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FAITHBASED MEDICAL BUREAUS AND HEALTH FACILITIES

A COMPREHENSIVE HEALTH SYSTEMS NEEDS ASSESSMENT REPORT

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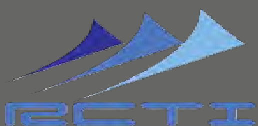

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DISCLAIMER

This needs assessment was conducted for the purpose of identifying health systems strengthening capacity needs towards generating recommendations for the growth of medical bureaus and their respective health facilities. The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) Private Health Support Cardno Program or the United States Government.

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Acronyms

AGM	Annual General Meeting
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Therapy
DHO	District Health Officer
DHIS2	District Health Information System Version 2
LLU	Lower Level Unit
HC	Health Centre
UBOS	Uganda Bureau of Statistics
GOU	Government of Uganda
PHC	Primary Health Care
HIV	Human Immune Deficiency
PWD	People With Disabilities
ACHAP	African Christian Associations Platform
RCTI	Research, Consultancy and Training International
HUMC	Health Unit Management Committee
OPD	Outpatient Department
NGO	Non-Governmental Organization
SOP	Standard Operating Procedure
SACCO	Savings and Credit Cooperative
PNFP	Private Not for Profit organization
CCIH	Christian connections for International Health
J.O.Y	Joy Medical Centre
UMSC	Uganda Muslim Supreme Council
SQIS	Self-Regulatory Quality Improvement System
NESH	National Expansion for Sustainable HIV Services
QI	Quality Improvement
UCMB	Uganda Catholic Medical Bureau
MOU	Memorandum of Understanding

CBO	Community Based Organization
ICT	Information Communication and Technology
IT	Information Technology
GAVI	Global Alliance for Vaccines and Immunization
COU	Church of Uganda
UEC	Uganda Episcopal Conference
CT	Computed Tomography
MW	Mega Watts
MAUL	Medical Access Uganda Limited
UHMG	Uganda Health Marketing Group
DHC	District Health Coordinator
SDA	Seventh Day Adventist
SDAUU	Seventh Day Adventist Uganda Union
EPRM	Electronic Patient Record Management System
DLG	District Local Government
iHRIS	Electronic Human Resource Information System
OVC	Orphans and Other Vulnerable Children
ISO	International Organization for Standardization
WENRECO	West Nile Rural Electrification Company Ltd
UMMB	Uganda Moslem Medical Bureau
UOMB	Uganda Orthodox Medical Bureau
UPMB	Uganda Protestant Medical Bureau
QIT	Quality Improvement Team
JMS	Joint Medical Stores
USAID	United States Agency for International Development
USA	United States of America
WHO	World Health Organization
NSSF	National Social Security Fund
VHT	Village Health Team

Executive Summary

This synthesis report details the results of a comprehensive needs assessment for 134 faith- based medical facilities and the four medical bureaus in the areas of human resource for health, health financing, coordination, health governance and the quality of services. Separate reports have been prepared for the different health facilities and the four bureaus. The bureaus which were assessed include: Uganda Catholic Medical Bureau, the Uganda Protestant Medical Bureau, the Uganda Orthodox Medical Bureau and the Uganda Moslem Medical Bureau. The bureaus accordingly coordinate and build the capacity of the member health facilities that are under them. For example UCMB coordinates the work of 309 health facilities, UPMB, 294, UMMB, 52 and UOMB, 17 facilities. All the bureaus have a faith under-pinning in their work, with religious morals spelt out in their methods of work and policy documents. The bureaus conduct their business through their regional religious partners i.e. diocesan, office and mosques.

As regards the organization of the bureaus, we find a rather complex and sometimes a bureaucratic governance structure. We find that there is a strong religious foundation, ownership and support in the bureaus. The difference is in the styles of management by the bureaus emanates from the differences in the history and management philosophies.

We found that the governance and the top management positions were filled with professionals with technical expertise and relevant experience for health service delivery. The governance bodies provide strategic leadership to the bureau, and the bureaus ensure that the good governance principles are upheld in the respective member facilities. There is generally a good understanding in the differentiation of roles between management and the governance structures whereby the governance is limited to policy making and the management oversees the technical functions.

However, there were cases where appointments of the technical people were influenced by the spiritual leaders.

As regards the human resources within the bureaus, there are resident technical competencies especially at the management level to deliver on their mandate. UPMB and UCMB were noted to; exceptionally employ a caliber of competent, experienced and professional personnel with the requisite qualifications. This is despite the fact that some bureaus including UMMB and UOMB have serious staffing deficiencies to deliver on their mandate.

From the funding perspective, generally the funding for the operations of the bureaus is from external sources, with a minimum percentage coming from sub subscription fees, government subsidy (PHC fund) and income generating activities. Over 55% of the health facilities assessed relied on donors as an option for financing. Besides there have been declining financial options, with donors becoming more stringent with their finances. It is thus recommended that resource mobilization becomes a key strategy and a resident skill among bureau and health facility staff towards increasing the resource bases of the bureaus and their respective health facilities. Other sources of financing health services at the facilities include; charging user fees (over 80% of the facilities), government subsidy in form of PHC fund (over 40%of the facilities). In addition, there are other least prominent mechanisms of financing the facilities including involvement in business ventures, loan acquisition, insurance schemes and voucher schemes. Moreover other modes of rising funding could be through social insurance contributions, private insurance premiums; community based financing, employer based schemes among others.

In terms of the quality of health services, the bureaus are in a continuous process of accreditation of the health facilities. The accreditation process checks for compliance with clinical guidelines by clinicians, assurance of patient safety and availability of essential drugs at the facilities in time. The bureaus also ensure that the government

quality enhancing mechanisms are understood and implemented at all levels. In order to reach the poor, the bureaus have advocated for fair services and in some instances provided guidelines for setting-up user fees. A good practice that was identified during the assessment is that UPMB and UCMB regularly conduct knowledge sharing workshops where the health facilities and other partners on similar projects meet to share experiences and learn from each other.

As regards assets and infrastructure; lack of computers by the different departments to perform their duties was cited as a significant challenge and an issue which also affects and exposes client data and information.

Coordination for the bureaus emerged critical for building strategic partnerships and networks, resource mobilization, business development and shared learning. However, the findings from the assessment indicate that inter-bureau cooperation is rather loose with no clear and sustainable structures. Otherwise, the bureau coalition arrangements allow for cross-bureau learning and that the individual entities perform their functions as per their comparative advantage. Moreover, there is need for strengthening of regional coordination, supported by the regional coordinators to conduct routine monitoring visits especially for the bureau earmarked project support.

Some successful partnerships were identified through the assessment i.e. the Joint Medical Store Partnership venture between UPMB and UCMB, which is considered a success story that has increased drug availability and access to affordable medical supplies. Moreover, there is an associations' platform (ACHAP) which aims to advocate and acts as a network forum for Christian health organizations. It emerged however, that there is need to strengthen the research components of all bureaus for informed advocacy efforts for effective PNFPs health service delivery.

Of the health facilities that were assessed, 74% had strategic plans that guided resource mobilization efforts. A higher number of health facilities had vision and mission statements but without a strategic plan. Those that had a strategic plan, also had a mission statement, and the same proportion of the facilities with strategic plans, had boards that understood the vision and mission statements. There is a correlation between strategic planning and good governance by the boards of the bureaus. Some of the assessed bureaus and health facilities ought to be supported and facilitated to develop strategic plans and other institutional documents to enhance good governance. Health facilities should further develop recruitment tools, plans and placement guidelines.

It addition, it was also reported that 41% of the respondents had no resource mobilization skills. This critical and important skill was lacking and inadequate within the facilities. The assessment results revealed that most of the health facilities perform above average as determined by the MOH quality indicators.

Based on the results of the assessment, we conclude that the capacities of the bureaus and the respective health facilities have improved overtime. However the results also indicate that there are areas which should be prioritized or even made stronger for the bureaus and their respective health facilities to function effectively. The areas that need to be developed and strengthened across divide include, but are not limited to: the need to strengthen the board structures, data management systems, financial procedures, inter-facility coordination; developing coordination, advocacy and partnership strategies and arrangements to promote, and engage for better and inclusive health service delivery by the PNFPs.

The role of PNFPs is critical and important, for this reason, the needs and the challenges identified through this assessment ought to be addressed such that the **PNFPs' roles are enhanced and promoted further. It is thus proposed that a** mechanism and or strategies are devised to address the issues emanating from this

assessment. This implies and calls for a participatory reflection by both the bureaus and their respective health facilities to develop strategies and implement the recommendations emanating from this assessment.

1.0 Background

1.1 Introduction

USAID/Uganda Private Health Support Program **is USAID's flagship projects** for the private sector in Uganda, implemented by Cardno Emerging Markets USA Ltd. The program aims to contribute towards viable, cost-effective health services by strengthening the **private providers' ability to contribute to the achievement of Uganda's health goals. The program has three** objectives, namely-

- *Expanding availability* of private health services through clinical and financial management training, access to finance, and service delivery grants for HIV/AIDS and orphans and vulnerable children (OVC) support
- *Increasing affordability* of private health services and products through public-private partnerships and market-based interventions
- *Improving quality* of private health sector facilities and services through enhancing technical skills and strengthening the regulatory and policy-enabling environments

Since 2014, the program has provided managerial and technical oversight support to 17 faith based health facilities under the leadership of the Inter-Religious Council of Uganda. Moreover, Cardno Emerging Markets Group has extended its mandate and supported the 17 facilities to deliver essential HIV/AIDS prevention, care and treatment services; to strengthen the health systems within the faith-based health sector as a foundation for sustained scale-up of services for people living with and affected by HIV/AIDS.

In a bid to strengthen health systems for improved service delivery through evidence based programs, USAID/Private Health Support contracted Research Consultancy and Training International (RCTI), to conduct a comprehensive health systems strengthening needs assessment for 134 faith-based medical facilities and 4

respective Medical Bureaus in key critical areas including human resource for health, health financing, coordination, health governance and the quality of services.

This report therefore combines the results from 130[1] health facilities and the four medical bureaus whose needs and opportunities have been assessed and results presented herein.

1.2 Context Analysis

The Ugandan Health Structure

According to Ugandan Health Policy, there are five levels of health service delivery: Village Health Teams (VHTs), Health Centre II, Health Centre III, Health Centre IV, with the Hospital at the top. Accordingly, hospitals are categorized at different levels, i.e. general hospitals, regional referrals and national referrals. The VHTs are community volunteers who assist communities with essential first aid drugs, and serve as the initial point of contact for health related issues in the community. At Health Centre II, treatment for common diseases like malaria is offered. A Health Centre II is ideally composed of an enrolled nurse, a midwife, two nursing assistants and a health assistant. The center runs an outpatient clinic which treats common diseases and offers antenatal care. Health Centre III is headed by a clinical officer with about 18 staff, runs a general outpatient clinic and maternity ward. On the other hand, Health Centre IV should have the capacity to admit patients under the supervision of and the management of a senior medical officer; should have a

[1] Four target facilities could not participate in the assessment and were thus not interviewed. Specifically, three dropped out of assessment (Old Kampala-UMMB, Alive Medical Center – UPMB and Luzira SDA – UPMB), while the fourth facility dropped out of UMMB list due to governance issues that were unacceptable to UMMB. The following facilities were assessed but are not analyzed because they fall out of the scope of this assessment. They are HCIIs, i.e. Taqwa – UMMB, Kakungube-UMMB, Bulyansime-UMMB, Ivukula-UPMB, Nandere-UCMB, St. Luke Society – UPMB, and Kisenyi Good Shepherd –UCMB).

theatre to carry out emergency operations. Moreover, a hospital should have all services offered at clinics as well as provide services of mental, dentistry and consultant physicians. There is an on-going discussion by the Government of Uganda (GOU) to ensure that healthcare is offered at a level of Health III and above, thus scrapping health centre IIs and replacing them with field health extension workers instead[2]. While this is a good initiative to propel services beyond first aid, some faith based health services might lose out since they are community self-help projects with no profit motives. On the ther hand, Health centre IIs provide last mile maternal and child service that might be difficult to be met by individuals[3] with majority of health facilities under PNFPs being Health Centre IIs.

Apart from the hospital, and the health centre structures, there are Private Not For Profit (PNFP) health service providers which, contribute up to 50% of health services in Uganda (Tumwesigye, undated). There are also private faith based health facilities which have been instrumental in reaching the poor and underserved communities. They are generally located in hard to reach locations and anchored in the faith-based philosophy of serving people. As such, their services are generally perceived more affordable than the private for profit counterparts. Because of their charity orientation, they have attracted funding from well-wishers, large donors but they also charge user fees for income generation. Due to their unique characteristics, these facilities require high level commitment from staff and various operators. Moreover, they often face a challenge of reluctance by clients to pay user fees since they are perceived to offer either subsidized or free services.

[2] The Daily Monitor Newspaper (6th October, 2016). Permanent Secretary MOH speech on Scrapping Health centre IIs.
[3] http://www.parliament.go.ug/index.php/about-parliament/parliamentary-news/1066-gov-t-shouldn-t-phase-out-health-centre-iis-kadaga

The private faith based health system structure

The private faith based health facilities operate as part of the national healthcare system and are part of the health system of the respective districts. At national level, they are part of the Ministry of Health Policy Advisory Committee and its technical working committee where they play a critical role in steering national policy direction. The PNFPs are divided into two categories: the facility based PNFP which are largely faith based, have a sizeable investment in place, and 75% of them are organized under the medical bureaus and the non-facility based PNFPs such as NGOs and CBOs which do not directly own or operate health facilities, rather they support or undertake health development activities in partnership with government.

In this assessment, we deal with the former who are mainly coordinated by the following medical bureaus; a) Uganda Catholic Medical Bureau (UCMB) established in 1956; b) Uganda Protestant Medical Bureau (UPMB) established in 1957; c) Uganda Muslim Bureau (UMMB) established in 1998; and d) Uganda Orthodox Medical Bureau (UOMB) established in 2009. The Medical Bureaus are observed to give a faster response to the needs of the facilities under them, have clearer focus on health systems strengthening, while the FB-PNFP have strong coordination structures both at the national and sub-national levels. The FB-PNFP are reputed to technical competency (in advocacy) and the services they provide are highly appreciated by the communities in their catchment areas.

For coordination purposes, the faith based health facilities are organised under umbrella organisations to enable them have a common voice, leverage resources from sister facilities and have a common platform for accreditation. The UCMB is for instance the coordinating body for catholic owned medical facilities including health training institutions. In the same way, the UPMB coordinates the Anglican Church and Seventh Day Adventists, UOMB for the Orthodox facilities and UMMB coordinates the governance and quality assurance aspects of Muslim health facilities in Uganda. This

religious underpinning of medical facilities has in the past caused questions on the quality of services, human resource practices, the governance of the bureaus whether they actually provide the oversight function on time and are as well have the capacity to provide and perform the oversight role.

There are initiatives to ensure coordinated health service delivery in faith based facilities. These include the establishment of standards of operation; accreditation systems which are being implemented under UPMB, UCMB, UOMB and UMMB. However, it is understood among the partners that the Bureaus, though they are independent units, have a mandate to ensure harmonized service delivery and to provide technical coordination among their health facility networks. The Bureaus have standardized program management tools, human resource management tools which they use to provide support to member facilities. However, there seems to be un-tapped opportunities to leverage on the shared resources between Bureaus and inter-facility towards a more effective and efficient resource mobilization, lobbying and advocacy for strategic engagements. The strength of medical facilities and the respective bureaus to deliver effective healthcare is assessed according to human resources capacities, leadership and governance, infrastructure and assets, financing and finance management, and the quality of health service delivery. To understand the faith based health sector needs, it is important to unpack the factors affecting these essential areas, the strengths and opportunities affecting health service delivery, specifically within the faith-based sector. This assessment focuses on building blocks of health systems strengthening in the faith-based sector of Uganda.

The capacities of human resources in faith based health sector

Government of Uganda (GOU) health facilities fetch from the same workforce like PNFPs. Government offers lucrative benefit packages for health staff, most of which are not available or guaranteed in private sector. Government employees for instance have permanent contracts, have retirement benefits and enjoy flexible work styles.

The faith based health sector compared to the government employees and staff attract less packages in form of short and largely alterable contracts, lower salary scale, have obscure human resource development options, little or no retirement packages and at the same time are coupled with heavier workload. Thus, the PNFPs face a human resource deficit. Previously, the government supported the PNFPs with staff seconded from public health facilities; however, this intervention has been reversed, resulting in increased wage bills for PNFPs and higher attrition rates. The faith based private health providers have to a large extent been cognizant of the shortcomings and as way of addressing the matter, they have incorporated incentives to attract and maintain a committed workforce. The PNFPs have been able to attract donors, who support particular health workers while the Bureaus manage their payrolls on project to project basis. All the four medical bureaus have for instance incorporated avenues for career enhancement through scholarships and study leave entitlements, but these remain few and limited compared to what the public sector offers. Some human resource management systems have been put in place by the PNFPs, for instance UPMB has instituted a computerized human resource management information system (iHRIS) which it uses to measure key human resource aspects for the subscribing institutions.

Faith based health sector financing

The faith-based private health facilities are financed from various avenues including subsidy from government through the Primary Health Care (PHC) fund, donor support, borrowing and user fees. However, funding gaps persist due to current market conditions, inadequate user fees that often do not cover the full cost of delivering health services, stagnating GOU subsides (about 22% of total faith-based expenditures) plus the challenges of unorganized, unplanned and un-sustained donor funding. Below is a pie-chart indicating the sources of PNFP financing expressed as percentages.

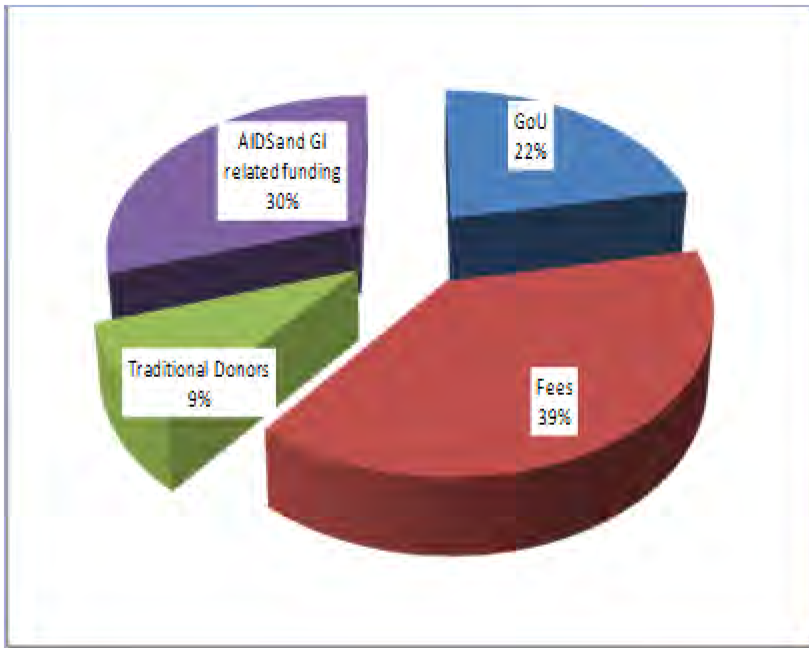

Figure 1: Pie chart summarizing the sources of PNFP financing

It is important to note that the cost of medicines and health supplies remain high despite the subsidy from the Joint Medical Stores (JMS). At the same time, the faith-based health sector is experiencing declining revenues as overseas donations from churches and other religious institutions decrease. Moreover, there are, apparently, limited innovative ways for health financing (like investment and insurance measures). Health insurance is not considered for sustainable capitation of PNFP health facilities due to the complex contribution processes. The health insurance companies consider the largely peasant PNFP clientele unpredictable and unable to afford regular costs. Besides, the challenges of sophistication and affordability, the culture of health insurance is yet to be appreciated and PNFPs have themselves hardly insured their assets. This further compounds health facilities access to capital to upgrade many of their health facilities, purchase equipment and build regional warehouses to enhance supply chain distribution. The World Health Organization (2007) notes that a good health financing system should raise adequate funds, and at the same time make sure that the people can use the needed services, and the people are protected from financial catastrophe or impoverishment associated with

having to pay for them while providing incentives for providers and users to be efficient.

Governance of the faith based health sector

Health facility governance and management denotes the manner in which power is exercised within faith based private-not-for profit health service providers that include bureaus and the subscribing health facilities. While the Ministry of Health provides the overall oversight and regulation of all health services in Uganda, it does not guarantee full observance of good governance principles in faith based sector whose management and service delivery is anchored in the religious doctrine. The dioceses, deaneries, fields and the Muslim districts health coordinating offices are responsible for the management of respective faith-based health services, while the medical bureaus provide technical oversight. The medical bureaus operate and are guided by the policies and values of their parent religious institutions and foundation bodies. For instance UPMB provides the leadership for the protestant, Seventh Day Adventist and the other members of the born again church founded health facilities in Uganda. The governance board of UPMB constitutes of the head of Church of Uganda, head of Seventh Day Adventist church (SDA), two technical representatives from the Church of Uganda, one technical representative from SDA. The board of **trustees' works** through dioceses and regional deaneries to provide leadership for the medical facilities and training institutions. In the same way, the governance board of UCMB is composed of the council of bishops. The Board of Bishops do not only own but also provide the oversight function to medical facilities in their jurisdiction.

Following the misappropriation of Global Fund/GAVI Funds, there has increasingly been the need to promote good governance as a critical block for health systems strengthening and streamlined leadership. As such stringent measures have been put in place to strengthen the governance systems. There have been efforts to put in place boards of health facilities for policy formulation, monitoring and implementation. At hospital and health facility level, the governance and

management oversight functions are provided by the hospital boards and health unit management committees who oversee supervision of senior health facility staff.

Quality of service and infrastructure in faith-based health sector

Given the perception that faith-based health facilities provide better quality services than offered elsewhere, high volumes of clients have been attracted to these facilities causing disproportionate workload to existing human and financial resources, infrastructure and systems capacity. As a result these facilities tend to have difficulty meeting minimum standards for quality of services, for instance the patient number versus latrine stance ratio are low compared to the standards, existence of flush toilets, the patient-doctor ratio and quality of customer care. It should be noted that faith based health facilities started as early as 1700 and have since existed serving the poor and underprivileged with subsidized or free medical care. As population has since increased, their capacity has been overstretched requiring larger patient wards, holding areas and the inevitable investment in staff welfare through housing infrastructure, water systems and electricity. A 2013 evaluation of USAID-community and faith-based programs noted that the physical infrastructure at most faith-based health facilities were in state of disrepair and could no longer hold massive volumes of patients resulting in chronic overcrowding and congestion. Thus, the need for quality services within the faith-based health sector is urgently critical given the trust and the high demand for health services.

More recently, the faith based medical bureaus have engaged the respective health facilities in a process of accreditation whereby improvements in areas of infrastructure, quality of care, governance and general adoption of government standards form the criteria for accreditation. The health facilities that pass the accreditation criteria are accredited and given a certificate for one year while others face closure or withdrawal of accreditation status.

1.3 Objectives of the needs assessment

USAID/Private Health Service program would like to conduct a comprehensive needs assessment to provide important and strategic information to guide interventions aimed at strengthening health systems at the medical bureaus and faith based health facilities. The assessment will inform future interventions not only by private health services but also for other development partners interested in health systems strengthening. The following system blocks form the guide for the assessment:

- Availability and capacity of human resources
- Availability and sustainability of financial resources
- Infrastructure at health facilities
- Governance and management of health services
- Coordination with public facilities and other stakeholders at district and national level
- Quality of faith based health services delivery

2.0 Approach to the comprehensive needs assessment

We adopted an approach that allowed for collection and triangulation of data and sources, ensuring data quality and integrity. Data was collected from 130 health facilities[4] (31 hospitals, 11 health entre IVs, 81 health centre IIIs, 07 health centre IIs). Quantitative and qualitative data was collected using a structured questionnaire, an observation checklist and an interview guide (see Annex 1). The tools were developed to guide collection of data on the status of selected PNFP health facilities in the key areas of human resources for health, health governance, health financing, and quality of health services, infrastructure and coordination. Questionnaires were administered at health facility and bureaus to the in-charges of health centres, medical superintendents of hospitals and officials at the medical bureau. Interview guides were administered to Key informants namely, medical bureau management,

[4] Target was 134 facilities but Masjid Noor was removed by UMMB due to unresolved governance issues that led to temporally suspension; Alive Medical Centre/Kampala and Old Kampala Hospital voluntarily dropped out of the assessment exercise.

District Health Officers, district level bureau leaders and selected members of hospital boards and Health Unit Management Committees. Observation checklists were used to guide the assessment teams on key areas of interest including equipment, documents, physical structures and compliance to standard procedures like triage and waste segregation among others. This assessment was conducted in phases: preparation, fieldwork, data analysis, report writing and assessment results validation.

Preparatory stage: This was the first and an essential stage in this assessment. It involved meetings between the client and the assessment team to build consensus on the needs and scope of the assignment, methods of assessment, key deliverables and timing of the assessment. At this stage, consultations were undertaken with the subject matter specialists and partners. Survey coordinators, pre-selected health centres and medical bureaus were named and key deliverables and expectations of the synthesis report specified. Due to the urgency of the assignment and the need to institute quality measures, we redesigned the data capture questionnaire for synching with a high end online data collection platform linked with mobile devices (ona.io). On the other hand, the qualitative forms were developed as google forms to collect mainly qualitative information from key informants.

Fieldwork: The assessment was conducted at four medical bureaus and 130 PNFP health facilities in 28 districts. The assessment was facility-based, entailing document review and collection of primary data through interviews with key informants, in-charges of health centres, medical superintendents of hospitals, members of HUMC, hospital boards and officials of the medical bureaus.

A data collection team comprising of experienced data collectors with background in public health was trained and introduced to relevant stakeholders and data management processes. The training for the fieldwork team covered; the USAID PHS program-expectations and the need for this assessment, reviewed the flow of questions and content, probing techniques, approaches to qualitative inquiry, data

quality dimensions (timeliness, precision, integrity, reliability, completeness). Pre-testing of data collection tools was done at faith-based health facilities that were not part of the selected sample. Survey coordinators mobilized respondents and scheduled the visits to facilities.

Documents that were reviewed include USAID/Private Health Support workplans, 5S implementation guidelines in Uganda, Health sector development plan (2016-2020), existing evaluation/assessment reports, strategies for resource mobilization, annual reports, financial and operational procedure documents, human resource management procedures, governing board management manuals, organograms, client charter, standard operating procedures, roaster for staff. The document review informed various aspects of the assessment including data collection, tools design and continuous review of the assessment plan.

Data analysis and report writing- Data analysis was preceded with cleaning for both qualitative and quantitative data. Analysis was done for different health domains comparing different health facility views and opinions, and making final aggregation and sense making. Reports were written for every health facility and Bureau assessed, based on information collected from various sources. Both primary and secondary data were compared to come up with individual bureau reports. A final synthesis report combining observations from each of 130 health facilities and 4 medical bureaus was compiled. The individual facility and bureau reports as well as the synthesized were shared with client for further review, before the final one was produced.

Validation workshop with stakeholders: Key health facility and bureau staff as well as other opinion leaders in the health sector were included in a 1 day validation workshop, as part of further data collection but also to validate information, and generate consensus/priority setting on important recommendations. The USAID/PHS and the consultant worked out an invitation list of workshop participants. The

workshop was attended by stakeholders from different health backgrounds, some of whom had participated in the assessment.

Ethical conduct: During fieldwork, ethical considerations were upheld. The assessment teams carried introduction letters, obtained written consent from respondents before conducting interviews and respondents retained a copy of the assessment information sheet with contacts of RCTI and bureau representatives for those that faced a necessity to contact the team thereafter.

Challenges encountered

At the time of fieldwork, other studies were being conducted in the same units like this study. This made respondents fatigued and in some instances reluctant to share the same information over and again. Many facilities complained that they never get feedback despite the many studies they participate in while others received lots of researchers intending to collect sensitive information on HIV/AIDS interventions, where consent is required from not only the patients but also the different partners. The end result was reluctance by some respondents to share information. In any case, we were able to gather all the relevant information to inform this assessment.

Some visited facilities fell short of what we expected, despite a thorough cleaning of the list prior to fieldwork. A case in point is Taqwa Health Centre III[5] under UMMB in Wakiso District, whose charter of operation is presented as Health Centre III but it had not registered or started offering any service apart securing a building where the facility would be located. Others include Kisenyi Good Shepherd under UCMB, Kakungube Muslim Centre in Mubende district, Ivukula Health Centre II in Namutumba and Bulyansiime Health Centre (in Iganga), Nandere Health Centre (in Luwero), St Luke Society Health Centre (in Kampala), all of which were in fact Health Centre IIs despite this assessment targeting centre threes and above.

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[5] We have graded this as centre II, for operationalizing this study

Data collection coincided with audit processes of facilities or annual events for some Bureaus. UCMB for instance invited most key organisation staff to attend annual general meeting Kampala in the week of data collection which led to some delays. There were similar events at Deaneries and Muslim facilities in the districts. These events were partly responsible for delay in the fieldwork but the exercise could not disrupt the normal functioning of the entities.

The needs assessment was in some instances perceived as a pre-grant award assessment. This was due to prior communication from the bureaus regarding potential funding from Cardno Emerging Markets/USAID. Despite our effort to explain the rationale for this study, most facilities tried to cover up the weaknesses and only would present areas of strengths. However, our team used objective assessment of the facilities and Bureaus rather than self-reporting by respondents.

4.0 Findings

This assessment covers six Health Systems Strengthening components that include human resource for health, health financing, coordination, health governance and leadership, quality of services and infrastructure. This report covers each of the above components as seen from both Bureau and health facility level perspectives. It is premised that Bureaus need to have a strong coordination system to guide and extend support to health facilities. The findings in here summarize what was assessed at each of the bureaus and health facilities. A separate report for each bureau and health facility assessed was also made.

4.1 Findings on Faith Based Medical Bureaus

4.1.1 Background to Faith based Medical Bureaus

There are four active medical bureaus in Uganda. These include, Uganda Catholic Medical Bureau (UCMB), Uganda Protestant Medical Bureau (UPMB), Uganda Orthodox Medical Bureau (UOMB) and Uganda Muslim Bureau (UMMB). All these medical bureaus coordinate the work of and build the capacity of member health facilities. UCMB is the longest existing bureau having existed since 1955 while the most recently formed was UOMB which got incorporated in 2008.

UCMB coordinates the work of 309 health facilities, UPMB coordinates 294 health facilities, and UMMB coordinates 52 facilities while UOMB coordinates 17 facilities in central, peri-urban and remote locations. All the bureaus have a faith underpinning in their work, with religious morals as spelt in their documentation. While the secretariats of these Bureaus are located in Kampala, various religious bodies represent these bureaus in better service delivery and governance of the facilities. The bureaus engage the health facilities in quality of service improvement avenues, while they have obligations to operate as independent organizations. Bureaus conduct their business through their regional religious bodies' for instance diocesan offices and Mosques.

UMMB is a national umbrella body that coordinates the work of affiliated Muslim health facilities. Uganda Muslim Supreme Council (UMSC) set up the UMMB in 1999 to coordinate activities of Muslim non-profit health facilities. In 2002, UMMB was registered as a company limited by guarantee by four founding institutions- Kibuli Hospital, Old Kampala hospital, Patience Nursing Home and Saidinah Abubakar Nursing Home. Member owners of UMMB are normally community initiatives by Muslim districts, Muslim communities and Muslim NGOs.

UPMB is a national umbrella organization for the Province of the Anglican Church of Uganda (COU), Seventh Day Adventist Uganda Union (SDAUU) and other Protestant Founded member health facilities and a technical arm of these facilities. It is registered as a charitable, faith-based non-governmental organization founded in 1957. UPMB is managed at the National level, by a professional Board of Trustees, and a Board of Directors. The Board of Trustees is composed of the Arch-Bishop, Head of SDA, two technical members from Church of Uganda and one technical representative from SDA.

UCMB is the health department of Uganda Episcopal Conference (UEC), and a coordinator of all health Roman Catholic Church owned health facilities in Uganda. It was established in 1955, making it the first and longest existing bureau in Uganda. It is a legal entity established as a self-accounting department of the Uganda Episcopal Conference. Its board is the Health Commission of the UEC that also reports to the **Bishop's conference. At lower levels, 19 diocesan health commissions coordinate the** work of health facilities and represent UCMB in ensuring quality of service delivery, and good governance.

UOMB is a national umbrella body that coordinates the work of member Orthodox hospitals and Lower Level health units (LLUs). UOMB Brings together Orthodox Churches in Uganda involved in Provision of Health Services. UOMB was registered in 2008 as a faith based Non-governmental Organization under the Trustees Incorporation Act (CAP 165). It remains the latest registered faith based medical bureau with 9 years of experience in health sector coordination.

4.1.2 Health governance and management

Bureaus were assessed based on governance and management of parameters including existence and functionality of governing bodies, strategic plans, documentation of business of organization for instance minutes or existence of rich

profiles, strategic focus of Bureaus, culture and values and how they are upheld, reflected and institutionalized in the day to day running of bureau business.

All the four Bureaus are legally established entities, with valid operation licenses. All the Bureaus are anchored in respective religious foundation bodies. UCMB is for instance anchored in the Uganda Episcopal Conference of the Uganda Catholic Church; UMMB is established by the Uganda Muslim Supreme Council, UPMB is established by the Church of Uganda and in the same way UOMB was founded by the Orthodox Church. There is a strong religious foundation ownership and support. However, there is a generally lack of historic information on important parameters like motivation for formation of these bureaus and the road map to present institutional arrangement. The available information is generally scanty or difficult to access from key resources in the bureaus. Quite often, there is differing levels of knowledge on institutional growth history as presented from the current leadership and documentation at Bureau level. Measures to document this across board should be welcomed.

We find engagement and involvement of governing bodies, for instance the Health Commission of Catholic Church and Board of UPMB are routinely involved in strategic visioning of the bureaus. In all, we find a rather complex and sometimes bureaucratized governance structure, of course with advantages and disadvantages due to differences in history and management philosophies. All the bureaus however have core values that are enshrined in the respective religious foundations from which other values are built. For instance all Bureaus have written or unwritten philosophy to provide health to all people in fulfillment of Christ ministry or Islamic faith.

All the bureaus have boards of governors, who convey annual and semi-annual meetings to execute board activities. At UPMB, the board meets semi-annually, while the AGM meets annually. At UCMB and UMMB, the board meets quarterly while the

AGM is annual. At UOMB, meetings of the Board have been irregular and only one AGM has happened since establishment. In these meetings, management shares information on progress of bureau work with the board. At UCMB, there is an added accountability mechanism where the bureau makes regular sharing of progress with other heads of departments at Uganda Episcopal Conference.

Board operations are guided by charters that state how the board should operate and how it interfaces with management. The Health Commission of UCMB has a Bishop as the chairperson and the vice chairperson is chosen by the members of UEC, while **UPMB's Board of trustees constitutes** of the Bishop of Church of Uganda, the head of Seventh Day Adventist Church and three other technical members from either church. Much as this guides constitution of Boards, guidance on operation of Boards is available in some but missing in others. The Board operation guide is available in the UMMB, UCMB and UPMB, but is still missing with UOMB. However, we note that the absence of this document does not imply lack of good practice and vice versa.

We see separation of duties between the Boards and Management and a clear understanding of their differential roles in all the four Bureaus. There is a generally good understanding of the differentiation of roles between the management and leadership/governance, whereby the governing council is limited to policy making, oversight and the management is responsible for the day to day running of the bureaus. However, there are instances where appointments of the technical people at the Bureau are made at the pleasure of the spiritual leaders. The executive secretary of UOMB is for instance appointed by the Arch Bishop of Orthodox Church to grow the business of the Bureau. We find that both governance and top management positions are filled by either medical personnel or spiritual leaders with strong views for health service delivery. This complexity in centers of power allows the values that guide the establishment of the bureaus to flourish, but at the same time is unlikely to comply with some of the best practices of good governance. For instance, some of the religious leaders find it unusual to be subjected to appraisal of

their performance, **to be given induction by their faithful's,** given that they are respected members of society and their performance has since been undoubted.

All medical bureaus are headed by medical doctors with wide experience in clinical practice and management of institutions. They provide strategic guidance in the implementation of bureau strategy and are a live link between practice and the leadership of the Bureaus. They lead in provision of governance advice to respective medical facilities including induction of new leaders.

Most boards have constituted committees for conducting board business. The committees reflect governance and management concerns of the Bureau. They also adhere to good practices in board functioning. For instance UCMB has in place the health training committee, scholarship fund committee, finance and planning committee, executive committee. These committees have a member of Board who is normally the chairperson of the committee. With these committees, the secretariats are able to conduct lots of business than would be possible with the whole board sitting singly. Despite the u**sefulness of these committees, UOMB's eight member** board does not have functional committees, though a plan exists according to their written by-laws. UCMB and UPMB have well-functioning committees to benchmark from.

All Bureaus have strategic objectives, vision and mission. UCMB has just completed its strategic period in 2016 and is finalizing a strategic plan formulation for 2017-2021. In the same note, UOMB will be finalizing its strategic plan but currently runs according to draft strategic paper while UMMB and UPMB have ongoing strategic plans that cover essential ingredients- vision, mission, core values, focus areas and monitoring mechanisms. All the plans key strategic areas reflect uniformity in approach to health systems strengthening. The plans envisage improved partnerships, service quality and advocacy while leveraging opportunities for the Bureaus to allocate resources appropriately while also serving as a fundraising tool that highlights funding and unfunded priorities. Both UPMB and UMMB for instance

outwardly present their focus areas, challenges and opportunities in terms of ongoing strategic focus areas as per the running strategic plans.

The governing bodies provide strategic leadership to the bureaus, while the Bureaus ensure that good governance principles are upheld in respective member facilities. UMMB has for instance set an example through deregistering or suspending non-compliant health facilities while UCMB has secured health facilities from director take over through providing legal and ecumenical advice, orientation and training for new management. UCMB is also strict and cannot accredit a facility that does not demonstrate catholic ethical values so long as it is owned by the Roman Catholic Church.

The composition of bureau boards is based on other important criteria than gender. UCMB for instance has a board composed of Bishops and heads of related partner agencies and health facilities. This breeds gender imbalance in composition of boards and trustee bodies. UCMB for instance has 1 female on board out of 14 member board, UPMB has 6 females out of 16 member board while UOMB has 3 female members on a 9 member board. There is need for deliberate gender inclusiveness in board constitution, which shall ultimately increase women participation on governance.

Recommendations

- It is recommended that experienced bureaus be further facilitated and supported to share and build the capacity of others in selected governance subjects. Both UCMB and UPMB are potential candidates to facilitate growth and expansion of other bureaus and their respective health facilities for improved service delivery in the health sector for the faith based health service providers.
- UCMB ought to be supported to speed up and finalize its strategic plan. Moreover, support should be extended to all Bureaus and facilities to disseminate pocket friendly copies of the strategic plan to fellow membership for benchmarking and managing performance expectations.

- Since bureaus have differing levels of governance capacities, there is need for continuous governance and leadership capacity building support and skilling at Bureau level. Support should be extended for standardisation of practices at the bureau level and as well, facilitate for functional, and gender inclusion in boards towards effective and efficient functionality of the same. Boards of the bureaus should be subjected to peer and internal critical reflection and performance evaluations. This should initially be externally led, but eventually could be handed over to internal teams to effect performance evaluations with respect to board functions as specified in terms of reference or appointment letters.
- It should become a practice that strategic plans are evaluated mid and when ending for all bureaus. Learning from strategic plan implementation should feed into and input into the new planning cycles.
- There should be greater gender inclusiveness in the composition of the Board. This should be well stated in the constitutions and board operations manuals. The Bureaus should consider including a gender inclusion clause in guidelines to board composition, and ensure that this is followed. Instances where these guidelines are already flexible and included should see this affected before the next board selection.
- All board charters and constitutions of Bureaus should reflect criteria for formation of board sub committees, their modalities of work. On the same note, the vision, mission and core values as laid out in the strategic plan should be translated into action through policies and procedures rather than being implied as has been the case
- There is need for a deliberate effort to document the history and formation of these Bureaus, and their roadmap to the present. Such documentation is important to understand not only the history, role played by the Bureaus but also to understand the likely possible shifts in visions, values and missions behind these establishments. This will further reinforce understanding in terms of the required areas of growth and possibly the reasons for continued existence as well as areas for further support.

- There is need to fund more AGMs by development partners but slowly graduate to a system where members can see the need to meet the expenses of the AGM. The secretariat should coordinate and ensure AGM happens. Only two Bureaus should be prioritized to benefit from this initiative namely UMMB and UOMB.
- Provide coaching to Boards in policy reviews and overseeing of policy management. Consultants and voluntary development partner organisations can be utilized for this task
- Board composition should cater for a broad variety of skills that are necessary to support and facilitate the bureaus to formulate and develop policies and execute their oversight roles over the bureaus.
- The status of the boards should be streamlined so that they are clearly under the founding bodies, for instance UPMB needs to re-consider its dual board status of board of trustees and NGO board, by dropping its NGO status. This is because having UPMB as a legal entity registered both as an NGO under NGO Act and under trusties incorporation act is not tenable in the long run.

4.1.3 Human resource for health

Bureaus were assessed based on human resource management parameters including existence and utilization of human resource management policies, existing staff capacities to effect the mandate of bureaus, employee performance management mechanisms from entry to exit.

Generally, all bureaus have relevant staffing to deliver on their mandate. The Executive Secretaries at the four Bureaus have relevant qualifications and experience; all of them have medical professional background as well as additional postgraduate qualifications. UPMB and UCMB were noted to exceptionally employ a caliber of competent professional personnel for instance various staff in program management and finance management hold professional qualifications with vast and relevant experience in their respective professions. The ICT team at UCMB is exceptionally positioned to see the organization deliver high-end IT solutions to the

membership but also lead other bureaus in use of information technology in health service delivery. Some exceptions exist though, for instance both UMMB and UOMB have serious staffing deficiencies to deliver on their mandate. In terms of staffing norms, we found that the UCMB and the UPMB have almost all the staffing positions filled up. However, it was noted that of the 21 established positions at UMMB only 7 are filled, leaving a gap of 14 staff. The UOMB has for a long time been operating under one official staff, the executive secretary, and others were volunteers from the host Hospital (Holy Cross Missionary Hospital, Namungoona). However, UOMB has just recruited seven new employees leaving a gap of another five staff to get all the staffing positions filled out. Understaffing has conflicted with staff annual leave at UMMB whereby each department has one staff, making it practically impossible to take leave and have the department continue to offer support function at the same time.

UMMB and UOMB do not consistently keep updated files of staff, including planning, recruiting, performance management tools like appraisal reports as well as exit processes. The staff filing system at UPMB is still a good example of a well-documented process with relevant paper trail in place. This is not surprising because where this would be comparatively practiced (UCMB) has no operational human resource unit. At UCMB, the office of Executive Secretary directly handles human resource issues together with the secretariat of the UEC, the employer of all staff at UCMB.

Due to the matrix nature of bureaus, it is not uncommon to find some staff involved in both b**ureau and religious foundation body's work.** This causes increased workload and staff inefficiencies. At UCMB, the accountants are for instance shared with wider episcopal conference while at UOMB; the Executive Secretary is also a mother and child nutrition specialist with Holy Cross missionary Hospital, Namungoona. This does not happen at UPMB or UMMB as their staffs are separated from the church and the Muslim supreme council activities, respectively.

All Bureaus have most guiding policy documents for instance; the human resource manuals which detail the basic human resource management guidelines, at the minimum. UOMB is exceptional given that the human resource manual is still a draft. While one might not find full documentation of human resource processes, there are some good practices in the different Bureaus. We find that UOMB, advertises for the available jobs on their website, while UPMB and UCMB post available jobs through their networks and newspapers. All the organizations keep records of processes of recruitment though there are areas of records keeping that need improvement.

Some Bureaus have adopted the human resource management information systems (iHRMIS Manage) where all human resource management processes are entered and analyzed. This has been implemented with UPMB and UCMB, however for UMMB they only access the server that is hosted by the Ministry of Health. Due to the low capacity of the server, connectivity issues as well as the low human capacity at the Bureau, this service is intermittently available for use. Even though with challenges, UPMB has the best case where this workforce planning and management tool has been implemented and can be scaled up. In fact, some UPMB member facilities (Kuluva and Mengo hospital) are already using this iHRMIS management tool. The paper based management system is still predominant in all the Bureaus, and in many instances insufficient as well.

The Bureaus have fair staff retention policies. Apart from push factors like low pay, staff retention at Bureau level is moderate, with most senior positions filled by people that have risen through the levels. The executive secretary of UCMB was the former Deputy Executive Secretary; the executive secretary of UPMB has worked with member health facilities of UPMB before joining UPMB at a senior level. However this policy of retention does not give chance to fresh energetic and differently experienced individuals, something that affects the innovation potential of the bureaus. There is a missing link in terms of talent promotion and talent management, which can become an issue, especially for long serving staff. The issue of not having adequate financial resources to position the bureaus as an attractive workplace for

young, qualified employees therefore becomes critical[6]. The staff attrition is caused by lower pay in some Bureaus, compared to environments where there is higher pay like in government hospitals and umbrella professional medical associations. UPMB however pays a competitive salary backed by a recently self-conducted salary survey. We find a comparatively higher staff motivation in terms of remuneration at the bureau level than at health facility level.

Medical bureaus are also known for scholarships and other study opportunities that they provide to their staff. UPMB and UCMB through the joint ownership of Joint Medical stores make some profit, part of which is channeled to staff career advancement. However, for UCMB, few staff had benefited since 2006, with most of this funding going for health facility staff. Other incentives include paid and unpaid study leave during school and exams, in-house staff trainings as well as flexible work hours. The scholarship scheme is however not yet pronounced in UOMB career enhancement schemes.

Recommendations

- Bureaus should plan ahead for staff capacity development. A capacity building plan should be developed with areas of need by the bureau staff, for instance the staff training needs that were identified during this assessment include project planning and management, human resource management, finance management, drugs and medical stores management
- There is need to streamline the staff appraisal system to match with staff development
- UCMB should review the staffing structure of the organisation, to ensure that all staff are accountable and adequate. Services of an external consultant should be sought with caution that the structure fits within the overall UEC establishment.
- There are key positions that should be filled whenever an opportunity appears within the structure of the Bureaus. Such positions include advocacy and

[6] Daniel Fries (2017). UCMB Report on Global Health Sector Challenges and Opportunities in a complex dynamic environment

partnership specialist, communications specialist, human resource manager, resource mobilization specialist, ICT support specialist.

- The Bureau IT staff should undertake trainings as Trainer of Trainers to rollout the human resource information systems. This could be handled together with the installation of adequate computers and servers at respective Bureaus. UPMB may take up a leadership role to roll this strategy to ensure that other Bureaus effectively pass on this technical capacity to health centres since its technical capacity to handle the matter is good.
- The board human resource committee should be trained on contemporary human resource practices

4.1.4 Health financing, finance and procurement management

The bureaus were assessed based on parameters like financing mechanisms like finance management, income generation, competence of finance staff, mechanisms to ensure financial transparency and compliance with statutory requirements and procurement standards. The parameters for procurement capacity include; availability of guidelines for procurement management, inventory and stock management at bureau level while those for financial management includes mechanisms to ensure value for money for instance availability of appropriate controls.

Generally, funding for bureau operations comes from external financiers, with a minimal percentage coming from subscription fees, government subsidy (PHC fund) and private income generating activities. Success in financing depends on already existing profile for the bureau, capacity of existing staff to put bids together as well as availability of a fundraising strategy that guides resource mobilization and allocation. The available financing options have been declining in the past decades, with donors becoming more stringent with a declining size of offer. For instance, **UPMB's share of donation income for recurrent operations has reduced from 22% to**

20% from 2011 to 2015 in hospitals, from 32% to 24.6% from 2014 to 2015 in health centre IVs and from 41% to 22% from 2014 to 2015 in lower level health units (UPMB annual report, 2014-2015). All member facilities of medical bureaus pay subscription fees, a measure that has become a requirement for accreditation. This has become a sure source of income for all Bureaus except in UOMB where affiliate members do not pay subscription fees and there are no strict payment enforcement mechanisms.

UPMB and UCMB established the Joint Medical Stores (JMS) that procures, warehouses and distributes quality medical supplies to both bureau and non-bureau PNFPs facilities[7]. JMS also sells to the general health sector and does business with donor entities like USAID. The profit from this entity is a source of income for the owners and is used to fund respective bureau work plans. This together with other externally sourced income makes the financial base that finance part of the health facility requirements. More than 70% of Bureau income in 2015/2016 FY was wired to health facility programs while the rest were used to finance secretariat recurrent expenditures.

The bureaus work to strengthen the financial management capacity of member facilities. They have assisted some facilities to install software for financial management. Moreover, some have adopted PASTEL, while others like St Francis Naggalama Hospital have shifted to NAVISION accounting software. Many facilities have not appreciated the value of investing in accounting softwares, while others have no technical competence to run them. Bureaus themselves have installed financial management software**'s**, for instance UCMB and UPMB use NAVISION and Quick Books respectively. Much as the software usage has additional internal control advantages including making and producing of swift accounting reports, bureaus have not fully shifted to the software but do keep an alternative accounting system as hard copy files. Both UMMB and UOMB do not use any accounting software. Both

[7] UCMB and UPMB own 50:50 percent share of JMS

UPMB and UCMB have well trained accounting personnel with advanced and professional accountancy qualification that not only ensure quality book keeping at bureau level but also pass on the skills to their respective health facilities through training and mentoring. Through ICT innovations, the bureaus have for instance increased trust in health services by introducing e-invoice and e-receipt system in some health facilities (for instance in Kibuli Muslim Hospital). The financial innovations and management in UOMB and UMMB is still limited and wanting as both depend on either shared accountant or a cashier (UOMB) with little or unrestrictive internal controls at secretariat level. At higher level we find stricter controls with the executive secretary being the only signatory of the bureau bank account (from management side) for instance, whereby the secretary general signs with the executive secretary of UCMB and UMMB for financial transactions. Both UPMB and UCMB have an audit department that reports directly to the Board finance committee. All bureaus engage the services of a competent audit firm that is hired for a specific period of time to audit the books of accounts.

Member health facilities have majority of in-charges as members of religious congregations who have minimal training in financial management. This makes funds advanced to them difficult to spend as per acceptable guidelines, which eventually becomes a bureau issue if the funds are channeled through the same.

Due to established systems, all the bureaus are compliant with statutory deductions including for instance staff income tax, employee contribution to staff pension (NSSF). These have put the bureaus in a good position for partnerships as less-risky partners.

All bureaus have procurement and financial manuals, apart from UOMB where it is still in draft form. At both UCMB and UPMB, a procurement officer is hired to ensure compliance with the regulations, among other duties. Procurement of supplies is done as per standard guidelines. UMMB, UPMB and UCMB for instance have pre-qualified suppliers list, which allows for multiple or single source supplier selection

methods depending on the value and quality specifications in the transaction. Depending on the size of transaction, the procurement committee is constituted to ensure value for money. In some instances Bureaus use their own procedures and networks to assist health centres acquire medical supplies from Kampala or abroad. All Bureaus employ a stores and supplies personnel who manages goods and supplies of the bureaus. For UMMB, the stores assistant had not attended any relevant training in procurement and stores management.

Recommendations

- The bureaus should build the capacities of health facilities for results based financing being piloted by the Ministry of Health. This entails the strengthening of financial management systems, matching expenditure with scope of work and ensuring that health facility or bureau funding mechanism is based on level of work.
- There is need for capacity building in financial management at facility level. An assessment of the financial management capacities could form the starting point. UMMB and UOMB need to adopt and utilise financial accounting softwares, recruit chartered accountants and procurement professionals in order to perform the accounting and procurement functions efficiently and effectively. All the bureaus should embark on a creative resource mobilisation strategy that maximizes both traditional and local sources of funding including investments, and locally owned health insurance schemes.
- There is need to undertake resource mobilisation strategizing and as well build the capacities of key Bureau staff to under go training and at the same support efforts geared towards increasing the resource bases of the bureaus and their respective healthy facilities.
- The bureaus need to streamline their procurement processes by documenting the guidelines and translating them into practice for use by the procurement commitees.

- Bureaus should support their network facilities to continuously meet the requirements for PHC funding. This requires retooling them on reporting, drug and other supplies management.
- Train bureau management staff on PHC grant guidelines 2016/2017, to ensure that the recipients are acquainted with the guidelines.
- There is need for continous coaching, mentoring and supervision of the health facilities, mainly in financial management and book keeping. The bureaus, notably UOMB that do not have financial guidelines and procedures in place need to set them up
- There is need for the bureaus to increase the financing options available to them to include for example franchises, Development Credit Authority
- It is recommended that a PNFP health fund is set up, where all donors and grant givers can contribute to a basket fund to benefit and build the financial capacity of the bureaus. Other modes of raising finances could include through: social insurance contributions, private insurance premiums, community based financing, employer based schemes, voluntary health schemes, solidarity funds, and develooing of pre-paid systems.

4.1.5 Quality of health services

The performance of the Bureaus was assessed according to how they provide quality health services as individual entities and through the health facilities they provide. Bureaus promote quality service delivery through capacity building initiatives by promoting clean environments, error free drug prescriptions, timely reporting of quality data and enforcing quality improvement methodologies in the management of health facilities.

The bureaus are involved in a continuous process of accreditation of health facilities. The bureaus have developed self-evaluation tools that assist facilities gauge their performance with respect to accreditation criteria. The accreditation processes checks for compliance with clinical guidelines by clinicians, assurance of patient safety and

availability of essential drugs at facilities in time. The bureaus also ensure that government quality enhancing mechanisms for health units are understood and implemented at all levels. The bureaus for instance are cascading the health sector quality improvement framework (2016-2020), the Self-regulatory Quality Improvement System (SQIS) guidelines through formation and training of Quality Improvement Teams (QIT) at health facility level and providing relevant tools that help health facilities assess own quality. To ensure that services offered reach the poor, the Bureaus have advocated for fair services and in some instances provided guidelines for drafting user-fees.[8]

The bureaus rely on regional coordinators at dioceses and district levels for coordination. These coordinators spare part of their time to work with these facilities but are otherwise employed elsewhere. They are facilitated with vehicles, fuel and sometimes motorcycles to do coordination. However there is no direct line of accountability between the coordinators and respective bureaus, but rather work closely with the respective dioceses or Muslim districts.

The bureaus do train health facilities on data quality. However, data quality management capacity at UMMB and UPMB is still lacking and wanting. There is no real time collection of strategic information for routine use. One of the major challenges is the poor reporting and non-inclusion of data from private sector health facilities in the National HMIS. As a result their contribution to the sector outputs and outcomes often miss out.[9]

While other bureaus do it irregularly, UCMB supports network facilities to conduct annual patient experience and satisfaction surveys. Information is collected from first-time and frequent patients to assess unit customer care, cleanliness of

[8] UPMB developed guidelines for charging user fees in PNFP health facilities (2009). It stipulates the rates to charge and circumstances where a charge is not advised
[9] MOH.2016. Health Sector Development Plan 2015/16-2019/20

environment, patient involvement in determining solutions and waiting time among others. On the same note medical students in PNFP health training institutions are asked to provide feedback on quality of the training using forms developed by the Bureaus. Feedback from such surveys help to improve the quality of care at health facilities and training institutions.

Due to the significant proportion of PNFPs in Uganda, Ministry of Health relies on Uganda Bureau of Statistics (UBOS) to capture overall healthcare performance. The bureaus also regularly shares reports, write ups and data to feed in periodic national reports and database including its best practices that further promote quality in affiliate health facilities but nationally as well. Bureau technicians have become part of Ministry of Health working groups that develop quality assurance tools and validate them. All the Bureau secretaries are part of a working group at the ministry of health and are regularly consulted when drafting policies and health sector guidelines. The Ministry of Health however, has had its management information system regularly updated and improved thus calling for regular training of staff on the latest improvements in the use of the system including tools used in that effect. There are also various data capture tools on the market which are used by the different facilities to collect and analyze different information. It has been the wok of these Bureaus to harmonize these tools and ensure that information collected is usable. The ICT and Monitoring units at UCMB has worked with health units to ensure harmonized tools across board. It has not become possible due to varied internal capacities, different levels of services delivered.

All the bureaus do not have a clear strategy for branding and communication, but do utilize various communication channels and other ad-hoc branding mechanisms. All facilities have online presence apart from UMMB which only runs a Facebook account where it posts ongoing interventions, procurement communications. The various channels include websites, Whatsapp, U-tube and twitter. The information shared in

these channels is generally irregular and uncoordinated implying the need for a more focused media strategy.

The UPMB and UCMB regularly conduct knowledge sharing workshops where health facilities and other partners on similar projects meet to share experiences and learn from each other. Due to the slim number and size of projects at UMMB and UOMB, this has not regularly happened. The partners of UPMB NESH program for instance have quarterly review meetings that are coordinated by UPMB.

Recommendations

- In addition to accreditation, the bureaus should explore possibilities to adopt relative measures of facility performance that allows facilities to belong to laddered performance levels.[10] This should promote competition among health facilities, allow low performing bureaus to measure progress and eventually increase bureau visibility and national rating.
- More staff at bureau level should be trained as trainers in private sector SQIS and Health Sector Quality Improvement Framework. In addition, there should be training of stores and logistics personnel in managing medical inventory.
- The bureaus should develop a robust communication and branding strategy. This initiative should build on existing brands, communication mechanisms and calendars of events at Bureau and Health Facility levels.
- There should be strengthened regional coordination by assisting regional coordinators plan for routine monitoring visits to facilities. To facilitate this, the coordinators should be included in bureau budgeting as beneficiaries and not volunteers even when there are active large programs.
- Review **coordinator's performance in** periodic peer or client reviews
- As quality criteria, all bureaus should invest in monitoring service delivery with respect to indicators of Quality, Efficiency and Equity. This is already being done

[10] This should be color coded or with symbols reflecting performance of a certain standard.

at UCMB, though **the criteria are not equally weighed. However, UCMB's practic**e should serve as the starting point for benchmark by others.

- Regularize patient experience and satisfaction surveys at the facility level. Results from these surveys should inform capacity development plans for health facilities to be implemented by the Bureaus or included as quality improvement projects
- Promote centres of excellence and use them as training platforms at regional level. These centres should help in the capture of case histories, document success stories and extend remote training through modularized online training resources for health facility and health training institution managers.
- Strengthen data reliability, demand and use in health facilities. This will be through training and retraining of data managers at health units and district level
- In consultation with regional coordinators, health facilities should press orders for drug supply requirements to the JMS so that supply is matched on expressed need rather than supply of a uniform package of drugs to all facilities without due consideration on need and demand.
- Promote frequent information and knowledge sharing events for all Bureaus as part of mentorship and capacity building support. Themes for these events should be discussed ahead to ensure that they capture pertinent issues in service quality.

4.1.6 Assets and infrastructure for health

Performance was assessed according to availability and ownership of essential assets and infrastructure, and how the assets are being managed. We find that all bureaus have deficiencies in number and capacity of vehicle fleet for operations and monitoring. UCMB which has the largest number of health facilities has 10 cars, seven of which are in good condition. UPMB, in the second position with five full time vehicles. UMMB has one vehicle that has frequent breakage issues while UOMB is in

final stages of acquiring a donated refurbished vehicle. There is generally a transportation/vehicle fleet constraint which makes it expensive in the long run, otherwise the bureaus have to either incur borrowing costs or postpone key activities in peak times.

While some bureaus have an asset management procedures manual in place, others like UCMB do not have a clear policy on asset disposal. This is probably why some of their vehicles have reportedly worked beyond their useful life. At UPMB, a policy exists that allows for disposal of assets when there is need. All UPMB vehicles are for instance comprehensively insured and have security tracking systems installed. UPMB has insurance brokers that ensures regular insurance of their assets and assist in preparing claims should there be challenges or accident. All the bureaus have engraved their assets and do keep asset registers despite the fact that some of the registers do not capture essential details. At UPMB the asset registers are detailed and complete while UMMB keeps basic asset registers which are lacking in dimensions like serial numbers (where applicable), asset value and date of approval of the registers. UCMB did not have an updated asset register or unpublished asset survey at the time of this assessment.

The bureaus assets are generally secured. The UCMB and UOMB institutional hosts provide all time manned security while UPMB hires the services of reputable private security firm for 24 hour surveillance of the office. Much as the security at UMMB is provided by the landlord, the availability of many informal shops and offices in the vicinity compromises the security during day or night.

The UMMB and UOMB lack adequate computers for staff use, which creates a conditions of sharing computers. Computer sharing is an issue for example for the human resource officer who shares computer with the program staff containing some confidential staff records. All the bureaus lack good quality furniture for both common places and offices. It is only UPMB that has a well-furnished board room for

both staff and other meetings, but also lacking strong furniture for the rest of the offices.

All the bureaus are located within or in the vicinity of founding religious secretariats. UMMB is found in the building belonging to UMSC, UPMB is on its own premises but in proximity to the Church of Uganda's secretariat. The UOMB is housed in a hospital environment belonging to the Orthodox Church, while UCMB is housed in the Uganda Catholic secretariat. In all bureaus, only UMMB is paying monthly rental fees but still has compromised premises traversing a noisy business parlor, and in a semi-finished cubicle. UMMB does not have parking space while there is shared parking space at UOMB and UCMB. UPMB has its own parking space but can only hold a few vehicles at a time.

All bureaus are located in Kampala (Capital city) where there is good internet, road access and mobile network coverage. All bureaus have installed and have functioning office telephone handsets, apart from UMMB whose handset has not been functioning. At UPMB and UMMB, intercom is installed that allows for efficient inter-departmental communication. Other social amenities like water are available on site, for instance all bureaus have main power grid electricity and running water apart from UMMB where toilets are not yet fitted with running water. All the bureaus do not have adequate storage space. UCMB premises looks an expanse office space but due to the nature and scope of activities, their supplies are quiet often stored outside the secretariat in hired containers due to space issues in the secretariat. UPMB is hosted on an improved estate previously not meant for office but turned into one through reworking and refurbishing of the asbestos houses and adding in a few containers to serve as temporary offices. There is visibly no space for storage at UOMB, UPMB and UCMB premises.

Recommendations

- Bureaus should fundraise to build their own and more expansive premises. No bureau at the moment can comfortably accommodate more staffing or storage of its assets and supplies given the shortage of space at current premises. It is recommended that the shifting by the bureaus should only be to strategic locations like their current locations, not detached from their foundation bodies. Bureau management should thus try option of discussing with founding religious bodies to allocate land for office construction.
- In the short run, it is important that the donor community and development partners continue contributing to Bureaus office space, where it has been the case.
- Bureaus should keep updated asset registers. These registers should separate out what is owned, shared and or borrowed assets by the bureaus. These registers should be approved together during the AGM business agenda.
- Asset disposal guidelines should be developed or reviewed to allow for disposal of old assets before they become costly to the bureaus in the long run.
- All bureaus should install a standby generator or solar system to ensure all day power availability.
- The Bureaus ought to acquire and adapt to more universal assets management guidelines to avoid conflict with various donor requirements. Asset management manuals should be updated and adhered to
- There is need to support the Bureaus with at least one extra 4 x 4 wheel vehicle to support the supervision of health facilities. These vehicles should be branded and comprehensively insured.
- Bureaus that require furniture, computers should table their request for in-kind contribution from ending USAID funded or other similar programs. The Cardno PHS programme could coordinate such an arrangement, by making recommendations on where assets can be acquired.

4.1.7 Health coordination and partnership

Coordination and partnership building are an essential aspect of health leadership. Moreover, leveraging resources existing in the organizations is a key governance function. Coordination thus enables access to resources in the organizational environment that individual organizations do not have or have less, which reduces their uncertainty and strengthens their ability to achieve their objectives.

The performance of the bureaus was assessed according to the ability to coordinate the work of member facilities, ensure information flow, advocate for PNFPs and represent them in different networks, ensure harmonized service delivery through setting and managing of partnerships among others.

Coordination for the bureaus is a critical aspect for building strategic partnerships and networks, resource mobilization, business development and shared learning. However findings from this assessment indicate that inter-bureau cooperation is rather lose only manifested in a coalition with no clear and sustainable structures. The bureaus have associated in a memorandum of understanding, whereby the relationship is about implementation of activities as per the MOU. However, the different activities in the memorandum of understanding are allocated to one bureau.

This coalition arrangement allows for cross-bureau learning and ensuring that individual entities perform as per their comparative advantages. Bureaus have in the past done joint technical supervision of health facilities as part of inter-learning. Despite the coalition not having immediate benefits; all the bureaus are apathetic about the would-be benefits of a deepened partnership (which would include a partnership fund as well). The bureaus are generally more concentrated on working with the current existing lose coalition. Some feel that the partnership fund would make some bureaus lose their niche as funding shifts from bureau level to the inter-bureau funding mechanism. However an argument is put that some catchment areas

are served by health facilities whose bureaus have not done well in fundraising and passing on proceeds to facilities thus making their patients bear the brunt.

In an inclusive healthcare system, all communities should equally benefit from both government and other development partner initiatives irrespective of their religious affiliations. According to Dr **Tom Tumwesigye, the Executive Director of UPMB, "***when* ***I fall sick or get unconscious, I'm rushed to a nearby facility whether private, not for*** *profit or religious***".** This means that all health facilities should get equal support irrespective of founding institution and that fundraising efforts should benefit all. This aside, there is visible inter-bureau competition for prominence that is at times played at the expense of victims of disease and pain down in the health facility or its catchment. There is therefore an urgent need for a clear framework through which the inter bureau cooperation can be developed and sustained, without jeopardizing the foundational niche of faith based health management frameworks. This should be done through a careful feasibility study conducted in a participatory manner in order to take care of the interests of the individual bureaus, and other faith based facilities outside the bureau network. At regional and district levels, interfaith meetings can be effected for coordination purposes among PNFPs, and as entities with a common goal.

There are some successful examples of partnerships for instance the Joint Medical Store partnership venture between UPMB and UCMB is a success story that has increased drug availability and access to affordable medical supplies. UCMB also partners with Uganda Martyrs University to provide governance and leadership training to health facility managers.

Bureau activities are planned and implemented through the respective Diocesan health boards or district coordination offices for Muslims. The boards appoint coordinators who ensure that facilities adhere to the expectations of respective bureaus and donors. Among others, the coordinators ensure that facilities operate

within the wider district health service through networking with district health focal point person. The coordinators are the first line recipients of capacity building that would go to health centres. As trainers of trainers, they pass on information to facilities through regular support visits.

These coordinators report to respective diocesan boards with dotted line accountability to the bureaus. However, we noted that these coordinators are generally overwhelmed with too much work that is in most cases poorly compensated.

Coordination with member facilities is mainly through communication channels like social media platforms like *whatsapp, facebook* and *twitte*r. Some bureaus like UPMB and UCMB have hosted individual facility email accounts which assist in quick communication including sharing of e-resources.

The bureaus are also members of health community working groups at the ministry of health and globally. They are active members of health policy working group of MOH. Both UCMB and UCMB are for instance members of African Christian Associations Platform (ACHAP), where UPMB is also a board member. ACHAP is an advocacy and networking forum for Christian health organisations and networks. UPMB is also a member of Christian connections for International Health (CCIH), a network organisation uniting organisations in global health interventions.

In all bureaus, the task of partnership and networking is solely vested in the office of Executive Secretary. This has limited their respective capacities to effectively create and nurture relationships, since this role has not been cascaded to other lower cadres or decentralized according to department.

Recommendations

- Strengthen the research components of all bureaus for informed advocacy efforts for PNFPs health service
- The bureaus should ensure that their strategic plans rhyme with facility plans. This can be achieved through bottom up planning processes where grassroot initiatives inform bureau resource mobilization and strategic planning, and harmonization of plans at local and Bureau level.
- Conduct a feasibility study on establishment of a joint support body for all bureau coordination
- Promote the establishment of an umbrella fundraising body for all bureaus to ensure fair access to resources for all people in need through the health centres country wide.
- The bureaus ought to build the capacity of district focal point persons to collect substantive information for advocacy. An advocacy desk should also be established at bureau secretariats.
- Bureaus should develop and implement advocacy, lobbying and networking strategies with streamlined mechanisms for cooperation to strengthen the existing relationships.
- The bureaus should conduct a capacity needs assessment for e-learning of the regional coordinators, and thereafter devise strategies to address the gaps.

4.2 Findings on Faith Based Health Facilities

This assessment covered 130 health facilities spread in 29 districts (i.e. 7 health centre IIs, 81 health centre IIIs, 11 health centre IVs, 31 hospitals)[11]. The largest numbers of health centers were from Wakiso, Luwero, Arua and Kampala where at least 10 facilities were selected (Annex 1).

[11] It should be noted that the seven health centre IIs was not included as part of the analysis. This study exclusively covers centre IIIs, IVs and Hospitals

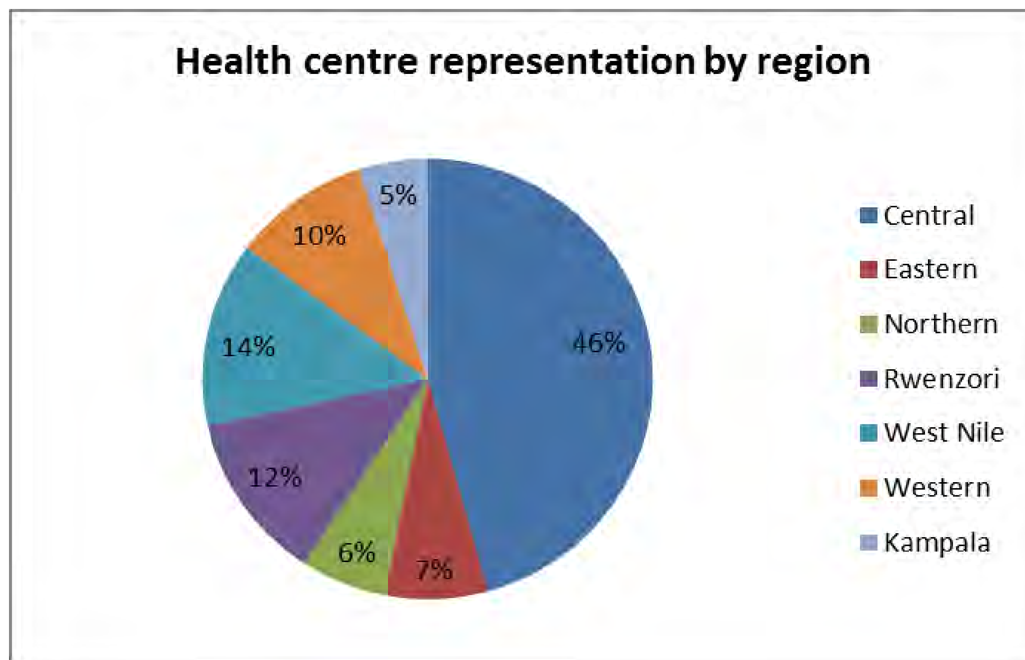
UCMB contributed the largest percentage of health Facilities (53%) while the least were from UOMB (4%). UCMB contributed the largest number of HCIIIs and Hospitals assessed as compared to other Bureaus, while UPMB contributed the largest number of HCIVs assessed (Table 1)

Table 1: Distribution of the assessed facilities by Medical Bureau

BUREAU	HCIII	HCIV	HOSPITAL	TOTAL	PERCENT
UCMB	48	3	14	65	52.8%
UMMB	13	1	4	18	14.6%
UOMB	3	1	1	5	4.1%
UPMB	17	6	12	35	28.5%
Total	81	11	31	123	100.0%

The region with the most number of health facilities assessed is central region (46%) while the least represented is Eastern region with only 7% representation of the health centers assessed (Figure 1).

Figure 1: Health center representation by region



While all health facilities under UCMB are owned by respective Trustees of the Catholic dioceses, some health centres under UPMB and UMMB are owned by individuals but affiliated to the church. For instance, both Oriajini hospital in Arua and Double Cure Medical Centre in Mpigi are owned by individuals but are affiliated to UPMB. Three of the UPMB facilities i.e. Kyetume HC III, Ishaka SDA hospital and Bugema University HCIII are founded by SDA church while Pentecostal Assemblies of God (PAG) HCIII Lira is founded by the born again church (Pentecostal church).

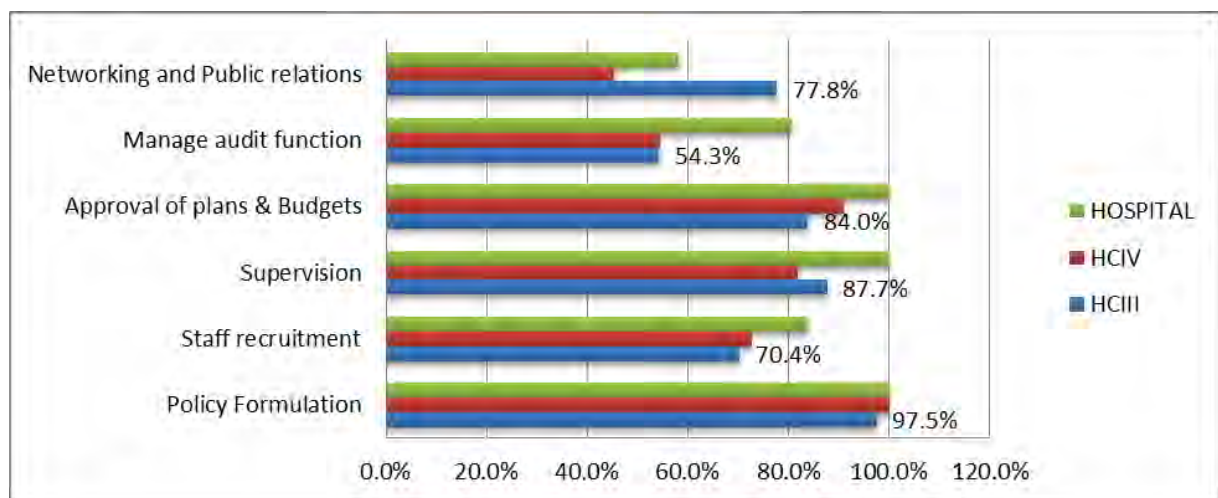
4.2.1 Governance and management of health facilities

The health facilities assessed are managed by medical personnel or members of religious congregation or a combination. Health facility governance is a responsibility of the board or Health Unit Management Committees (HUMCs). Hospitals and health centre IVs have boards while health centres IIIs are governed by health unit management committees[12]. These governing bodies monitor the general administration of hospitals and health centres, approve budgets ensuring that it reflect priority needs, monitor procurement, storage and utilisation of facility goods and services. All the health facilities visited had these boards/committees in place. All boards of HC IV and hospitals were meeting quarterly while only 12% of HUMCs were not routinely meeting on a quarterly basis (n=123). We find that 96 out of 123 boards or HUMCs have at least one sub-committee that is functional (Details in Annex 4).

It was also noted that most members of health facility boards were involved in policy formulation (121 out of 123), supervision (111 out of 123) and approval of budgets and plans (109 out of 123) (Figure 2). At hospital level, the board is more involved in policy guidance and ensuring value for money through supervision and budget control as seen from the graphs below.

[12] Boards and HUMC is used interchangeably in this report

Figure 2: Board involvement in core responsibilities



The boards and HUMCs have delineated roles that are different from those of management. In few health centres, like Boroboro HC III, medical staff decried of management committees to have taken up the roles of staff allocation and technical areas of facility management, the roles that would be suited for management. The HUMCs or boards generally lack basic knowledge on how to make policies and participate actively as a board member.

A total of 115 health facilities (93.5%) have operational licenses acquired from the relevant government authorities. Although it emerged that some health centre IIIs do not have operational licences from relevant government authorities, none of centre IVs and one hospital assessed did not have an operating license (See annex 4). It was also established that only 80% (n=123) of the health facilities have clear constitutions or other binding documentation for instance by-laws that provide for their existence and streamline the governance and structure of the healthy facilities (annex 4). The majority of those without constitution were from health centre III while two hospitals and one health centre IV did not have updated constitutions.

All health units perceive or have a clear process for election of board members with hospital process being clearer and well-articulated in the guidelines for formation of

hospital boards. Others have adapted the government guidelines on operation of HUMC and boards as main guidelines for governance. Of the 99 health units with constitution, 87 of them provide for gender inclusiveness on the board.

On the other hand, while boards for HC IVs and hospitals are selected through a clear process, the competence of HUMC to deliver on their function falls short of what is seen in the former. More than 90% of respondents in hospitals believe they have competent boards while 79% of HC III HUMC believes that their committees are competent to deliver on their tasks. It was reported by some of the respondents that in some of the medical facilities, personal confidants and relatives were elected on Boards, something that offends good governance principles.

All hospitals and HC IVs believe that their boards are a representative of key stakeholders while a slightly higher percentage of HC IIIs (82%) believe that the **HUMC's are** a representative of key stakeholder groups. However, the tendency to ensure gender inclusive policies diminishes from lower level units to the hospital level. However, the functionality of board or health unit management committees shows a reversed finding where hospitals have the highest performing committees as compared to lower level health units.

Accordingly 31% of the health centre committees are reportedly not functional at health centre IIIs level as compared to 3% at hospital level (Figure 3). There could thus be other parameters of performance other than having gender inclusive by-laws. Gender inclusiveness might not necessarily be the only intervention that can improve health outcomes but the competencies and the processes leading to the selection of representatives is paramount for boar performance.

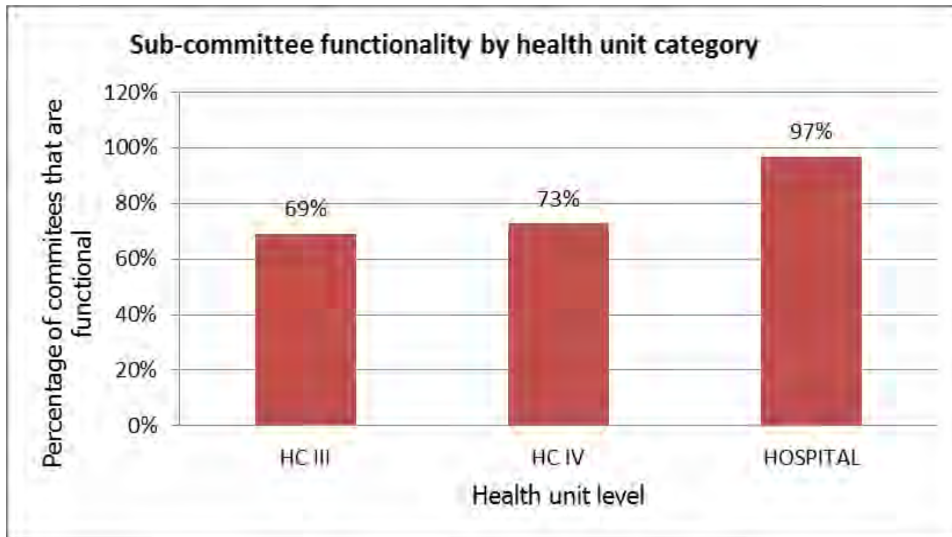


Figure 3: Sub-committee functionality of governing boards

Of the 123 health units assessed, 91 of them (74%) had strategic plans that guided resource allocation decisions. More hospitals than other levels have strategic plans (Figure 4). A higher number of health facilities had vision and mission statements but not a strategic plan. We see that those that had a strategic plan also had mission and vision statements and that the same proportion of facilities with strategic plan also had boards that understood the mission and vision statements. We thus affirm that having a plan or statements is not enough but there should be a process of orientation that encompass this. There is a positive correlation between the level of health facility and the understanding of the strategic plan including vision and mission statements, irrespective of whether the facility has a documented plan. Staff and Board at hospital and HCIV level do understand the provisions in the strategic plan and the process involved than those at HCIIIs.

Table 2: Health system level and understanding of facility mission

Level	Have strategic Plan	Understanding of Stategic plan
HC III	70.4%	85.2%
HC IV	63.6%	90.9%
HOSPITAL	87.1%	96.8%

Recommendations

- Strengthen governance at the facility level by training HUMCs on their roles and responsibilities and supervision of health facility operations.
- Board representatives should be trained in lobbying and advocacy as a means to enhance their advocacy roles.
- Advise facilities to reconstitute HUMCs after every 3 years. The next recruitment should ensure gender inclusiveness, involvement of prominent personnel in community, and inclusion of medical personnel
- Subject boards and HUMCs to performance reviews for improved decision making, efficiency and effectiveness in playing their roles and guiding the facilities.
- Health facilities should be provided with reading materials and guideline documents, including board charters and HUMC guidelines. The HUMC manuals should be translated in local languages and availed to committee members.
- HUMC should be offered experiential learning through exchange visits. They should also receive in-house training to broaden their leadership role and functionality.
- The health facilities ought be facilitated and supported to draft strategic plans. Given that some of the facilities have their mission and vision statements in place, it should be easier for them to articulate and develop plans to guide their operations. All health facilities should be supported and facilitated to develop institutional documents to enhance good governance documents including constitutions and by-laws.
- The HUMC structure ought to be operational and functional, thus PHC funds could be applied for and utilized to support the operation of these structures.
- There is need to facilitate and provide funds/resources to undertake board and HUMC evaluations.

- Health facilities should proactively make linkages with respective medical bureaus, the Ministry of Health, Parliament, and other advocacy organizations like UHF to lobby for inclusive Medicare care and resources.

4.2.2 Human resources for health facilities

Human resource for health in faith based facilities was assessed based on staff motivation, staffing levels, management systems, capacity development, qualifications of existing staff and their benefits.

Much as there are exceptional cases, health centres IIIs employ an average of one clinical officer, one registered nurse and mid-wife, two enrolled nurses and one assistant nurse, as well as a laboratory assistant. Specialist medical officers are employed in centre IVs and hospitals with hospitals employing an average of six (06) specialists while health centre IVs employ an average of one specialist. Only hospitals employ pharmacists (average of one pharmacist) while assistant Pharmacists are employed by both HCIVs and Hospitals. This means that drug dispensing and quality control is done by other cadres like clinical officers and nurses for HCIIIs (Table 4).

Contrary to the Ministry of Health policy guidelines on recommended staffing minimum and levels, there are various health centre IIIs that are not headed by a clinical officer- but are headed by a member of religious congregation or a higher level cadre like a specialist. 46 HCIIIs are headed by a clinical officer while 08 are headed by a medical or Nursing officer, while the rest of the 81 HCIIIs are headed by lower level cadres or administrators. **St Noah's Ark Health Centre** and Jinja Islamic Health Centre are HCIIIs with a specialist medical officer as the incharge. Much as this is commendable for providing specialized services, these health units should graduate to HCIVs or hospital status to fairly accommodate and compensate these medical cadres.

Table 4: Human resource staffing levels (average) in the facilities[13]

Cadre	HC III	HC IV	HOSPITAL
Specialist	0	1	6
Medical Officer	0	2	6
Clinical Officer	1	3	7
Registered Mid Wife	1	2	7
Registered Nurse	1	2	11
Enrolled Midwife	1	2	17
Enrolled Nurse	2	9	29
Assistant Nurse	1	5	7
Counselor	1	1	3
Laboratory Technician	0	2	6
Laboratory Assistant	1	2	6
Pharmacist	0	0	1
Assistant Pharmacist	0	1	2

Most faith based facilities have adopted human resource practices as prescribed by the respective medical bureaus. As such, they keep copies of bureau supplied human resource guidelines which they have adopted to guide their operations. Of the 123 health facilities assessed, 95 (77%) have human resource management guidelines. Health centre IIIs experienced the highest proportion of health units without human resource management guidelines (31%), compared to 19% and 3% for HC IVs and hospitals respectively. These policies guide staff recruitment, remuneration, retention, development, discipline and other human resource related decisions. While 84% of assessed facilities had a system of structured salaries in place, they were rarely utilized for making human resource acquisition and development decisions. Staff remunerations are largely dependent on their negotiation success especially at

[13] Refer to Annex 4 for details on the total number employed per facility, the total number of established posts per cadre, the number of staff in service/employed and the unoccupied positions per cadre

entry stage. According to the in charge sister at one UCMB health, staff pay is pre-determined, although allowances are subjective and depend on the staff performance and also the discretion of the in-charge**.** "Remuneration is based on my discretion, and those I consider to be contributing more get paid an allowance which I determine." Says the facility in-charge. Such instances demotivate other staff members who feel that their remuneration cannot be planned for and predicted compared to their counterparts in more setups where policies rule on staff remuneration. Despite this selective practice of rewarding highly performing staff in some facilities, most facilities (59%) had documented procedures on rewarding and sanctioning of performers and underperformers, respectively. However, some realities and practices made sense and were understandable to staff about selective rewards for better performers irrespective of their positions. This was common in health centre IIIs, where mid-wives were considered a critical and essential staff and could bargain their way and in some instances get paid better salaries than clinical officers or in charge officers.

Eighty nine percent (89%) of facilities keep staff files with up to date data on staff contracts for full-time and casual laborers. The contracts either have embedded job descriptions or these are annexed as part of a full contract. Some of the health facilities are managed through the respective Bureaus or larger facilities, who keep the records for human resources. St. Luke Kkonge under UCMB is one example where all staff are posted from Nsambya Hospital with all health facility staff files retained at Nsambya Hospital. Such situations puts health units at ease not to tackle any benefits or staff sanctions including staff performance management since the health unit has no capacity to make such decisions and staff are only posted there.

There are also special instances where the health facilities do not keep records for human resources due to special and or unclear reasons, for instance All Saints HC III Kagoma in Jinja is managed by a man and his wife as the key employees and managers of the facility. They do not see reason to keep records on themselves. On the other hand, 35% (n=123) of health facilities assessed keep human resource data

online or use digital platforms like computers where human resource related files are kept.

Most health facilities employ professional people as per their statutory requirements. The medical personnel regularly get licensed by respective bodies depending on the cadre of staff. Only 2 assessed facilities had staff whose personnel were not regularly licensed, and these include Kyatiri Health Centre (Masindi district) and Benedict Medical Centre IV (Kampala).

The health facilities offer various levels of career advancement opportunities ranging from long term scholarships to few day trainings and workshops. These have improved staff capacity and retention. For example, 64% of health facilities have plans and schedules for continuous medical education. Overall, hospitals were seen to have more career opportunities for their staff with 50% of hospitals which participated in the assessment having such opportunities for staff. Most of the facilities that offered career advancement opportunities (81%) sent them for workshops and seminars ranging from few days to many weeks. Health centre IIIs are at the bottom of pyramid regarding offer of such opportunities to staff, with only 37% of them reported having career advancement opportunities. The most common opportunity is sponsorship for workshops followed by unpaid study leave (Figure 8).

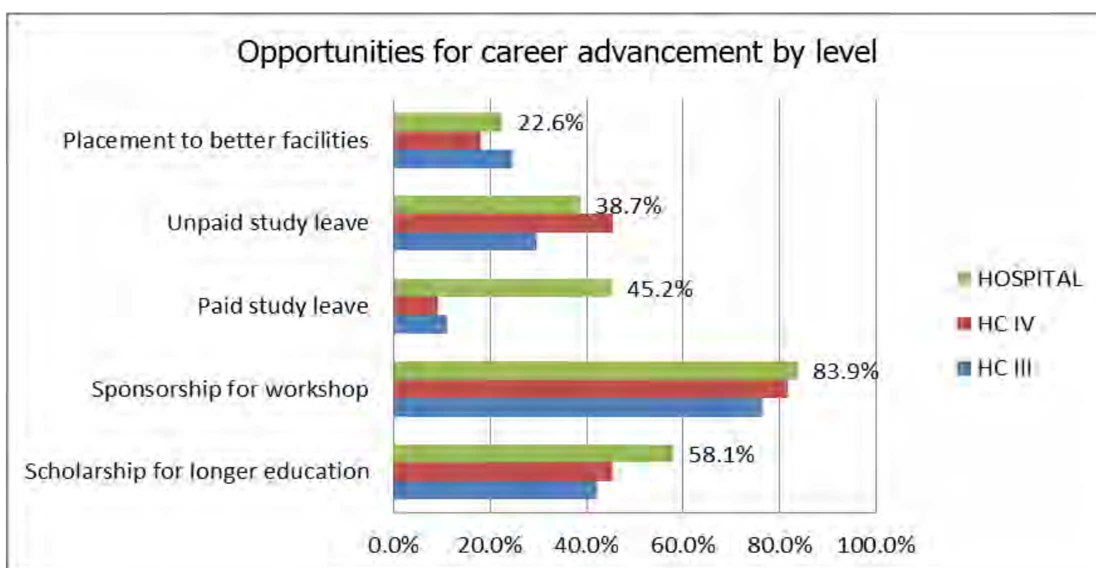


Figure 8 : Opportunities for career advancement

UMMB has the largest proportion of assessed health facilities (72%) with staff continous development plans, followed by UPMB at 71%[14] (Figure 9). These plans are realised through trainings and workshops as well as search for partners that support staff capacity development. Many facilities rely on the Bureaus for career development opportunities, but there are also other opportunities provided by the government and other organisations from which the staff can tap into. Some health facilities also felt that support from the Bureaus towards staff capacity development has unclear guidelines. However, there is evidence of staff expressing interest to benefit from scholarship committees at both UCMB and UPMB just line their counterparts at health facilities continually do.

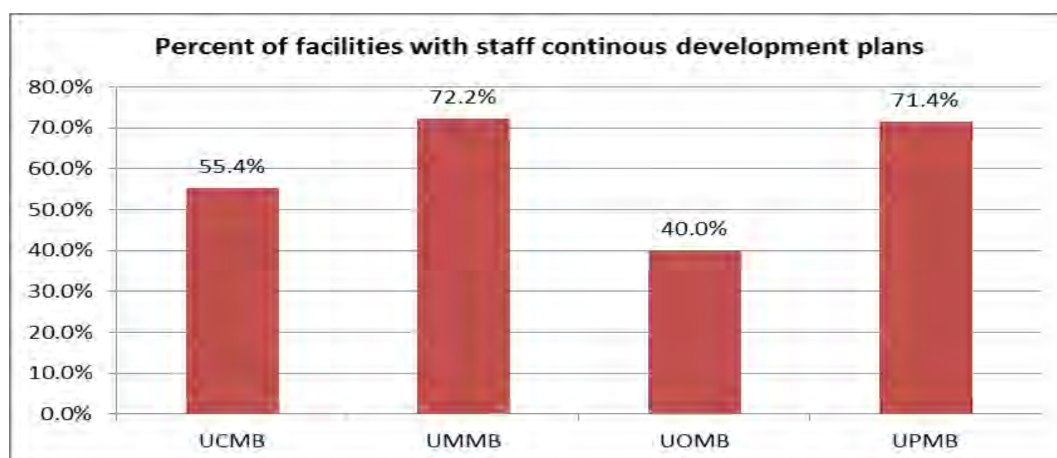


Figure 7 : Staff continous development planning

All staff are entitled to leave from duty, much as it was not a practice in some health facilities that were assessed. Most departments are run by one or few staffs, so it is difficult for such a staff to go on leave when there is no substitute or somebody to stand in. However, we note that 90% of health facilities have provisions for staff leave much as its often deffered due to lack of complementary staff due to

[14] This figure does not consider which facilities or at what level.

understaffing. In some facilities like Holy Cross Orthodox Hospital, staff leave is mandatory to allow for rejuvination and as a statutory requirement.

Housing for staff is provided by most facilities (82.9%) as most health facilities have extra housing, in most cases being provided for by the church or muslim district structures. This is an incentive for medical personnel, but also an assurance to clients that personnel are available for service at the facility in cases of emergency and when they are needed. However these staffing units are not available to all staff and sometimes key staff miss out on such benefits since the long serving staff at times already occupy these houses.

Despite this and other motivational factors, faith based health facilities assessed experience remarkably high staff turn-over reportedly due to poor and stagnant pay across the facilities.

Recommendations

- Support should further be given for the development and review of human resource manuals of the different health units. This review should ensure compliance with national guidelines and ensure they capture health centre specific circumstances
- There is need to second specialist medical practitioners in the fields of Opthalmology, ENT, Radiology, Orthopaedic to health facilities for improved service delivery. This will also mean that the respective facilities should prepare to meet extra allowance for these specialists.
- The health medical facilities should be supported to come up with a volunteer program that attracts retired medical practitioners from within and outside Uganda. These could be in the specified fields within the different facilities given the staff shortages therein.
- Health facility focal persons for human resource management should be trained in iHRIS software as well as protocols for record keeping.

- Health facility managers should be facilited to go for refresher courses and training in staff motivation and general staff perfrmance management to appreciate the role of remuneration and implement a functioning reward system for efficient performance by the facilities.

- Staff should have continuous professional development so as to further their careers in line with their job requirements and keep up to date with innovations in the health sector.
- Staff housing should be improved through increasing the number of available staff quarters and or refurbishing the existing ones. Staff houses should be tagged to staff roles in the facility, while the other criteria could be secondary.
- Apart from human resource policies in place, facilities should further develop recruitment tools, plans and placement guidelines.

4.2.3 Health financing, finance and Procurement management

The financing of health facilities is essential for their sustainability. This study assessed financing based on sources of financing, resource mobilization strategies, documented financial health. Financial management was also assessed based on the capacity to handle expenditure and existence of income generation activities, availability of financial systems and controls and compliance to mandatory financial and procurement regulations.

Due to their religious affiliations, the faith-based health facilities have not found it easy to adjust user-fees or get involved in shrewd income generating activities. Moreover, 57% of the health units assessed have documented user fee guidelines for the clients and such notices are displayed on noticeboards. There are efforts to develop and circulate user fee charging guidelines, particularly so with UPMB and the respective health facilities which are adopting the same.

Over 55% of the facilities assessed relied on donors as an option for financing. Donations take the form of cash, medical equipment and supplies like vehicles and medicines. Other sources of financing include user fees (over 80% of facilities),

government subsidy in form of Primary Health Care fund (over 40% of facilities). Other least prominent mechanisms of financing include; involvement in business ventures, loan acquisition, insurance schemes and voucher scheme (Figure 8 below). Of these options, user fees remain the highest source of financing (about 79% of the assessed health centers), this is followed by donors funding which benefits about 12% of facilities. Health centre IVs take the largest dependency on donor funds with 18% of them reporting it as largest source of income compared to their counterpart HCIIIs at 12% and 10% (by the hospitals) respectively.

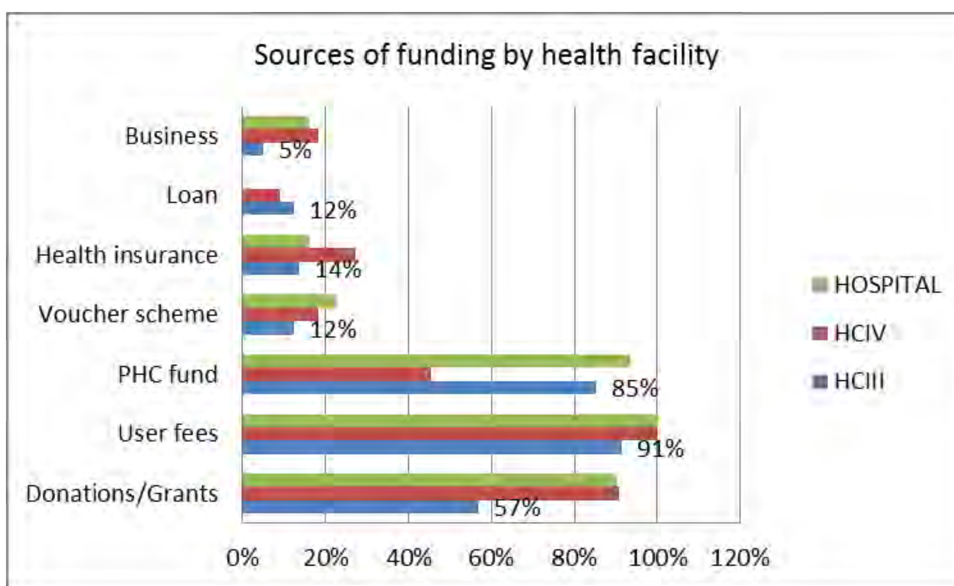


Figure 8: Sources of funding by the health facilities

Much as insurance and loan schemes have not been significantly adopted, they are very promising avenues for facility financial sustainability if well managed. Kitanga Health Facility (UCMB) has for instance cultivated a relationship with a prominent Rukiga SACCO with whom they also share an administration block. They have borrowed money from this SACCO to install a water tank and acquire solar power, while paying the installments at flexible rates. The Bitooma Health Centre (which is under UCMB) has acquired a loan from a village SACCO to acquire two motorcycles which assist in facility operations. The user fees have been used to repay the loan to the SACCO. This has been a successful strategy for this Bitooma Health facility,

compared to if the facility opted to wait and accumulate the money for buying the motorcycles. Service user fees thus provide unlimited financing capabilities to the healthy facility including enabling the ability to pay recurrent expenditures and salaries of staff. However, facilities that do not charge user fees like Good Shepherd-Kisenyi (Health Centre II) still find growth a challenge meeting their recurrent needs despite being routed in the spirit of serving the vulnerable.

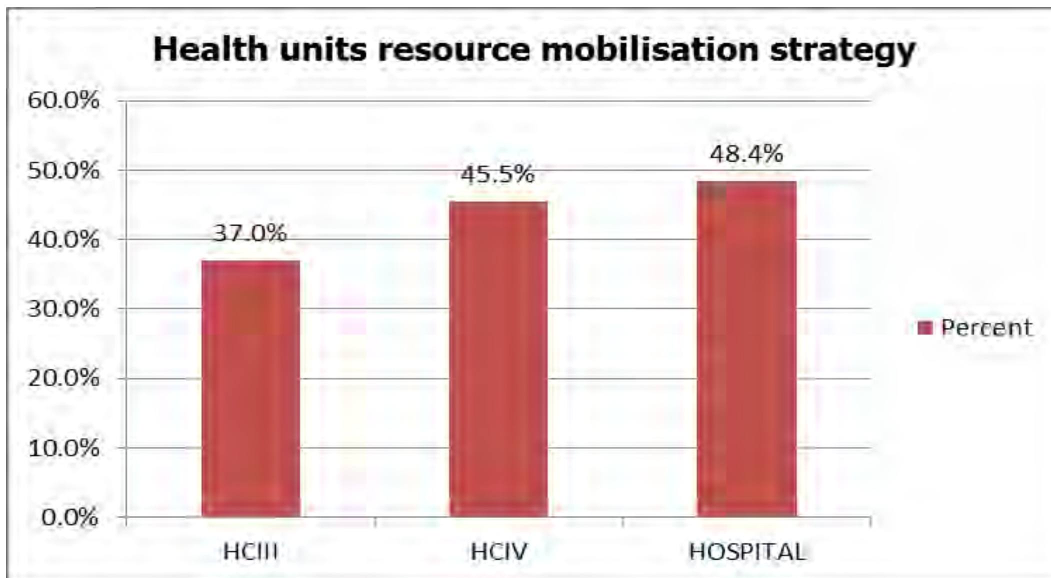
Some facilities have devised health insurance packages for the vulnerable groups of people who make monthly cash contributions to the health centres in return for treatment of their families when they fall sick. The model has been successful in western Uganda and parts of Ankole where government worked with health facility coordination unit and took lead in sensitizing people about the scheme. This scheme is reportedly in 23% of hospitals, in 18% of the HC IVs and 12% of the HC IIIs among all the assessed facilities. Some of the examples of the health facilities that have health insurance packages include: Kuluva hospital (Arua), Njovu Islamic hospital (Buikwe) and Kisiizi hospital (Kabale). Community led health insurance schemes could also be developed and promoted given that the government insurance scheme has taken long to take off, and even so such schemes only target the salaried, yet faith based health providers target and reach the poor.

Almost all health units were able to work with annual income collections and meet their recurrent expenditures. The expenditure to income ratio for centre III was 98%, 97% for HC IV and 96% for hospitals. Most of these facilities relied on few sources of funding or were experiencing difficulties in income generation from user fees or donations. Health centres were less optimistic of increased resource envelopes, with 37% of them not sure of whether their financial needs in the current year would be met.

The health unit management is normally responsible for resource mobilization, but this skill was rarely existent within the health centres assessed. Hospitals seemed to

have more competent staff to mobilize resources than other units (Figure 9). It was for example reported by 41% of the respondents that resource mobilization is an important and relevant skill which is however lacking and inadequate with in the facilities. Most facilities were found to be on the resource receiving side from medical bureaus. A total of 59% of health centres lacked a resource mobilization strategy that seeks to build the current income streams and generate new opportunities for funding.

Figure 9: Health units with resource mobilization



There are however efforts to acquire funding from government and other sources by the different facilities. As such, 71% of the health facilities reported that they are in dialogue with grant making institutions including engagements with the central government and the Ministry of Health. Such engagements have previously hit a dead end due to the capacity gaps at these facilities, busy schedules of staff who would otherwise follow-up considering that there is general lack of dedicated personnel for resource mobilization.

The majority of the facilities (69%) had financial procedures manual, though were not followed in some instances (details in Annex 4). Most of these facilities did not have accounting software for capturing financial transactions and producing reports, but kept paper based financial systems. 63% of health units employed well qualified accounting team but in other health centres, they relied on on-job trained cashiers or at times this was embedded in the work of the administrator or incharge. For example, the person in charge of Boroboro Health Centre (Lira) has a certificate in accountancy while in other centres, the qualifications range from Diplomas to Bachelor degrees with additional professional courses. Despite the observed low skills among finance staff, 61% of health facilities believe they have a strong finance team. (Details in Annex 4). Moreover, 69% of the assessed health units have clear and separate roles from management, while 31% still have internal control issues, where for instance the health in-charge is also charged with income collections and which other facility supervisors have no access to. In addition, 61% of the health centres have books of accounts that are audited annually by a credited financial firm (details in Annex 4).

Half (50%) of the facilities assessed have a procurement manual, but this did not mean procurement processes compliance. Much as a slightly higher percentage of health centres (60%) followed appropriate procurement processes irrespective of whether they have the manual or not, while others did adhoc procurements at the discretion of the facility administrators. The hospital boards and HUMC were frequently involved in procurement of some essential supplies depending on the size of transactions.

Recommendations

- Health facilities should ensure that their resource mobilisation efforts are planned for and supported by management.

- The facilities ought to develop strategies on how to take advantage of user-fees without compromising their core mandate especially of meeting the medical needs of the disadvantaged.
- All facilities should be assisted to acquire Primary Health Care (PHC) funds.
- Medical bureaus should work with health centres to promote community based health insurance but also to build trust among clients to acquire annual insurance. Hospitals and health centre IVs should seek out opportunities for guaranteed loans. The loans borrowed can facilitate and ensure that essential equipment is available for use in service provision on a cost recovery basis.
- Health facilities should ensure that they have all essential operational documents and guidelines in place, the most significant being the financial manual and the procurement policies.
- The facilities should install accounting software and equip the relevant staff with the necessary skills.
- The key staff of the facilities should receive training in finance and resource mobilisation. The resource mobilisation and financial management staff should benefit from placement experts that could offer support in these areas.

4.2.4 Quality of health services in health facilities

Quality of health services assessment was based on standard parameters like-customer services, client-facility relationship, the adoption level of quality improvement tools and projects, waste management practices, staff and patient safety practices, healthcare information acquisition and disposition, medicines and drugs supply as well as capacity to manage such supplies.

We find that most health facilities perform above average as determined by quality indicators of the ministry of health (MOH). 106 out 123 facilities (86%) have sign posts either at the health centre or on the nearest access road to the health centre. This normally specified the distance to the health unit and the kind of services offered, as a guide for clients hoping to seek services in the facility. However, some

health centres were found to have signposts whose wordings had faded out, or did not spell out the kind of services available at the centre. In other instances, the signposts were still in store and were not erected, thus not serving the purpose. Kyotera Muslim Health Centre had a signpost that was reported to be temporarily in store as they awaited restoration. It was knocked by a vehicle. Below in the picture inset, is an example of a colorful signpost that serves other branding needs of the health unit apart from outlining the services being offered at the health unit.

Figure 10: Signpost for missionary sisters of Mary Mother of the Church HC III

Additionally, most compartments in the health units are appropriately labeled, including areas with restricted access, parking areas, waiting rooms, drug dispensing and restrooms. The health facilities also ensure that there is a clean and welcoming environment. This is made possible through good hygiene practices around the facility including toilets, compound, waiting area among others. Moreover 87% of the facilities have drinking water for both patients and staff. The triaging system in

the outpatient department is organized through registration, a person to organize the clients and chairs for patients. In many facilities furniture was for instance inadequate and the person organizing patients was overwhelmed with too much work(details in Annex 4)..

All health facilities generate voluminous amounts of litter which are disposed-off using different methods. Some observed methods of disposal are improvised and might not certify the ISO recommended modalities of disposal. Good practice for instance specify that sharps and biodegradables should be separated but this was not always done and in some instances (94% of facilities), containers for different kinds of litter were not color coded for better selection.

Figure 11: An example of color coded bins at St Assumpta HC III, Alivu-Arua

Burying is the most used mechanism of waste disposal as reported by 86% of health units while use of private garbage collection firms is the least used (10%). Use of incinerator is the second prominent method after burying. Some incinerators are **electrically powered but some like at St Mary's HC** III-Namaliga are fueled with firewood. With overuse, this incinerator can become dysfunctional or inefficient like the one found in Nyenga Hospital (Buikwe).

Method	Frequency	Percent
Burning	74	60.2%
Burrying	106	86.2%
Inceneration	76	61.8%
Private services	12	9.8%

Table 11: Waste disposal mechanisms

Figure 12: An incinerator at one of the facilities

Figure 13: A septic tank at one of the health facilities

There are guidelines for patient and staff safety as seen in 86 out of 123 health facilities (70%). These guidelines are written on noticeboards and quiet often translated into the local language of the facility. We for instance find that 68.3% of health centres do vaccinate their staff against opportunistic infections notably Hepatitis B (details in Annex 4). This was practiced in 59% of HC IIIs, 82% of HC IVs and 87% of hospitals that were assessed. In addition, 83% of health units had their staff using protective gears while on duty and also had such supplies in store. The health units that had client charters were displayed by 82% of HC IVs, 74% of hospitals and 37% of HC IIIs (details in Annex 4). Customer service is institutionalized in the facilities, and is usually provided by the staff on duty. Customer service for example includes provision of safe drinking water and seeking feedback from patients by asking about customer satisfaction and listening and answering to the questions they may still have. The efforts to keep high quality and professional health services were evidenced and promoted through feedback mechanisms from clients and staff. The staff and patient satisfaction surveys were implemented alongside other such mechanisms. The other prominent mechanisms for gathering feedback and their relative densities are presented below (Table 12).

Table 7: Feedback mechanisms[15]

Feedback mechanism	HCIII	HCIV	HOSPITAL
Suggestion box	60.5%	63.6%	67.7%
Learning sessions	53.1%	18.2%	29.0%
Client satisfaction survey	39.5%	54.5%	64.5%
Exit interviews	32.1%	18.2%	29.0%

The most prominent mechanism for feedback in all levels of health system is the suggestion box as reported in 63% of health units followed by client satisfaction surveys. Suggestion boxes and client satisfaction surveys are relatively more prominent in hospitals than other levels, while learning sessions and exit interviews are most prominent in HC IIIs than other levels. Other mechanisms used for feedback include; one on one interaction with clients and staff as done by St Francis Nkokunjeru Hospital and St Stephens Hospital-Mpererwe, and availing staff contacts to community members for immediate feedback as done in Rubanda PHC and Bitooma HC III as well as interaction with governance committees during one of their regular visits to the facility.

Some facilities have piloted the use of mobile phones to get real time feedback from clients when they are at the facility and after exiting. UCMB in partnership with member facilities has piloted a digital scheme to solicit feedback from patients when they enter the health facility and on exit.

Asked how they rate the use of information and communication technology in service delivery, 59% of the facilities said that it is sufficient while 41% felt that it is still insufficient. Regarding collaboration between other healthcare providers including private and public entities in the integrated health chain, 46% of health units felt that it was sufficient while 36% felt that the current level of collaboration with other

[15] (Details in Annex 4).

healthcare providers is moderate. The moderate and sufficient rating present an opportunity for faith based healthcare givers to leverage their abilities and utilize the power of existing technology and innovations to improve service delivery. Print media and other publications are the current prominent sources of healthcare information as reported by 76% of health units (Table 13). This is followed by mobile phones in form of data transfer and audio conversations to acquire and share healthcare information, as reported by 49% of health facilities. Internet is being used by 74 of the hospitals, 29% of HCIIIs and 73% of the HC IVs to acquire information, and has become a vital information channel when combined with own investigation and social media platforms.

Table 14: Sources of health care information

Mechanism	HCIII	HCIV	HOSPITAL	TOTAL
Print media/Publication	72.8%	90.9%	80.6%	76.4%
Social Media	9.9%	0.0%	12.9%	9.8%
Mobile phone	43.2%	63.6%	58.1%	48.8%
Internet/Email	29.6%	72.7%	74.2%	44.7%
Own investigation	18.5%	18.2%	6.5%	15.4%

62 out of 123 health facilities have electronic systems for data management (preparation, collection, storage, retrieval, analysis and sharing). This includes patient data, financial, procurement and human resource management data as well as information tracking progress on various projects. Data is captured using computers and on web to meet internal and external information needs. Taken individually, 36% of health centre IIIs (HCIIIs), 82% of HC IVs and 94% of hospitals do have electronic systems for data management. All health units have data focal points who are normally records officers, monitoring and evaluation officers for hospitals and clinical officers/in-charges for HC IIIs. Besides, 58% of the healthy facilities make use of HMIS manuals supplied by the respective Bureaus or by the

Ministry of Healthy to ensure data integrity, completeness and precision during data management processes. In addition, 47% of HC IIIs have Standard Operating Procedures manuals as compared to 73% of HC IVs and 81% of the hospitals. The manuals spell out the Standard Operating Procedures for health data management.

Despite the investment in data systems, rarely did the data make it to inform decisions in terms of health supplies ordering, planning for increasing patient numbers or even for making informed referrals and build-up of resilience structures. On the other hand, 19 HCIIIs (23%), 03 HC IVs (27%) and 06 hospitals (10%) still do not always make timely submission of reports to the Digital Health Information Management System (DHIS2).

The Joint Medical Stores (JMS) meets 90% of drug and medicine supply needs of hospitals and HCIVs. Although JMS supplies about 70% of HC III needs, the rest are being procured from open market and from non-facility health suppliers like Uganda Health Marketing Group (UHMG) and Medical Access Uganda Limited (MAUL). The supplied drugs have designated stores as well as dispensing rooms depending on the level of health centre sophistication. MAUL supplies all drugs for HC IV patients at St Monica-Katende including provision of a separate computer for HIV clients.

The drugs that require refrigeration are put in refrigerators, some of which were seen to be partially functioning. About 95% health facilities refrigerate drugs that require refrigeration while the proportion of health facilities with atleast one functioning refrigerators is 92%, meaning that about 3% of health facilities store drugs in dysfunctional refrigerators. In Kyotera Muslim HC III, the refrigerator is broken down but the drugs for immunization are kept with the District Health Officer (DHOs) office refrigerator.

Issues of drug and other medical supply management are crucial for the functioning of a health centre, otherwise uncalled for stock outs come in or drugs get wasted due to exposure to bad conditions or their life span expires before they can be utilized.

Moreover, 46% of the health units assessed had run short of essential drugs, supplies including laboratory reagents, one month before the assessment.

Because of this, some health centres have trained key staff in stores and supplies management, while 95 facilities (77%) had at least one person trained in drug supply management. Examples of facilities without a personnel trained in drug stores management include Nabingo Parish HC III (UCMB), St Anastasias Mwebaza HC III (UOMB), Arahamah Muslim Centre IV (UMMB) and Amuca HCIII (UPMB and SDA church).

At HC III, the cadres receiving training are mainly clinical officers, registered and enrolled nurse. At HC IV, the trained were pharmacist and clinical officers while at hospital the trained staffs were mainly pharmacists or the store keeper. There is visibly a tendency to delegate the task of drug storage management to the drug dispensing officers at the hospital level and more to the senior staff at HC IIIs who normally also double as a drug dispensing officers.

Due to erratic demand, irregular supply of drugs and poor drug management practices, it is not surprising that 52% of the assessed hospitals have run out of essential drugs in the last one month preceding the study. The proportion of HC IIIs and HC IVs running out of essential drugs in the same time period is 53% and 64% respectively. These health units have a perpetual challenge of drug outage which is partly attributed to the idea that essential drugs are expensive to stock but also due to the increasing number of clients amidst meager resources.

The health facilities have adopted the Health Sector Quality Improvement framework and implementation plan (2015-2019) which has been rolled out among government partners including PNFPs. It emphasizes safety, waste reduction and returns on investment ensuring that healthcare managers provide leadership in managing quality and are accountable for the healthcare outcomes while ensuring that the beneficiaries play their critical role and responsibilities as elaborated in the MOH patient charter 2010. The framework requires establishment of Quality Improvement

(QI) teams to review progress, challenges and work on improvement in fundamental areas. All hospitals assessed had at least one QI team, while 77% and 73% of HC IIIs and HC IVs had QI teams (n=101). The QI team composition generally includes healthcare users as a good practice and recommendation from MOH. Local representation includes members of VHTs, peer educators and teachers. The largest proportion of health centre IIIs reported local representation on QI teams (71%) followed by the hospital level (63.4%) and HC IV (62.5%)(details in Annex 4).

Some members of health facilities have received training in Quality Improvement Framework which has given impetus to formation of QI teams or at least strengthened already existing ones. Members from 49 HC IIIs, 7 HC IVs and 27 hospitals out of the assessed had had at least one staff member trained in QI. However, 80% of those facilities, where a member received training, also had at least a QI team in their health facility. Moreover 20% of those who received training had not formed QI teams in respective facilities. This shows the likely impact of this training to the functionality of the teams in respective facilities. As such 20% of QI teams have not engaged in QI project while 80% were already engaging in QI projects. At Warr Agier Mach Health Centre, QI teams were running two projects- one on ART- Viral load monitoring and adherence to treatment while the other one was for the maternity section for monitoring the progress of labor using a pantograph. However, there is high demand for trained staff causing increasing attrition of trained staff for alternative higher paying jobs.

Government has also introduced assessment modules under the Self-regulatory Quality Improvement System (SQIS), with which PNFPs will be using to judge their own strengths and weaknesses and act on them. Both the bureau and government structures are already creating awareness on these modules through trainings and informing communities through district representatives. 41% of health facilities assessed had either been trained on SQIS or were already aware about the development. 39 health facilities had conducted self-regulatory assessments- including 23 HCIIIs, 06 HCIVs and 10 hospitals.

Some facilities (63%) had conducted quality improvement learning sessions where the staff were engaged to reflect on the progress and forge a way forward based on the assessment results where applicable. Of the 78 health facilities engaged in QI learning sessions, 39 of them had received training in SQIS or were already aware of the same initiative from other sources while 69% had members already trained in QI. It is likely that the prior training in QI and SQIS tools promote self-improvement and adoption of quality improvement framework as a learning tool at facility level.

Recommendations

- There is need to proactively mentor the health facility staff in QI and SQIS with emphasis on sustainability and continuity aspects in light of the high staff turn-over rate in these facilities. Also observed was the need to incorporate the service users in QI and SQIS teams since they are cognizant of their welfare and living condition hardships.
- There is need to support efforts towards the computerization of outpatient, and patient registration process, including building capacity of the support staff to manage the new electronic system at all levels.
- There is need to support and facilitate the procurement of more furniture in the outpatient wing and as well ensure that there is adequate staffing to improve on customer service.
- The health facilities need to improve on their patient referral systems by seeking partnerships with organisations offering treatment vouchers to reduce the cost of referral treatment for clients.
- Medical bureaus and health units should deliberately study why some facilities prefer to procure out of JMS, with a view of strengthening JMS and also ensuring that the facilities get quality drug supplies, at an affordable cost in the required time.
- There is need to train the relevant health facility staff in data management beyond Microsoft excel, so that they can supply quality data and find the task less daunting.

- Health facilities ought to train data managers in electronic data storage and visualisation tools.
- Seek avenues to ensure that each department at a facility has a computer that only handles its data, without having to share it with other departments. This is largely for the security of client data.
- Facilities should supply customized QI manuals for each department or problem area.
- There is need to procure, where possible and supply health units with solar panels to be able to sustain the required temperature in refrigerators and other uses when electricity goes off or in case the generator fuel is inadequate.
- The relevant staff should to be trained in drug, stores and supplies management. Recommended staff include store keepers, dispensers and QI team members
- There is need to train the QI teams in customers service, particularly the Kaizin quality management model.
- Promote learning through scheduled staff meetings, QI team meetings and sharing of information resources among health facilities, for instance, the use of client satisfaction surveys.
- The QI teams should be reconstituted and trained on planning, initiation and implementation of QI projects.
- The expectations of SQIS and QI projects should be harmonized early and communicated to the facility staff.
- Health facilities should be encouraged to share tools used in program implementation, for instance the survey questionnaires for cross-learning amongst the facilities.

4.2.5 Assets and infrastructure for health facilities

This section analyzes the health assets and infrastructure necessary for service delivery including improving client relationship, improving timeliness of service and ensuring inclusive service delivery.

From health centre III to the hospital level, the faith based medical facilities have varied access to assets and medical facilities that facilitate service delivery. Some of these facilities are bestowed by nature or by the government of Uganda. Kisiizi hospital in Rukungiri is for instance located in vicinity of Kisiizi falls that generates adequate electricity for the facility while most other health facilities survive on electricity generated from the mean hydro electricity grid line as well as from other dams like Nyagak hydro power station for Zombo district (Figure 15: Kisiizi falls). Some facilities are located in raised locations which pose advantages for internet connectivity and telephone network coverage compared to others.

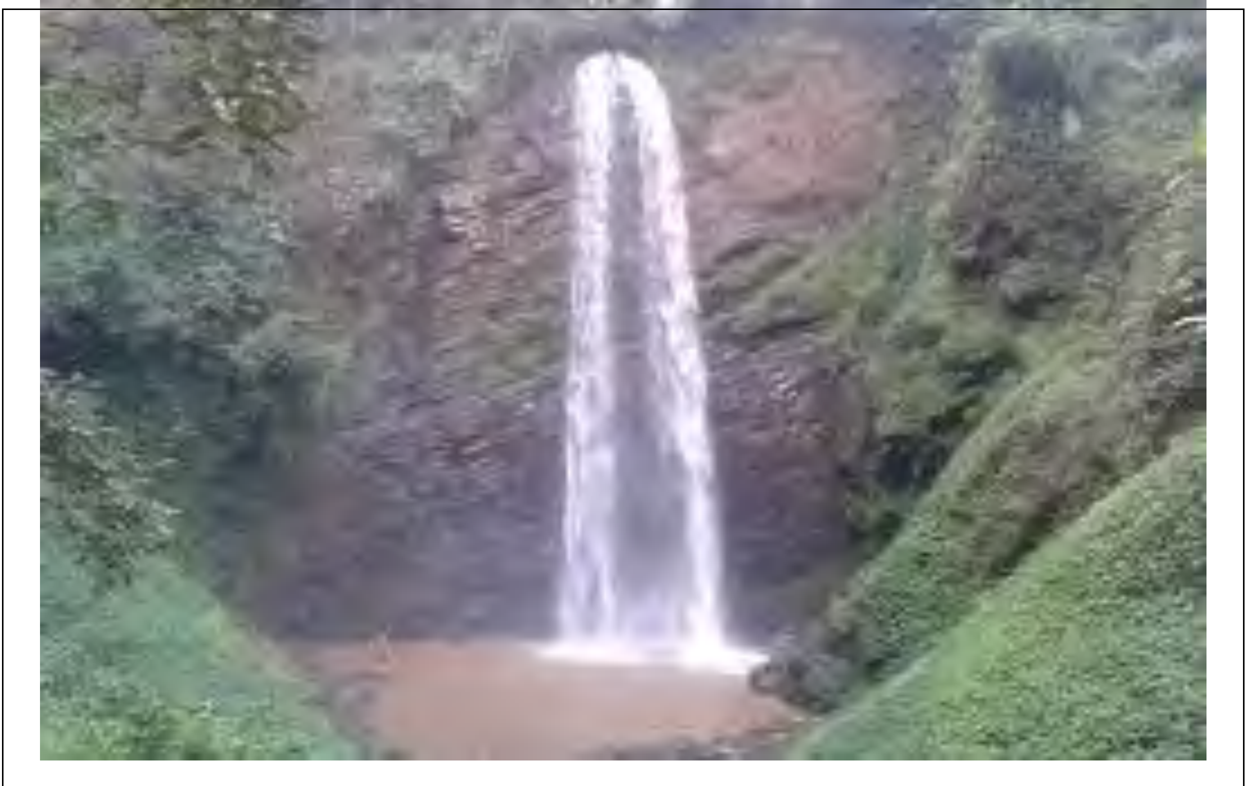


Figure 15: Kisiizi falls which generates all the electricity for Kisiizi hospital.

Most facilities do not have own means for transporting staff or patients in cases of emergency or other need. There are however some health centres with both ambulance and private motor vehicles that facilitate movements and increase visibility through branding. 70 out of 123 facilities (56.9%) of the assessed health facilities have vehicles for transacting in health service delivery including referrals and outreach programs. These include ambulances and other types of staff and outreach vehicles. Most of these facilities have private motor-vehicles that also work as ambulances as well as for transportation of staff but not allocated to key staff as benefits.

Figure 16: Picture of Comboni Hospital (Bushenyi) ambulance vans

Figure 17: Picture of North Kigezi Health Centre IV ambulance

There are however disparities in ownership of such vehicles. For instance as seen in picture (figure 16 and 17) above, Comboni hospital (Bushenyi) has two vibrant ambulance vans while its counterpart North Kigezi health centre IV has one of the strongest Land Rover ambulances mechanically grounded for some time. Hospitals have the largest number of motor vehicles with an average of 2.5 vehicles and approximately 2 trucks on average. Other health facilities make use of other transport mechanisms like bicycles and motorcycles which assist in mobility of patients and staff. Only two health centres have motorcycle ambulance that assist in transporting patients for expert support in the neighboring locations. These health centres include Lyantonde Muslim health centre and Kakatunda HC III which normally refers health client cases either to Kabale hospital or the nearby Kisiizi hospital. Only three health units have bicycle ambulance services, including hospitals and HC IIIs. These include Lugazi Muslim Health centre, Nabingo parish health centre and Kakatunda Health centre III (details in Annex 4).

Due to poor availability of ambulance services, patients normally pay for the bills transportation after referrals by hiring private means on their own or paying for the service after referral. Only 23% of health facilities have the commitment to ensure

that patient referral gets immediate attention by earmarking funds for such transportation during emergency referrals (see figure 18). There are however few instances where referral expense is footed through the voucher scheme much as there are existing voucher scheme provisions covering maternity related illnesses or complications, where the service in districts where such programs are offered.

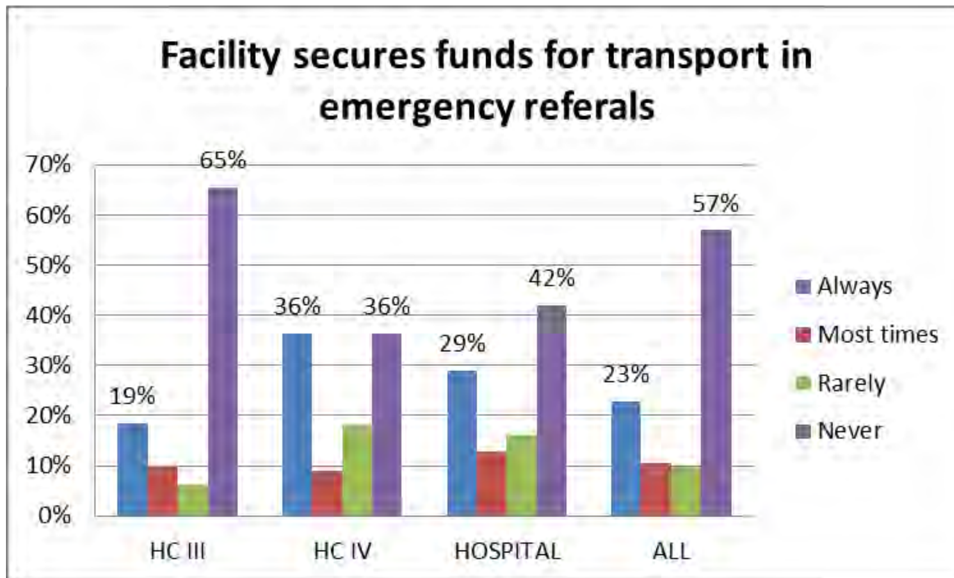


Figure 18: Facility funding for transport

Patients or visitor vehicles and ambulances require parking space in the facility or within the vicinity. We noted that all facilities have endeavored to provide such facilities apart few instances like J.O.Y Medical Centre whose would be expansion area is a public road instead or Family Care Hospital, which is located in a housing project with some installations improvised since they did not serve their original purpose. Nevertheless, 80% of facilities have sufficient space for the services they offer while the rest some have flexibility to expand. Slightly more than half of health facilities (51%) have infrastructure with provisions for People with Disabilities (PWDs) including walk ways, toilet facilities. For facilities erected in for instance church land, they have found it easy to request for additional space whenever they want to add a new installation like maternity ward or simple spaces for allocating incinerator or

constructing a store. Others have provided waiting space from outside where they provide triage in OPD services and avoid congestion on service corners inside main structures (See Figure 19).

Figure 19: Donor provided tent for clients at Kakungube Health Centre III-Mubende

All facilities have storage rooms for various supplies, though in varying physical conditions. Some of these rooms are used for storage of drugs or specific supplies like for HIV interventions pharmaceutical corners, laboratories while others contain laundry equipment. Some of these stores also double as dispensing rooms or examination rooms. An ART clinic in Buwenge hospital and medical centre for instance doubles as a Pharmacy as well, a practice that ensures one stop service centre but also puts essential medicines at exposure and unwarranted risks. In figure 20 below is drug store at St. Kizito Nyattole that also serves as a pharmacy.

Figure 20: Drug store at St. Kizito Nyattole

These storage rooms are generally well kempt apart from the physical wearing of some buildings. Inside drug stores and pharmacies are compartments, stacks and shelves that allow for management of stock, cleaning and guarantees aeration. Only 20% of these storage structures were rated as poor or fair otherwise most storage structures were rated good (Details in Annex 4).

Most facilities provide housing for key staff for instance the in charge and staff on night duty. Some of these facilities are in good condition while others are in dire need of renovation or expansion to accommodate more staff and interns (Figure 21).

Figure 21: Picture showing separate sisters houses and other staff housing in the same surrounding of St Kizito Health Centre III.

Most facilities (93.5%) had running water that serves all departments of the facilities. Water is used for cleaning the facilities and for meeting patient water needs like washing clothes for those admitted. Most of this water comes from national water supply system (National Water and Sewerage) or from district water supply schemes or trapped rain water that is later accessed from installed piping in the health centres

Piped water is the most common source of water at all levels of health service delivery, and generally available in 59% of health units assessed. Other sources include hand pump, rain water and spring/well water. To ensure all year round supply of water, health facilities have invested in water reservoir systems like below ground and overhead water tankers. 92% of health facilities have water reservoirs for smoothening water availability throughout the year (Figure 22: A water reservoir system).

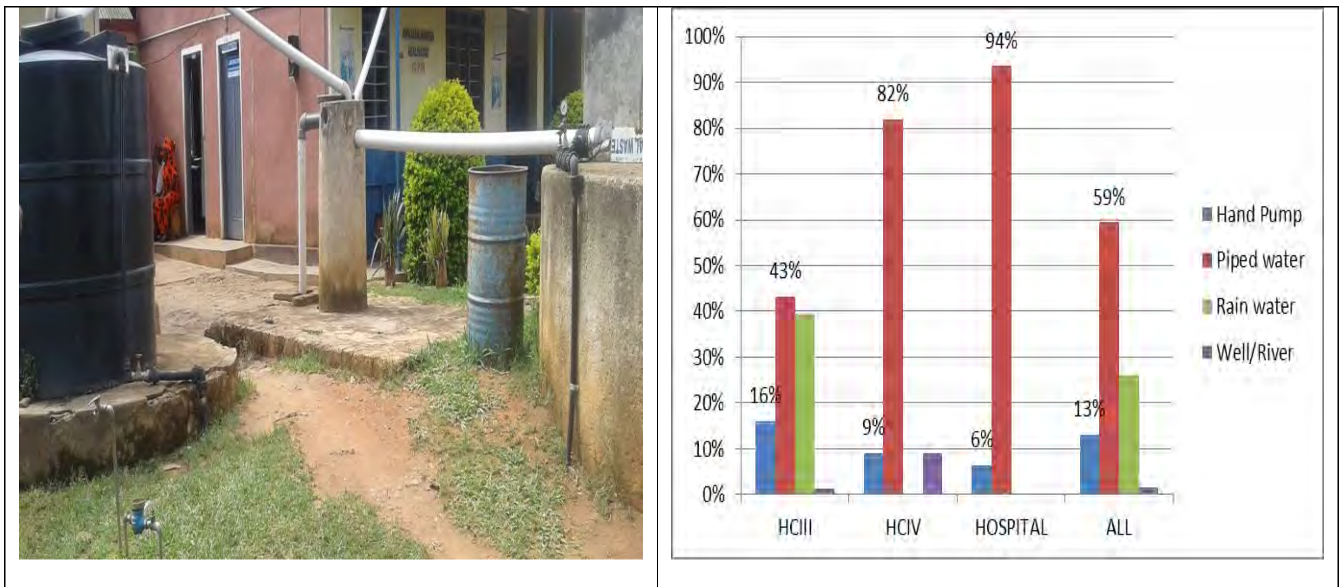
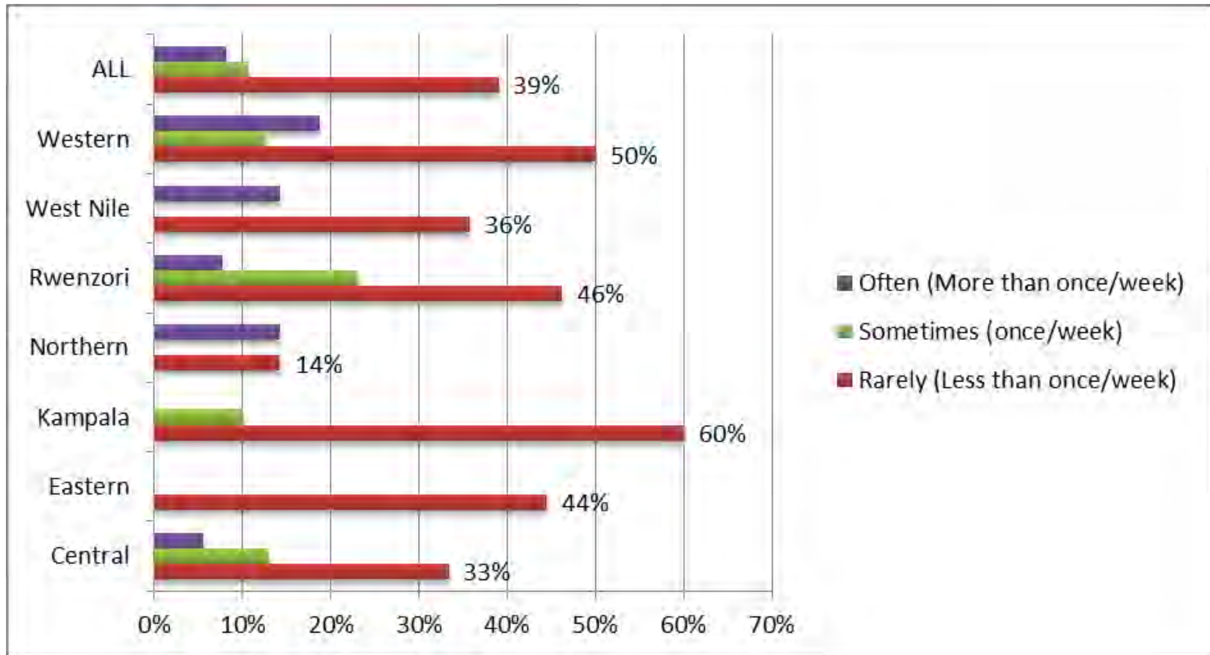


Figure 22A water reservoir system

It was noted that 60% of the health facilities in Kampala rarely experienced water shortages considering the month preceding the assessment. Facilities in Western region experienced relatively less disruptions in water availability second to those in Kampala. West Nile and Northern Uganda experienced the highest incidence of water shortages reported at 18% (Figure 23). On average, health facilities spent 8 days of the month of March 2017 without running water. Amuca Health centre (Lira) and St. Luke Katiyi for instance spent a full month without their normal source of water

supply.



All facilities have toilets (pit latrines or flush) internally or in vicinity of the facility. Overall, 73% of facilities have designated toilets for staff or client use, and in some instances separated to serve both staff and patients. 23% of these facilities have toilets that are not designated but are left to be shared between patients and facility staff.

Figure 23: Client pit latrine with PWD provision at St Monica Mpigi on the left and staff toilets at St. Nektorious Gulu/Akonyebedo on the right

Most of these toilets (in 70% of facilities) do not have provisions for people with wheel chairs or with other special needs.

The assessed facilities are generally within the electricity power grid radius, making it possible for facilities to balance using various sources of lighting, heating and running essential medical functions. The main grid/power line serves majority of health units (80%) followed by solar power (18%) and generator power (2%).

It was noted that facilities that relied on only grid power line as the only power source suffered significantly in periods when it was off. The situation worsens when such locations are in areas prone to chronic power outage like west Nile. Health centres spent about 6.7 days without electricity in the reference month, the most outage reported in West Nile at 26 days and the least being in Kampala region at 2.3 days. Besides 53% of the health units assessed either did not get electricity disruptions or had experienced shortages for less than a week prior to this assessment, while 48% of them had experienced power shortage for more than a week or more often.

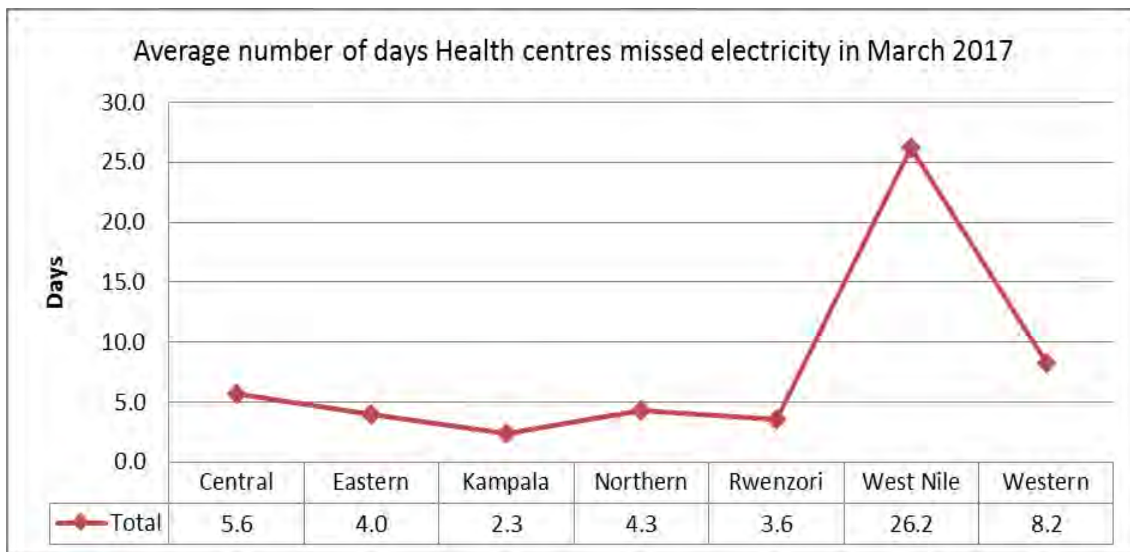


Figure 25: Accessibility of electric power by the facilities in March 2017

West Nile had the worst exposure to electric power load shading since November 2016.[16] The region experienced power challenges due to the prolonged dry spell in the region coupled with construction works that led to water levels to go low on the Nyalubaale hydroelectric plant. The 3.5MW power plant that serves all West Nile together with few thermal generators had been operating below capacity, because the water to run turbines had gone low, prompting the operator to ration power supply at specific times and leading to losses of up to 20 days a month in terms of forfeited supply of power to health institutions.[17] The facility was installed to serve 30 health centres, 6000 households among others.

While the worst load shedding was experienced in West Nile, some facilities in West Nile never experienced any power outage. This is mainly because their original source of power was not from Nyagak grid but through a combination of generator and solar power which they had invested in as back-ups. These health facilities include Zombo HC III in Zombo district, where the plant is and Warr Agie Mach HC III.

Most health units that relied on solar power did not have disruptions in power supply since its usage was planned for. For example, Buhara health centre III (Kabale) is not yet connected to the main power grid because the area is off the national grid, and they did not report any power disruptions over the month preceding the study since they plan and use solar power. Those facilities that reported longer days in a month without power did not have back up power.

Despite the practice of investing in back-ups with 93 out of 123 health units having power back-ups, only 65% of HC IIIs had functioning back-ups while 93.5% of the hospitals and all HC IVs had invested in electricity power backups to use, when the

[16]http://www.newvision.co.ug/new_vision/news/1445730/dams-operate-capacity-rivers-run-dry

[17]West Nile Rural Electrification Company Ltd (WENRECO) is the distributor of electricity in the region. All districts in the area have experienced load shedding apart from Adjumani which was recently connected to the national power grid.

main grid power goes off. The reasons advanced for not investing in power backups were related to the high costs involved in the buying and maintenance of the backups. Lugo HC III had one but was retrieved by the donor when the project ended and resupplied to another health facility.

Facility use of telephone for patient referrals was common, and only 3.3% of the health facilities did not have a clear telephone for use at the facility. Majority of the health facilities (69%) were using personal cellphones for doing facility work. In this case, clients are offered staff contacts for inquiries and making any appointments by clients. Other facilities relied on facility designated cellphones (36%) and fixed line telephones (35%). However facilities that invested in fixed line telephones are seen to attract client trust. In all regions, health facilities in Kampala had the most investment (70%) in facility fixed telephone lines, followed by West Nile (43%) with the western region trailing at 13% (Figure. 26 and more details in Annex 4).).

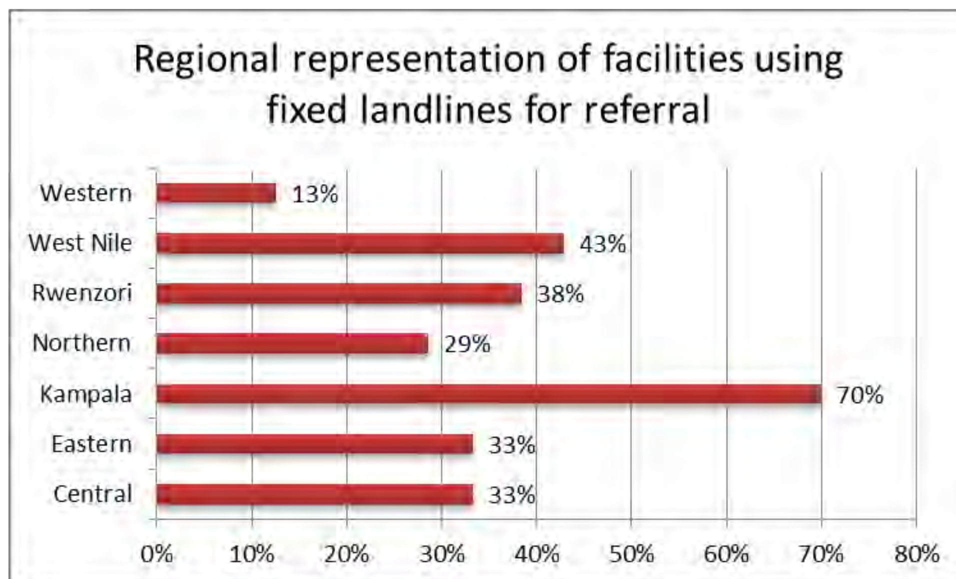


Figure 26: Telephone facilities (landlines) in the health facilities

Irrespective of the telephone framework, most health facilities (90%) had reliable telephone signal. This has ensured good communication between patients and staff, and information sharing with other health service providers. All the facilities had a

moderate internet coverage at least with varied network providers. The staff accessed mobile internet services using dongo, Local Area Network (LAN) and sometimes tapping onto active wireless hotspots. Respondents rated internet as reliable by 90% of hospitals, 82% of HC IVs and 56% of HC IIIs respondents with respect to their facilities.

More than half of health facilities (56.9%) have access to and use computers for health service delivery. It was however a common practice that facility owned computers if any, were either not in good condition, thus the capacity to use computers was low or were for instance used in finance department but not in making prescriptions or making reports. It should be noted that 14 out of 32 UCMB hospitals (43.7%) accessed local area networks, were used for continuous training and for Electronic Patient Record Management System (EPRMS). During 2015, 9 out of 14 facilities already had serious power problems which was addressed by equipping them with inverter systems. Ccomputers are at times utilized in silos for instance HIV related programs and work could gazate own computers as a precautionary measure against revealing vital information to third parties. In Holy Cross Health Centre for example, the only available computer is used by the in-charge for technical and administrative purpose.

It should be noted that facilities generally lack diagnostic machines like X-rays, CT-Scan, MRI, Haematology as well as inadequate space for theatre and maternity. Attention should be taken to equip facilities with specialized equipment for improved health facility infrastructure and the service delivery possibilities that come along.

Recommendations

- There is need for the facilities to streamline the safe custody of health facility assets through appropriate book keeping, and filing of important legal documents with the registrar of documents.

- Most of the healthy facilities ought to acquire power back-ups especially through the acquisition of solar power. Installation of such should have after-sales service benefits to ensure knowledge transfer in running the gadgets.
- Health centres should be provided with flexible financing options to acquire missing diagnostic machines like CT-Scan, MRI and X-Ray. The support by the development partners in this regard would be of great significance to the health facilities. Health facility assets should be ensured against theft and other eventualities. The facilities should put in place emergency plans and infrastructure in case of disaster. All facilities should for instance install fire systems.
- Most if not all of the facilities need assistance to acquire transportation systems e.g. vehicles for field operations and ambulance to transport patients.
- The donor and partners of the facilities could support the installation of reliable internet and avail 2-3 computers to every health facility in need.
- The facilities need to consider planning for extensive renovations across the different components of the health facilities for instance staff quarters, toilet facilities, incinerators, storage rooms.

4.2.6 Health coordination and partnership for health facilities

Health coordination and partnership was assessed on the basis of existence of inter-faith synergies and efforts to streamline such synergies at district, region and national level. In the same way, we assessed the relationship between government district health support office and individual health facilities and the demand for technical support by PNFPs.

All the health facilities are members of the respective district health services networks and they contribute information for monitoring national progress as per World Health Organization (WHO) indicators. These facilities have periodic meetings at the district level which are coordinated from DHO office. There are also annual

interfaith health service provider's meetings where they discuss issues affecting PNFPs and make strategic decisions. These meetings normally happen in different regions of Uganda and are coordinated by Bureau. These meetings have been applauded for promotion of learning and as advocacy platforms to claim the space of faith-based medical bureaus to access financing to provide subsidized medical services for the vulnerable.

Through the district health office, health facilities have been encouraged to share best practices and tools with others including paying learning visits. 86% of health units interviewed agree that there is a level of resource sharing between health units irrespective of if they have faith orientation, and 23% of them believe that the relationship with other health providers is good. The Buikwe district health office has for instance engaged St Francis Hospital-Nkokonjeru (Buikwe) to provide support visits to Lower Level health units in the district. Such efforts by the DHO have improved coordination between QI teams at the facility level and their respective coaches. From the assessment, 52% of the respondents believe that strong partnerships exist between QI teams, the respective coaches and QI focal persons.

We find more of intra-faith coordination than interfaith or general coordination with public health providers because of the linkages fostered by respective district health coordinators, as compared to inter-faith coordination. Coordination is more in silo than operational. The respective bureaus target support to member facilities in improving service delivery. These facilities often come together under the auspices of the bureau to discuss pertinent issues in a given health sub sector for instance implementing HIV programs or part of a larger consortium where the bureau is the coordinating body. Other coordination meetings include; Bureau AGMs where heads of facilities attend. Facilities generally depend on the District Health Officer (DHO) to link them to other facilities, thus there is no natural effort aiming at improved coordination.

Interaction with other health workers occurs at workshops, trainings and other meetings organized by the DHO and other implementing partners. Majority of health facilities rated inter-faith coordination as medium at both district and national levels. This means that there is a slight positive difference in coordination in favor of district level coordination to national level inter-faith coordination. Districts would like to see a more positive coordination role of the inter-faith institutions at national level in terms of new extended opportunities, shared resources at grassroot level and making use of information generated at the district to inform national level advocacy efforts.

The PNFPs that were assessed referred some medical cases for higher level support and sometimes borrowed resources from sister medical facilities to solve emerging challenges. We find an efficient referral mechanism in some health facilities with referral phone contacts and a good working relationship between the sending and receiving facilities. Akonyibedi Health Centre (UOMB) and Azur Health Centre (UPMB) make prompt references to Lachwo hospital and Hoima hospital, respectively, on a regular basis and the two facilities have established formal linkages as seen in customized referral forms. Such practice is missing in other centres like All Saints Health Centre (Kagoma) where referrals were seen to be received from Magamaga Health Centre and other neighboring centres but without consistent documentation of the same. Most Health Centre IIIs also make contacts with Village Health Teams who regularly refer cases in form of recommendation.

Most health facilities do not have formal public relations mechanisms. However HUMC members regularly broker information flow between facilities and external environment. The introduction of the community assemblies and enrolment of a community representative to health facilities keeps them in touch with the interests of the community that they serve. Besides 30% of assessed health facilities do not have a concrete and well-articulated communication plan encompassing who, where and which of the stakeholder engagement and information sharing platforms are relevant and appropriate for the facilities to be part of.

The governance of these health facilities ensures that there is technical and community representation on the board. Through bureau-facility relationships, budgets and plans are approved for implementation at lower level. Both bureau and facility expenditures and plans go through a tiered approval process to ensure value for money. In addition, 93% of the health facilities conform to this tiered process of management while the rest still have lose coordination structures where the in-charges or directors make minimal consultations in execution of plans and budgets.

The partnership between health facilities and districts is generally weak and at times seen as regulatory enforcement rather than hinged on support, yet this relationship has proved as a working mechanism to network and learn new developments. DHOs have also not paid much attention to PNFPs because they are looked at as independent entities with self-regulatory mechanisms, but instead are more committed to monitoring healthcare in facilities receiving PHC funds[18]. There were instances where the district health office was seen as against some health centres where as in others there was a close working relationship between the two parties. In others like Mukono Church of Uganda hospital, the working relationship with the district is cordial, reports are received on time and the DHO is spearheading efforts to ensure that the hospital becomes a teaching hospital.

A significant number of health facilities (42%) do not have a partnership strategy in place to guide the kind of partnerships they engage in (details in Annex 4).. There are informal networks of friends, sister associations that the facilities belong to. If such networks are formalized and planned for by the health facilities, they have the potential to continue at the epitome of influencing health policy, reaching the vulnerable at subsidized rates. Considering also that only 48% of health facilities have staffs that are in charge of partnerships, meaning that the largest percentage of

[18] A significant number of Faith-Based Health Facilities has not started received PHC funds

health units have not designated staff to coordinate partnerships and networking. Considering that few of these designated staff also double as heads of institutions for instance the medical superintendents and in-charges for health centre IIIs trickles to lack of dedicated effort for ensuring fruitful partnerships and networking, albeit low level of networking skills for the institutions and staff.[19]

Through targeted efforts and from well-wishers, faith based health facilities also directly link to friends outside Uganda including Missionaries and Muslim organizations who have at times provided staff on secondments and in exchange programs to provide apprenticeship support. Mukono Church hospital received medical equipment worth 450,000 USD in 2014 from World Medical Mission because of reference and cultivated friendship with overseas friends of the hospital. From the assessment, 94 health facilities (76%) belong to such health related networks either at the district, national or global level, where they learn about new opportunities and share resources.

Recommendations

- There is need to further share the program management tools, human resource management tools among health facilities. The bureaus have a role to facilitate this process.
- A partnership and networking strategy should be put in place. Bureaus should develop a template to guide this process to ensure that partners are smoothly enrolled, managed and exited.
- All health facilities should sign MOUs with the District Local Government (DLG). This should be for the purpose of improving the quality of services and monitoring performance.

[19] 48% of facilities reported having right partnership and networking skills

- Districts should mobilize PNFPs into active fora to discuss issues that concern them. DHO or his regularly designated facility representative is advised to preside over these meetings.
- The office of DHO should be strengthened to ensure adequate technical support to PNFPs, in addition to what is already provided for by DHCs. This can include among others secondment of technical staff to health facilities and getting first-hand information from the national level.

- Bureaus should invest in strengthening QI coordination and collaborate with the respective coaches.
- The facilities should look out for QI coaches that move across facilities to join the network of QI in the district.
- Almost all the facilities need to have a public relations focal point to actively manage public information needs and demands at health units.
- The importance of referrals should be emphasized and invested in. Health facilities should ensure a good working relationship with each other.
- There is need for capacity building for staff of bureaus and health facilities to appreciate coordination for service delivery. This should be supplemented by periodic coaching sessions based on set milestones.

5.0 Conclusion

Based on the findings of this study, we conclude that the capacities of the bureaus and the respective health facilities under their networks have improved overtime. However, there are some areas that need to be prioritised in order for these institutions and their structures to be made even stronger. The Boards of the bureaus are such a strong pillar as regards the functioning of these institutions, and their structures. As such the board structures ought to be strengthened through peer review mechanisms, facilitating internal critical reflections and performance

evaluations. Moreover, there are already best practices at the bureau and health facilities level where UOMB and some of UMMB facilities could learn from.

The bureaus exist as advocacy organisations to provide a platform for knowledge sharing, mutual cooperation as regards the functioning of the health facilities. In this regard, it becomes important to develop ICT platforms at the bureau level to stimulate and promote the advocacy role as championed by UCMB for example. The advocacy role emerged critical at the bureau level, and so, is the need for regular meetings between the bureaus which calls for the position of the Advocacy Advisor at bureaus to coordinate the advocacy engagements. The advocacy engagements imply the need for synergy building despite the fact that the different bureaus are distinct in many respects. To promote synergies as regards the functionality of the bureaus, it is important to undertake benchmarking exercises so as to level the ground for inclusive and informed participation of the institutions and the structures involved.

Improved data management systems are a key to better performance, facilitate improved reporting, and a strategy to attract funding. Therefore there is need to promote and use ICT innovations to attract funding and promote efficiency in health service provision at the different levels.

Governance issues are prominent in the health facilities. We found that there were already internal and structural ways of handling discrepancies in practices at the level of facilities. This includes deregistering some of the facilities due to non-compliance. This is a practice that can be adopted by bureaus to ensure compliance especially with the issue of the founder syndrome, where the founding members want to dominate and manipulate management decisions. UCMB and UMMB have deregistered over 5 health facilities in the last six years, after summoning the respective health coordinators to the health commission without improvements.

The health facilities could benefit from charging user fees, however there is need to streamline such arrangements by the facilities to ensure that there is transparency in the management and use of the generated resources. The charge for the user fees should be informed by the values of the facilities and there should be a transparent process for coming up with the same in order to maintain and keep the client confidence.

It was found that there are no proper functioning financial procedures at the bureau level mainly. This needs urgent attention and support to ensure that the issues of financial accountability are effected, which have an important reflection on the performance and the quality of services provided by the PNFPs.

The primary Health care (PHC) fund is an important contribution by the Government of Uganda to the Health facilities. It emerged through the assessment that this fund may be utilised better if it is channeled directly to the Health facilities as opposed to channeling 50% through the Joint Medical Store (JMS), which pays for the drugs that might not be needed in some facilities. Additionally, the functioning of the JMS needs to be studied in order to have it strengthened and remain responsive.

Generally, the role of the PNFPs is critical and important as it emerged from this assessment. For this reason, the needs and challenges identified through this assessment **ought to be addressed such that the PNFPs' roles are enhanced and** promoted further. It is thus proposed that a mechanism and strategies are devised to address the issues emanating from this assessment. This implies and calls for a participatory reflection by both the bureaus and their respective health facilities to develop strategies and implement the issues and recommendations emanating from this assessment.

6.0 Annexure

Annex 1: Distribution of health facilities by District

District	HCIII	HCIV	HOSPITAL	TOTAL
Arua	9		2	11
Buikwe	5		3	8
Bushenyi	1		2	3
Gulu	1			1
Hoima	1	1		2
Iganga	1			1
Jinja	3		1	4
Kabale	3	1	1	5
Kabarole	4		2	6
Kampala	4	1	5	10
Kiruhura	1		1	2
Kumi			1	1
Kyenjojo	5			5
Lira	3	1		4
Luwero	8	2	1	11
Lyantonde	1			1
Masaka		1		1
Masindi	1	1		2
Mayuge	1		1	2
Mpigi	6	1	1	8
Mubende	3			3
Mukono	5	1	2	8
Nakaseke	1		1	2
Rakai	1			1
Rubanda	3			3

Rukungiri		1	2	3
Wakiso	8		4	12
Zombo	2		1	3
Grand Total	81	11	31	123

Annex 2: List of people interviewed from the medical bureaus

UCMB

S/N	Staff	Position
1.	Sr. Catherine Nakiboneka	Manager, Training Schools
2.	Monica Luwedde	Patients Safety, Quality and Data Manager
3.	Genard Ntakyo	IT Officer/Systems Development
4.	Dr. Sam Orach	Executive Secretary
5.	Emmanuel Nsubuga	ACT Program Finance and Compliance Manager,
6.	Bamenya Florence	Finance Officer
7.	Mr Charles Kirumira Kizza	M&E Officer
8.	Daniel Fiess	Consultant, Horizont3000

UMMB:

S/N	Staff	Position
1.	Dr. Karama Saidi	Executive Secretary
2.	Dr. Karama Said	Executive Secretary
3.	Mr. Kivumbi Muzamiru	Monitoring and Evaluation Specialist
4.	Ms. Nansamba Lukia	Finance Specialist
5.	Ms. Ibanda Yusuf	Human Resource Specialist
6.	Ms. Nakabugo Nooriat	Training Advisor

UOMB

S/N	Staff	Position
1.	Dr. Sande George Binna	Executive Secretary, UOMB
2.	Ms. Christine Nalubwama,	Adminstrator

UPMB

S/N	Staff	Position
1.	Dr. Tonny Tumwesigye	Executive Director-UPMB
2.	Ms. Merinah Baganyizi	Finance manager, UPMB
3.	Ms. Dorothy Nakyanzi	Human Resource Manager, UPMB

Annex 3. Other Interviewees

S/N	Name	Position	Contact
1.	Mr. Wambewo Abudalaziz	Bio-statistician, Mbale District	0786755224
2.	Fr. Silverio Twinomugisha	Kabale Diocese	
3.	Sr. Katembeka Priscilla Birungi	Diocesan Health Coordinator	
4.	Mr. Kazibwe Lawrence	HMIS Focal Point, Buikwe district local government	704135278
5.	Dr. Okello Ayen Daniel	KCCA, Deputy Director- Curative Services	dokello@kcca.go.ug
6.	Dr. Ronald Nyakoojo	Health Services Team Lead, USAID/Uganda Private Health Support Program	0772388970