedback from the beneficiary communities</i></p>	<p>30. Evidence of resolutions taken by Council on issues raised by citizens on PHC services 31. Evidence of the implementation of resolutions on PHC services passed by Council 32. Evidence of the DHO's Office receiving complaints from Citizens on PHC services 33. Evidence of DHO's Office responding to the complaints received from citizens on PHC services</p>

Principle	Definition	Critical Assumption (Desired outcome)	Indicators
<p>9. Equity</p>	<p>A highly subjective concept, equity can be defined along many dimensions, such as justice, rights, treatment of equals, capability, opportunities, resources, wealth, primary goods, income, welfare, utility (Ramjerdi, 2006). Levinson's typology of equity includes: Opportunity or process equity—the extent to which there is fair access to the planning and decision-making process (Fairness) and Outcome or result equity—the extent to which consequences of a decision are considered just (Levinson, 2010:37).</p>	<p><i>Mechanisms are in place to ensure that PHC services reach special interest groups such as women, youth and Persons with Disabilities</i></p>	<p>34. Evidence of disaggregation of health outreach beneficiaries by gender 35. Evidence of disaggregation of health outreach beneficiaries by age category (youth/elderly) 36. Evidence of strategies and plans to improve equity in provision of PHC services 37. Evidence of implementation of strategies and plans to improve equity in the provision of PHC services.</p>

Annex 2: Excerpt of FY 2002/03 PHC Grant Utilisation Guidelines

Utilisation of funds by Lower level units (excluding drugs) shall be as shown below.

- Allowances for outreach activities - **40 percent**
- Transport (fuel, maintenance of vehicles) – **30 percent**
- Facility and property costs (maintenance of buildings and minor repairs, compound, utilities, stationery and maintenance of equipment, purchase of charcoal, paraffin) – **30 percent**

2.7.2 Health Sub-District Management

Amounts for running health-sub-district activities will be defined every financial year. The activities include support supervision, planning and budgeting, preparation of reports and liaising with the district director's office.

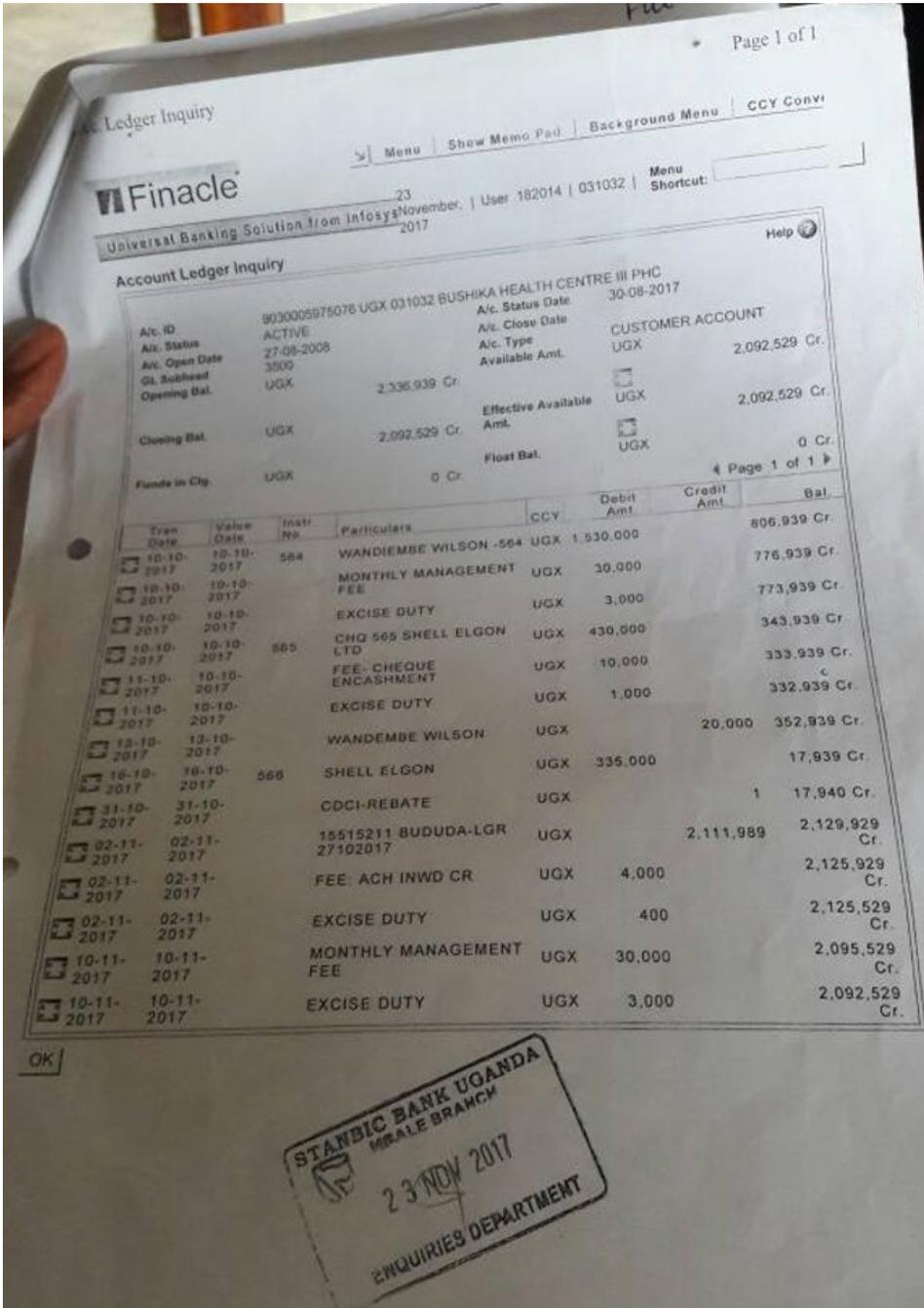
2.7.3 Service delivery costs of health centre IVs

Health centre IVs are mini-hospitals. amounts to run them will be defined every financial year. **Fifty percent of the funds should be for purchase of drugs.** the other 50 percent can be used on the following :

- Allowances for outreach activities - **30 percent**
- Transport (fuel, maintenance of vehicles) – **30 percent**
- Facility and property costs (maintenance of buildings and minor repairs, compound, utilities, stationery and maintenance of equipment, purchase of charcoal, paraffin) – **40 percent**

Source: MoH, 2002.

Annex 3: A Bank Statement of PHC funds received By Bushika HCIII



ABOUT THE AUTHORS

Emmanuel Keith Kisaame is a Research Fellow at ACODE. He is an Economist with over 7 years of experience in public expenditure reviews, Disaster Risk Reduction, gender policy review and economic empowerment. This experience has mostly been gained in developing country contexts including in post conflict settings. He has authored research in areas of public expenditure reviews, pro-poor budgeting, healthcare expenditure, Agricultural expenditure, disaster risk reduction, and poverty dynamics. He holds a M.A in Economic Policy and Planning and a B.A. in Economics from Makerere University. He has also acquired extensive training in social accountability. Keith previously worked as a Research Analyst with Development Initiatives, overseeing DI's work in Uganda.

Moses Mukundane is a Research Associate at ACODE. He holds two masters degrees; 1) International Social Welfare and Health Policy (International Public Health) from Oslo and Akershus University College of Applied Sciences, Norway; 2) Public Administration and Management from Makerere University. Moses Also holds a BA Social Sciences (Public Administration and Sociology) from Makerere University. He previously worked at Makerere University- Director of Research and Graduate Training (DRGT), Institute of Social Research (MIRS) and Elizabeth Glaser Pediatrics AIDS Foundation (EGPAF- Uganda-Mbarara) as Project Administrator and Researcher respectively. Moses' research interests are Health Systems Strengthening, Maternal and Child Health, Adolescents' Sexual and Reproductive Health and Rights, HIV and AIDS, Social Security/ Welfare, Poverty Alleviation and Rural Development, Local Government Administration and Service Delivery, and Public Policy and Development.

Ramathan Ggoobi is an Economist and Policy Analyst. He is a Lecturer of Economics at Makerere University Business School (MUBS), where he heads the MUBS Economic Forum. He is also the Chief Economist for Operation Wealth Creation in Uganda. He has extensive knowledge and experience in both quantitative and qualitative research, with special interest in rural economy, economic development, policy analysis and political economy. Ramathan is also a Member of the Board of Directors at Uganda Development Corporation (UDC). He holds an M.A in Economic Policy and Planning, and a B.A. in Economics from Makerere University. He also holds an International Certificate in Sustainable Development (*With Distinction*), Columbia University U.S.A, 2015, and a Certificate in Energy Economics, Total France.

Richard Ayesigwa is a Research Associate at ACODE. He is an Economics and Statistics Graduate of Kyambogo University, currently pursuing a Master of Arts in Economic Policy Management from Makerere University. Richard has four years of work experience in the areas of economic growth and sustainable development. He has contributed to ACODE works in line with Research, Governance of Service Delivery and Capacity Building. He also possesses extensive ability in data analysis and manipulation of both qualitative and quantitative data using various data management software.

About ACODE:

ACODE is an independent public policy research and advocacy think tank registered in Uganda. Its mission is to make public policies work for people by engaging in contemporary public policy research, community empowerment to demand for improved service delivery and advocacy. ACODE has for the last four consecutive years been ranked in the Global Go To Think Tank Index as one of the top think tanks in the world.



ADVOCATES COALITION FOR DEVELOPMENT AND ENVIRONMENT

Plot 96, Kanjokya Street, Kamwokya.

P. O. Box 29836, Kampala. Tel: +256 312 812150.

Email: acode@acodea-u.org / library@acode-u.org

Website: www.acode-u.org