Sector Description

5.1 During the 19505 and 19605, Uganda established one of the finest public health systems in Africa, combining preventive disease control programs with an expanding network of clinics and hospitals. Together with modest parallel efforts by NGO facilities, mainly mission hospitals, this resulted in a steady improvement in Ugandans' health. This progress was dramatically interrupted by the disruption of the economy and the collapse of social services during the late 1970 5 and early 19805. The infant mortality rate, which had fallen from 200 per 1,000 in 1948 to 92 by 1973-77, rose to 115 in 1978-82. Economic recovery and the resumption of social services has now begun to reverse this negative trend but the current rate of 101 remains well above that of the early 19705, the average for low income countries (76) and neighboring Kenya (72). A similar trend characterizes child mortality (Table 5.1). Much of the successful reversal is due to immunizations, especially against memles; 48 percent of 12-23 month children are now fully immunized against the six major childhood diseases. .

5.2 The breakdown of the health information and statistical system, which has still to be restored, means that normal health data are not available in Uganda. All the partial evidence that does exist is consistent, however, in pointing to patterns of mortality and morbidity that are dominated by a resurgence of diseases like diarrhea and malaria that are relatively easily prevented, coinppunded by high population growth, malnutrition and the emergence of HIV infection as a very serious new threat (Table 5.1). Total fertility has increased from 5.9 children per woman in the . 19SOs'and 19605 to 7.4 in the 19805 and shows no sign of decline; while 33 percent of married women surveyed in 1988 wanted to space their children by at least two years and another 19 percent wanted no more children, only 5 percent used modern forms of contraception. In addition, the rate of maternal mortality is increasing rapidly even in Kampala hospitals, where the best care - in Uganda is provided, implying a much worse situation in the country as a whole (Table 5.2).

Anemia and malnutrition accounted for 7 percent of recorded hospital deaths in 1981 but 17 percent in 1988; several studies in the 19805 show 21-30 percent of 0-5 year old children to be chronically malnourished and a 1988 survey indicates a figure as high as 45 percent. Malnutrition also contributes to the morbidity and mortality of pregnant and lactating mothers. By the government's figures, 1.3 million of Uganda's 17.0 million people are HIV-positive and there are over 12,000 cases of AIDS. HIV/AIDS-related illnesses are now said to account for over 30 percent of all hospital admissions; the present level of HIV infection alone wi1l generate 12,500 new cases of AIDS each month by the mid-l9905. Finally, the breakdown of disease control programs has led to the reappearance of diseases that had virtually been eliminated from Uganda, such as trypanosomiasis, sometimes to epidemic proportions.

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Table 5.1: Hospital Inpntieut Mortality and Morbidity, 1981-88
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R ,.- -irnto Infections -
Anemia
1 Tuberculosis
i Malnutrition
mvmms
Note: Outpatient Ind survey data presented in the me two reports’ point toward 1 general morbidity
attern including much higher incidence: of diarrhea. malaril, respiratory infections, wor ms.
P
skin end eye infection: than shown by inpitient data.
Sources: UNICEF, P. 34981), Mini: 0 Health, Health In orman’on Quarterly, Dec, 1989
5.3 Uganda has 81 hospitals (48 public and 33 N60), 105 health centers (97 public) and 76 5
’ lower level facilities (601 public). Hospitals are staffed with doctors; health centers encompass a
wide range of facilities with Varying services, some staffed with doctors and some not; l ower level
facilities do not have doctors. While both Government and NGO health services and facilit ies
deteriorated during the years of disruption, the NGOs have largely rebuilt and expanded, due
panicularly to external assistance and higher staff morale and are important for both pre ventive and
curative services. In Mbaie district, for example, NGO facilities expanded by 71 percent from
1985 to 1990 and primary health is estimated to adcount for over 30 percent of their tota l
expenditure. Most government units remain in a state of severe disrepair, however, with r elatively
unmotivated staff who are only very poorly paid, as elsewhere in the public sector. In’te rms of
population per hospital bed, for example, Uganda is typical of low income countries; howe ver this
masks that the bed is usually just a frame, without a mattress and without supporting sup plies. The
decline of the public sector has led an increasing proportion of the population to seek c are at both
N60 and private facilities; indeed the latter, ranging from small doctor-run clinics to c ommercial
phannacies, have mushroomed all over Uganda, delivering care of highly.variable quality a nd
creating a culture in which good care has come to be associated by the patients with the availability
of injections and of drugs, regardless of their medical appropriateness. Recent surveys i ndicate ’

Table 5.2: Material Mortality Rates per 1,000 Deliveries in
Five Kunpulu Hospitnls, 1972-86 ’
3 Source: Makerere Medical deol, Clinical Report 1970-72; Kampikaha, Maternal Mortality in 5
l Kampala Hospitals, 1988 .
that 17-35 percent of people seek care at government facilities compared to 30-53 percent at NGO
and private ones; the remainder patronize traditional healers. While private, NGO and traditional
health providers are thus very important in Uganda, a particular difficulty in carrying out this
review is the complete lack of any data on their expenditure. .
5.4 Access to both public and private services is uneven; nationally, 27 percent of the
population are within 5 km of a health unit and 57 percent are within 10 km. The situation is
particularly severe in the North, however, where only 43 percent are within 10 km. (T able 5.3);
in addition over 50 percent of all hospitals and most health centers are in or near trading centers,
so access is much more difficult for rural than for urban Ugandans. Almost all family planning
services, including those provided by NGOs, are located in urban areas.
5.5 Uganda is worse off than other low income developing countries in terms of its population
. per physician (about 22,000, compared to 14,000), particularly striking as Uganda was so much
better off in 1965 (about 11,000 compared to 28,000). Thus the ratio of physicians to the
population has halved in 25 years, largely due to emigration which continues, reducing the social
retums to medical education provided by Makerere University. That of nurses has improved, from
one nurse per 3,000 people to one per 2,100. However, the bulk of health personnel remains in
the urban areas and in hospitals; in 1988, 74 percent of all public sector health staff were located
in urban areas and 76 percent worked in hospitals. Yet Uganda’s population is 90 percent rural.

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S of Po-ulation Within 1
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Source: Alnwick et aL. Population Access to Hospitals. Health Centers and Menage Maternit y Unit:
L m _,_ M’Usa. 1935, p.6

5.6 Not only are many public facilities in poor physical condition, there is little effec tive management and their staff are inadequately paid. This has in itself contributed to the d evelopment of the N60 and private sectors; it is now common for government health workers both to ho ld second jobs at N60 and private facilities and to practice private medicine out of public premises. Indeed de facto charging has become the norm at theoretically free government units. The management issue is partly a matter of training but mainly one of motivation. It is also a reflection of the poorly coordinated structure of responsibility for health services in Uganda. The Ministry of Health make: health policy, runs national donor-funded vertical primary programs, runs all public hospitals but one, and seconds staff to local governments as District Medical Offi cers and as primary health care workers. Districts and municipalities are responsible for primary and preventive services under the overall guidance of the Ministry of Local Government. Mulag o Hospital has been semi-autonomous since 1986 but functions more as a primary and secondar y care facility for Kampala than as the national referral, teaching and research hospital as whi ch it was designed. As an example of the deteriorated quality of the healthsystem, Makerere Univers ityhs Degree in Medicine - which uses Mulago as its teaching hospital - was derecognized by the General Medical Council of the United Kingdom, a severe bIow for what was once known as t he ftnest medical school in Africa. ’ ’

5.7 As part of this public expenditure review, a special study was carried out of health services in two districts, Hoima and Mbale, in order to confirm and expand on broad fmdings at the national level. Neither district has a health plan or even a work plan for the various pr ograms run V in it. Both have N60 and private as well as public facilities, with the NGOs operating in an entirely uncoordinated and unregulated manner. The broad morbidity and mortality patterns are similar to those at the national level. Public sector buildings in both districts are in a poor state of repair and no funds are set aside for maintenance; in some cases, communities and exte rnal agencies have repaired health centers but they have not since been maintained. Staff sala ries are very low; the highest paid worker earns less than US$15 a month. Delays in being paid of up to two months are quite normal and staff in poorer counties tend not to be paid for up to tw o years.

While services are theoretically free in public facilities, there is extensive de facto c harging in both districts. ’

5.8 The supply of drugs at district hospital outpatient departments has improved since these departments were included in the donor-funded Essential Drugs Management Program (EDW). (However, it remains inadequate in some other districts, for reasons that are not clear as all districts participate in the EDMP). The inpatient drug situation is not so good in Mbale but is adequate in Hoima. At small dispensaries and health centers, the drug supply is also satisfactory but that at the larger health centers is inadequate; shortages are difficult to assess because there is clear overprescription of some items like procaine penicillin and probably also chloroquine. In a number of units, untrained staff continue to see patients and prescribe. The supply of consumables, especially gloves, and of contraceptives, particularly injectables, is seriously inadequate in both districts. Both had an appropriate number of vehicles, motorcycles and bicycles, mainly supplied through the vertical programs and run with funds from the vertical immunization program, although there is no transport control and coordination and no maintenance system.

5.9 Progress on child immunization is very good (74 percent coverage for measles, polio, BCG and DPT in Mbale and 45 percent in Hoima), with measles ever less of a problem. Drop out rates remain high, however, and tetanus toxin coverage for women of childbearing age is very low (22 and 18 percent, respectively). Neither the diarrhea! disease control program’nor the information system is functioning in either district. Neither has clear plans for AIDS control activities. In Hoima; 51 percent of women interviewed in a survey did not know that there was HIV infection in the district; teaching about AIDS in Mbale is concentrated on the schools. Health workers do not all know enough about needle sterilization to prevent HIV transmission through injections.

While the commonest cause of morbidity and mortality in both districts is now malaria, very little is being done about it. Yet low cost environmental strategies, which worked in Uganda in the 19605, remain feasible.

Sector Strategy

5.10 Since 1961 there have been various commissions and workshops which have deveIOped approaches to health policy. Rarely, however, have their recommendations been translated into specific actions. In 1978 Uganda became signato y to the Alma Ata Declaration on Primary Health Care but no action followed. In 1983 the then Government again endorsed Primary Health Care but did nothing to formulate a specific implementation policy. With the National Resistance Movement’s Ten Point Program and Rehabilitation and Development Plan, however, Uganda has made a stronger commitment to community panicipation in the planning and implementation of basic social services through the Resistance Committees. In 1987, the Government appointed a .

Health Policy Review Commission to develop a health policy of ’availingprimaty health care for Uganda through the health strategy of prevention of disease and promotion of health and through popular participation ’and establishment of functional health units at all levels.’ Following the Commission’s report, the Government in 1989 adopted a national health policy, reconfirming primary health care, based on the health center as the basic health delivery unit with the hospitals playing an essential referral function. This policy remains essentially non-operational,

however,
and has neither been translated into a series of specific actions nor used in health budg
eting. The
Ministry of Health is at present engaged in producing a National Health Plan through the
year
2000; the first drah, completed in early 1990, has not been accepted by the Ministry of F
laming
and Economic Development because, while it calls for a system based on primary health car
e, it
proposes the continued concentration of resources on hospitals. It has no explicit priori
ties and
takes no account of either the financial resources likely to be available to the public s
ystem or the
role of the private and NGO sectors.

5.11 The effective absence of a practical health policy thus continues the situation deplored by the Health Policy Review Commission in 1987: . -

’there is uncertainty as to what specific policy the Ministry is pursuing across a wide range of its activities. Hence, even senioroflicers are not clear as to the Ministry’s policy on specific issues. The absence of clear policies in turn leads to inadequate determination of priorities for the Ministry as a whole. Consequently the external donors take advantage of the apparent policy vacuum to lobby high political and top civil circles thus prejudicing - the policydecisions in their favor but not necessarily in the national interest.’

5.12 Moreover, the Government’s de facto policy is to concentrate resources on hospitals and not on primary health care through health centers (para 5.21 below). This general pattern of resource allocation is not unique to Uganda but is rather typical of many African countries; what is peculiar to Uganda is the degree of concentration of resources on hospitals. The same conclusion can be drawn from the organizational structure of health services. Consistent with NRM policy, the District should be the principal implementation unit for health services. Yet there is no clear. accountability. The District Medical Officer (DMO), a Ministry of Health appointed and paid official seconded to the district, reports variously to the Regional Medical Officer, the District Executive Secretary, the Ministry of Local Government and the Ministry of Health. His staff, the District Health Team (DHT), are employees of the District. Based on a survey of two districts and consistent with impressionistic evidence from others, the DHT controls only about 10 percent of health resources in the District (8.5 percent in Hoima and 11.5 percent in Mbale). The bulk is controlled by the Ministry of Health, which rum the District hospital(s) and also the donor-funded vertical programs such as immunizations and essential drugs, though the latter falls to the DHT to implement; donors are unwilling to decentralize fuiancial functions because of relatively poor accountability at the District level. The DHT has no authority over the public hospitals or over any N60 or private health services. Almost no districts have health plans, although some are now trying to develop them with NGO assistance.

5.13 While the Government’s general objective of primary health care is thus entirely consistent with the community participation and poverty alleviation goals of the Economic Recovery Program, it has as yet little practical content. A particular difficulty is the lack of a long term vision for the sector and the lack of an explicit def’mition of the role of the public sector compared to the N60 and privatehealth services. The pattern of govemment-controlled spending appears to reflect not so much its avowed policy of primary health care but rather a very understandable, but unaffordable, attempt to rebuild the public health systemof which Uganda was justifiably proud in the 19605.

5.14 Health is both a public and a private good. As a public good, there is a prima facie case for government intervention to achieve the social returns from preventive services. As a private good, there is also a case for direct government provision in terms of both equity and basic needs, to ensure access to services to those who cannot afford it at private and NGO facilities or who have no such facilities near where they live. Thus, a pragmatic health policy for the 1990s wo

uld be
for the Government to ensure initially that cost-effective primary and preventive health services are
supplied to the maximum number of Ugandans, with a secondary objective of rehabilitating the
hospitals necessary for referrals. Such a policy would mean accepting that it is not necessarily the
government’s obligation itself to provide services but rather to ensure that they are provided. It
would also imply increasing the public sector’s resources through cost recovery at the most

expensive points of the system: drugs, hospital inpatients and private patients at public facilities.
It would mean that public health expenditure: financed out of general revenue: would be cohcentrated on preventive services such as immunizations, family planning and AIDS education and on the provision of primary curative services in areas like the North where N60 and private facilitiw are inadequate. It could also mean the contracting or subsidization of NGOs to provide services in certain regions where this would be more cost-effective than public provision. Modest eitperiments along these lines are currently underway in Uganda but they have hot as yet been integrated into a coherent approach. Some have suggested that the government should confine its activities to prevention, but this is not practical given the history bf public health in the country, the distribution of N60 and private facilities, and the very urgent need to maintain and improve primary curative services at a time of economic adjustment. Evidence is scanty but would seem to indicate the importance of simple curative services in order to keep people healthy enough to continue to work and generate income. An untreated bout of malaria, for instance, can ruin a small farmerls attempt to bring in a harvest.

5.15 Given the weak capacity of the existing public health system, such a policy could be implemented only by building on the system’s strengths and overcoming its weaknesses. There are four main strengths. Foremost among these is the quality and number of Uganda’s health personnel, both inside and outside the country, who are actually and potentially available for the system The second is the existence and increasing number of NGOs. The third is the success of two donor-funded vertical programs: child immunizations and essential drugs. The fourth is the publicls willingness and ability to pay for services, as evidenced by official charging by N60 and private providers and de facto charging at many public facilities. The chief weaknesses of the system are the poor salaries of all public sector health personnel; overstafting; the serious shortages of consumables; the urban arid hospital bias of most services; the poor physical condition of most public facilities and their relative lack in the Nonh; the lack of managerial capacity and work planning; and the fragmented administrative structure which results in almost no accountability.

Issues in Sectoral Public Expenditure Program

5.16 Requirements and Phasing. Over time, the Government should consider moving toward a system in which all health expenditure: and facilities in a defined geographical area, presumably the district, come under the direction of the DHT, headed by the DMO or a professional manager.
It will take time to move toward such a system, however, and this will involve the consolidation of resources currently spent under several different budgets and the training of district health teams in management practices.

5.17 Meanwhile the priorities for public expenditure should be to improve the functioning of . the present system, taking account of the existence of alternative facilities run by NGOs "and the private sector and focusing on one or two types of standardized health centers as the crucial point in the system for delivery of primary care. Once this is done, the higher levels of the system can be improved, starting with district hospitals and then moving up to referral hospitals. There is,

however, little point in rehabilitating hospitals beyond the minimum necessary to keep th
em
functioning until the lower levels of the system are operating better, and until provisio
n is made
to meet the hospitals’ recurrent costs. .
5 . 18 Overall Expenditure. The absolute minimum recurrent expenditure necessary for effe
ctive
primary and secondary health care is equivalent to about US$34 per capita per annum; a mo
re
reasonable level would be twice this - Kenya spends U856, Zimbabwe US$14 and Botswana

Table 5.4: Financing of Local and Foreign Expenditure on Health. 1988/89
’ (U Sh million)
US$29, all countries which also have significant N60 and private health providers in addition to
the public sector. At a ininimal level of US$35 per capita, Uganda should spend about U Sh 22
billion on primary and secondary care, before including both recurrent costs at the tertiary level
and capital costs. In fact, total public health expenditure on all purposes in FY89/90 will be about
U Sh 17 billion, less than the minimum recommended for primary and secondary recurrent care
alone. Recurrent spending on that seems likely to be equivalent to about US$1.7 per capita, or
only one half of that minimally necessary. Furthermore, largely as a result of the governments
dependence on aid, only one third of this (US$06 per capita) is funded by the Ugandan central and
local government; the bulk is financed by donors. The Government is financing only about 43
percent of total foreign recurrent expenditures (Table 5.4) and, as discussed in the next section,
these expenditures are well below those minimally necessary.

5.19 The overall level and tinancing of recent expenditure is summarized in Table 5.5. There
are three levels and five principal sources of expenditure: central government (Ministry of Health,
Mulago Hospital, and Ministry of Local Government), local government (Districts and
Municipalities) and donors. Hard data were collected for the central government and the donors;
expenditure by local government was estimated on the basis of the historical 65 percent of their
health budgets that has actually been spent by Districts and by taking four times the Kampala City
Commission expenditure for municipalities; data for FY89/90 are extrapolated from mid-year
results. Overall expenditure has incrmed from U Sh 2.4 billion in FY87/88 to about U Sh 17.4
billion in FY89I90, a real increase of 96 percent, largely reflecting expanded donor financing as
a result of both increases in aid and the depreciation of the shilling. The donors’ share in total
spending has risen from 47 to 70 percent. Total public expenditure on health has gone up from
US$25 to US$10 per capita, from 4.8 to 8.7 percent of public expenditure, and from 0.7 to 1.3
percent of GDP.

Table 5.5: Total Public Expendimi’e on Health. 1987/88 . 1989/90. ’
(U Sh million)
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5 .20 According to the financing, one would expect recurrent spending to consist of that under recurrent budget heads and capital spending to be that under development budget heads, in cluding all donor funding. On such a budget head basis, recurrent expenditure would represent abo ut half the total. In practice, however, some government development expenditure and much donor expenditure is for recurrent purposes; when the data are corrected for this. the proponio n of total spending accounted for by recurrent expenditure rises to about three quarters.

Table 5.6: Total Real Public Expenditure on Health. 1987/88-1989/90
(constant 1987/88 - U Sh million) . .

5.21 Just over 60 percent of total expenditure went for primary health care. The pattern is very different when a comparison is made of the composition of central government, local government and donor expenditure, however. On average in FY 87/88 and FY88/89, expenditure on primary health are accounted for only 33 percent of that financed by central and local government but for 83 percent of that funded by donors. When it is considered that all local government expenditure is only for primary health, it can be seen that a very low proportion of locally-ftnanced central government expenditure is for primary care. By contrast, the one tertiary hospital, Mulago, alone accounted for 20 percent of total government-financed expenditure on health in each year and for 10-11 petcent of total spending from all sources.

5.22 Thus not only is the total level of health expenditure very low indeed, it is increasingly financed by donors. Donor funding has risen steadily during the 1980s from about USSS million in FY82l83 to US$35 million in FY89I90 and indeed is expected to rise to US$46 million in FY90I91 simply on the basis of existing commitments. While government funding of health did increase in real terms from FY87/88 to FY88/89, it will fall in FY89/90 (Table 5.6). The low government share reflects not only low budgeted amounts but also a consistent pattern of realized expenditure falling well short of that budgeted. The recurrent budget of the Ministry of Health in FY88/89 was only 17 percent of its real level in FY70/71. Moreover, actual recurrent spending by the Ministry of Health in FY88/89 was about 65 percent of that budgeted. Overall central government spending on health in the same year was equivalent to 64 percent of that budgeted, rather higher than the 55 percent achieved in FY87/88 and the 4-4 percent that seems likely in FY89/9O (T able 5.7). Comparisons of budgeted versus actual expenditure by donors are essential! y impossible to carry out, because the development budgets do not even roughly reflect estimated donor disbursements on existing projects. much less new ones. (This is not a problem peculiar to the health sector, however.) Local governments spend about 65 percent of their health budgets.

5.23 The consistent pattern of the Government failing to spend its health budget was largely due to ’suspensions’ by the Ministry of Finance, as discussed in Chapter III of Volume 1. The health sector is particularly susceptible to suspensions in its capital budget; in FY89/90, for instance, development spending by the Government will likely equal only about 19 percent of that budgeted. But the health sector, which depends on imported drugs and supplies, is also vulnerable to suspensions on its recurrent budget due to shortages of foreign exchange. In March 1990, for

Table 5.7: Central Government on Health. 7
Actual versus Budgeted,’.l987/88-l989/90
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Minjst of Health
example, or nine months into the fiscal year, Mulago Hospital had not been authorized by the Ministry of Finance to spend any of its FY89/90 budget for drugs and consumables. If donorsl were not funding the bulk of the drugs necessary for primary health care, there would be a very serious situation. ’

5.24 Recurrent Expenditure. As Table 5.8 shows, the effect of these suspensions is that wages, salaries and allowances dominate govemment-funded recurrent spending (57 percent) while drugs and consumables dominate that funded by donors (48 percent). Overall, personnel accounts for 42 percent of recurrent expenditure and drugs and consumables for 33 percent. This distribution is reasonable. Yet in practice its results are not; as overall expenditure levels are too low, the level of spending on both personnel and supplies is seriously inadequate.

5 .25 In the case of personnel, the situation is greatly complicated by massive overstafl ’mg. This, plus the overall low level of expenditure, results in excessively low average salaries, as is typical of the Ugandan public sector as a whole (Volume 1, Chapter 4). A District Medical Officer, for example, received in March 1990 a salary of about U Sh 7,000 per month; a mid-level manager in the private sector with equivalent responsibilities earned about U Sh 150,000 per month, or 21 times as much. Similar ratios apply at all levels of staff. The very low salaries are frequently paid very late, especially those paid by local governments in the poorer counties. The result is a poorly motivated staff at all levels, reflected by high attrition rate: (40 percent for nurses and 50 percent for medical assiktants in one year, 1986, alone); the de facto charging in many places for nominally free services, and, as reported by many officials, high levels of corruption, ranging from stealing of office and medical supplies to kickbacks on construction and other contracts.

58. Compo’ne f mt Health Expenditure, 1987/88
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5.26 Because public sector health personnel are employed by so many bodies, there is no accurate inventory of their numbers, especially at the critically important local government level.

Approximate figures are available for the Ministry of Health but not for other public sector health employers: they indicate that about 8,300 of the 9,200 established posts are currently filled, with 5,900 staff confirmed or on probation, and 2,400 unconfirmed. in health as in other sectors (see Volume 1, Chapter 4), steps are being taken to regularize the established positions, but about 30 percent of the staff, including most people hired within the last five years, have yet to be continued in permanent and pensionable status, further dampening morale. The present regularization is only - on the basis of the payroll, however; urgently needed also is a comparison of positions against requirements. There are no staffing norms in Uganda’s public health sector, although the Health Policy Review Commission recommended some. These norms were applied at the district level in Hoima and Mbale and indicated overstaffmg of 70 and 27 percent, respectively. In both cases, 60 percent of this was due to group employees. indeed, group employees have increased in number throughout the health sector. There are currently 13,200 paid by the Ministry of Health; figures are unavailable for earlier years but it is clear that the numbers have increased very substantially.

5.27 Resolving the salary issue cannot be done in the health sector alone but must be pan of a wider solution at the level of the public sector as a whole. This will clearly have to involve reducing the numbers of group employees. Of the Ministry of Health’s 13,200 group employees,

for instance about 4,000 are performing important health functions. as nurses' aides and similar.
If the Ministry were to reduce the remainder by half, it would realize salary savings of U $11 15
million per month. This would be three times as much as is needed to pay DMOs the equival ent
of private sector middle management salaries. Other actions can be taken by the health se ctor
alone. Most important among these is, first the establishment of staffing norms and their comparison with the current actual situation and, second, increasing the salaries and ope rating
budgets of those with supervisory responsibilities at all levels.
5 .28 The Central Medical Stores (CMS), located in the Minisz of Health, is the main proc urer
of drugs and consumables for public sector health institutions, with the exception of Mul ago
Hospital. Drugs and iconsumables are largely imported and may be considered a foreign expenditure. Located within the CMS is the Essential Drugs Management Program (EDMP) whic h
provides essential drug kits for health centers and hospital outpatient departments, fund ed by
DANTDA at an average level of about U833 million per annum, and has been a reliable sourc e of
supply. The unavailability of foreign exchange has made the funding of the remaining drug s for
district and Mulago inpatients very difficult. Total drug expenditures including those by Mulago
are currently running around US$10 million per annurn, but foreign exchange is not made a vailable
when needed and barter agreements, including dubious valuations of drugs, have frequently been
used.which has likely not been a cost-effective method of procurement. A spot check by th e CMS
on two common items from a barter shipment, for example, found one to be valued at twice and
the other at four times its price in private pharmacies in Uganda. There have also been l ong delays
in receiving a number of barter shipments, with significant proportions arriving after th eir expiry
date with implications for efficacy and safety.
5 .29 Opinions differ on the adequacy of the drug supply. Field work during the mission d id not
indicate any severe problems, though hospital inpatient departments and especially Mulago were
relatively poorly stocked. Annual expenditures of US$10 million compare with a 1988 WHO estimate of public sector requirements, excluding Mulago, for essential drugs only of US$ 6.1
million and a CMS estimate, also excludingMulago, of US$10 million for all drugs includin g those
for hospital inpatients. Mulago's needs have yet to be ptoperly estimated but are likely of the
order of US$2 million. It would therefore seem that aboufUSSlO million of Uganda's total public
sector requirements of about US$11 million is being made available, but, except for essen tial
drugs, the supply is not consistent and there are long periods when drugs can be in short supply
in hospitals.
5.30 While the bulk of drug funding requirements are met,.the picture is very different f or
consumables - surgical materials, dressings and other medical supplies. The CMS estimates requirements at about USSS million, plus perhaps another USSI million forMulago. Yet only about US$01 million has been spent in each of the last two years. The result is evident: Serious
shortages of supplies throughout the system, from Mulago down to small health centers. Th is is
particularly serious for supplies associated with MCH such as gloves, forceps and catgut. all of
which are virtually nonexistent at present. Consumables suffer even more than drugs from the

Ministry of Finance’s failure to release suspended items; their absence may not seem as dramatic to those outside the health system but is striking to those within it.

5.31 Field work in Hoima and Mbale also indicated that there was a serious supply problem with regard to family planning supplies. Demand for injectables was very high in both districts but supplies have not been available since August 1989; the method used in 80 percent of cases was thus pills. Only two types of pills were available in Mbale and only one in Hoima.

Table 5.9: Health Sector Vehicles. early 1990
Sources: Mim’my of Health
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5.32 The distribution system within Uganda for the essential drugs under EDMP is very effective. Those for other drugs, consumables and family planning supplies is less so. The CMS makes two distribution rounds each quarter, the first for essential dmg kits and the second for bulk drugs and supplies. The second round is typically subject to long delays, ohen of months, because of both a lack of fuel and of allowances for drivers, funds for which are both in the suspended category, and a shortage of lorries as a result of their poor condition and shortages of spare parts.

The Government should consider expanding the use of the highly efficient EDMP distribution system to cover all drugs and supplies. i

5.33 The other principal components of recurrent expenditure are training (about 6 percent of the total), and operations and maintenance of buildings (3 percent) and vehicles (2 percent).

Training is equally funded by the Government and donors. Very high attrition and emigration rates of clinical personnel do raise questions about the returns to training. The Government may wish to consider a moratorium on clinical training to channel training resources toward improving quality and supervision, the redeployment and reorientation of some medical cadres, and managementtraining, for which there is a serious need at all levels of the public health system.

Operations and maintenance responsibility goes along with operating responsibility i.e. the Ministry of Health is rapo’nsible for hospitals, Mulago for itself, and local governments for health centers and lower level facilities. Almost all operations and maintenance expenditure has gone for operations, e.g. utilities for buildings and fuel for vehicles. Spending on maintenance has been minimal, with the result that even recently rehabilitated facilities have begun to deteriorate. There is urgent need for a 15hysical facilities maintenance program. it is striking that there is neither a program not a budget for equipment maintenance.

5 .34 The situation regarding vehicles (T able 5.9) is more complicated and varies at the district, hospital and national level. There is an adequate supply of vehicles in the districts, indeed perhaps an excessive supply, as a _result of vertical projects funded by donors. Each district has at least three vehicles; Hoima and Mbale each had six, of which four were functioning. Yet the very provision of vehicles by different vertical programs precludes the rational uSe of transport; in general all vehicles in the districts are being run by immunization program funds, regardless of the vehicles supposed purpose. There is no transport control and coordination and very little maintenance. New vehicles are provided regularly by donor projects so that non-operational , vehicles are fairly quickly replaced. At the Ministry of Health hdspitals, 73 percent of the vehicles are in poor condition and there are only 56 vehicles for the entire country, making patient transport

7 Tbale 5.10: Donor Expennuedi by Level, Type and Prom 1988/89
- (USS million)
almost impossible on referral or in emergency. Ministry of Health headquarters has 74 vehicles,
one half in poor condition. One third (24) are assigned to individuals and not to programs or
depamnents. Ministry operations and maintenance expenditure is inadequate for the 130 vehicle:
it runs, therefore, as evidenced by the high proportion that are in poor condition anti that only 15
are in 'good' condition. It is noticeable that the majority of both total Ministry vehicles and of
the better functioning vehicles are held at headquarters rather than assigned to the hospitals which
have a greater nwd. Some reallocation could have very high returns, though the operations and
maintenance expenditure would still have to be increased.

5.35 The pattern of recurrent spending across levels of care is illustrated in Tables 5.4 and 5.5
and mirrors that of spending as a whole (para 5.21). Almost 60 percent of the total goes for
primary health, including 100 percent of that by local government, almost 90 percent of that by
donors but only 9 percent of that by the central government. Overall, Government is funding only
about a quarter of total recurrent expenditure on primary health. The built of central government
recurrent expenditure goes for urban secondary hospitals (44 percent), Mulago Hospital (25
percent) and central administration (22 percent). Yet Uganda's population is overwhelmingly rural.
Donor funding of recurrent expenditure, by contrast, includes only 11 percent for secondary
hospitals and 2 percent for Mulago. Thus, 'as with total spending, the overall allocation of
recurrent expenditure by program fits the government's priorities only because of donor
expenditure and not because of that by the Govemmentitself. In saying this, it must be recognized
that both the tertiary level Mulago is at present also providing primary and secondary care and the
secondary level district hospitals are providing primary care.

5.36 - Public Investment Plan. There are serious problems of consistency among the information
contained in the government's Rehabilitation and Development Plan (RDP), in its annual
development budgets, and in donors' data on expenditures. The RDP, for instance, lists 10 priority
projects in the sector yet donor project names and components straddle these. The IDA First
Health Project, for example, includes elements in support of six of the ten projects. This makes
matching of the projects as defined by the Government and as defined by the donors very difficult.
Despite this, broad conclusions are possible, although detailed ones are difficult. A further
complication is what is included in the plan. In theory, the public investment program should
correspond to development expenditure and should consist only of capital formation and technical
assistance. In practice, while development expenditure (defined as that by the Government under

its development budgets plus that by donors whether budgeted or not) appears to account t ot about ’ i
50 percent of sector spending, one half of this is on recurrent items. Thus ecapital and technical
assistance expenditure account for only about one quarter of total sector spending.
5 .37 Donor funding dominates both true capital (70 percent) and total development (90 pe rcent)
spending. This section thus concentrates on analyzing donor expenditure in recent years a nd as
anticipated in the future on the basis of the government’s plans and donor intentions. Es sentially,
nine major projects/programs can be identified:
Physical Rehabilitation and New Construction
(i) ’ Mulago Hospital
(ii) Secondary Hospitals
(iii) Primary Health Care Facilities
Vertical Primary Programs:
(iv) Immunization (UNEPI)
. (v) Essential Drugs (EDMP)
(vi) AIDS (ACP)
(vii) Population
(viii) Other (CDD, etc.)
Training
(ix) Health Training and Planning
5.38 While donor spending is largely donor determined, it has generally corresponded with government’s stated priorities, although no explicit criteria appear to have been used by either
Government or donors to arrive at this situation. Table 5.10 shows spending for FY88/89, which
was broadly similar in its distribution to that in both FY87188 and FY89/90. Over 80 perc ent has
gone for primary care, most channelled through three vertical programs: the Essential Dru gs
Management Program (EDMP), the AIDS Control Program (ACP) and the Expanded Program on
Immunization (UNEPI). Within these three programs, the bulk (80 percent) of expenditure h as
been for recurrent items. Remaining donor support at the primary level has been both for other
vertical programs and for health center rehabilitation.
5.39 The 20 percent of donor funding that has gone to levels above the primary has been s plit
roughly equally between recurrent expenditures and physical rehabilitation at both second ary and
tertiary levels (there has been very little new construetion). The very low levels of gov ernment
funding for development expenditure have largely been to provide counterpan funds for the donors’
vertical programs and also for very modest physical rehabilitation at all levels of the p ublic health
system.
5.40 The volume and pattern of donor spending looks likely to change, however, on the bni s
of disbursements from existing commitments and government intentions regarding the future public
investment program. On the basis of existing commitments, funding for the vertical primar y
programs is likely to continue at around its present level. That for physical rehabilitat ion of health
centers should increase slightly. Basic tehabilitatiOn of secondary hospitals and Mulago is set to
increase very significantly. Pending completion of its health plan through the year 2000, the
governments longer term intentions remain to be determined.

5.41 The nine major projects are brieny considered below:

Physical Rehabilitation and New Comtruction

(i)

(ii)

(Iii)

Mulago Hospital functions as the primary and secondary care facility for Kampala and as the national referral, teaching and research hospital. Some basic rehabilitation of Mulago is currently underway which should prevent further deterioration. Much of Mulago's patient load could be met in a very oost-effective manner by rehabilitating and possibly expanding the number of primary health care centers run by Kampala City Commission. All further expenditure on Mulago must therefore be placed into both the Kampala and also the broad sectoral context.

Secondary Hospitals. Eight of these are to be rehabilitated and one new one is to be constructed in Rakai district. In general the rehabilitation will be appropriately basic. The Government will wish, however, first to assure the rehabilitation of the primary health care centers in the nine districts and elsewhere. As with Mulago, it must also develop a program to fund the hospitals' recurrent costs. Without such funding, the rehabilitated facilities are in danger of rapid renewed deterioration. The Government intends to introduce user charges throughout the public health system (paras 5.47-5.49). Recovering at least some of the costs of drugs and consumables and of inpatient stays would likely make the hospital recurrent cost hnancing problem more manageable. Priority for hospital rehabilitation and, ultimately, for new construction, should go to those districts which have no adequate NGO facilities.

Primaly Health Care Facilities. These should be the priority for physical rehabilitation and for new construction in areas such as the North, Rakai and Kampala where their number is inadequate. As with secondary hospitals, priority should be given to geographical areas without adequate N60 and private facilities. Plans must be set up to maintain the facilities, once rehabilitated. At about US$1 million per annum, funding for the rehabilitation and construction of health centers is currently inadequate.

Vertical Primary Programs

General Comment. Vertical programming in and of itself need not be a bad thing and indeed has resulted in two very suceessful programs (EDMP and UNEPI). However . vertical programming has very high costs in terms of administration and duplication unless different vertical programs are at a minimum coordinated and preferably integrated. Unfortunately the health sector abounds with instances of both duplication of effort and administrative overload. Nowhere is this more apparent than in Information, Education and Communication (IEC) activities. Each major donor has an IEC component, including UNICEF (AIDS; primary/matemai health including irmnunization), IDA (general health; AIDS), USAID (family planning, family health), UNDP (AIDS) and WHO (AIDS). Similarly the existence of the different vertical programs in each district drives the funds available to the DHT and does not permit their allocation to the highest priorities in each district.

(iv) Immunization. The UNEPI program has been very successful with regard to child' - immunizations, particularly for measles, though there are high dropout rates. It is seriously deficient, however, with regard to tetanus toxoid protection of pregnant women, as evidenced by both immunization and maternal death rates. The program should be continued and improved for tetanus toxoid.Conside1-ation could be given to using its effective IEC channels to deliver other IEC messages.

(v) Essential Drugs. EDMP has been a very successful program, costing US$34 million per annum for drugs and USS! million in technical assistance for management support. The' principal funder (DANIDAIDanish Red Cross) intends to discontinue. the management support after 1993. It seems unlikely, however, that CMS will have adequate capacity to fully manage the procurement and distribution of drugs and consumables for the public sector by that date, and technieal assistance for this should be a priority for continued donor funding. Consideration should also be given to utilizing the very effective EDMP distribution system for drugs not on the essential drug s
list (or for redefining the list to include them), for family planning supplies and for consumables.

(vi) AIDS. The AIDS Control Program has not been effective at the critical district level ,
judged from the mission's findings in Hoima and Mbale. Even though the AIDS problem is more grave in some other districts, the Government also has serious concerns . about the effectiveness of the AIDS Control Program and has recently adopted a multisectoral approach to AIDS. An AIDS program is clearly of very high priority, given the extent of HIV infection in Uganda; urgently necessary work has only just begun, however, to determine its scope and costs.

(vii) Family Planning. As noted,de1nand for family planning outstrips the availability of supplies and contraceptive prevalence is very low. This appears to indicate that the very modest current program has been effective in stimulating demand through its IEC activities but has not done enough to supply contraceptives. The mission did not examine this program in any detail and so this conclusion must be considered tentative, though supported by the Hoima and Mbale field work. There would seem to be a case for a major expansion on the supply side, possibly using the effective EDMP distribution system. ' Nor should there be any diminution of demand-stimulation.

(viii) Other Vertical ngrums. These programs, including Control of Diarrheal Diseases and various Health Education efforts, do not appear to have been very Successful, although they have not accounted for much sector expenditure. Consideration should be given to reexamining them as vertical programs and integrating some of their activities into DHTs' routine activities. In addition, it is critical also to establish effective ma laria
control and STD programs.

Training

(ix) Health Training and Planning. The mission did not examine these programs in any depth, especially on the clinical side. As with govemment-funded training (para 5.33), however, it notes that high attrition rates raise questions about the returns to these programs and that there is an urgent need to improve the training of management and planning staff and that current efforts are ill coordinated and inadequate. Prerequisites are some reorganization of responsibility 1n the sector as discussed below (paras 5. 49-5.55).

prter 5: Health
Proposed Sectoral Expenditure Progmin
5.42 The discussion in the previous section indicates the priorities for the medium term. To reach minimum levels for effective primary and secondary care, recurrent spending at these levels should be doubled in real terms. Within this, primary care should have priority as it is the most cost effective. Equally, it is not feasible to close secondary and tertiary facilities, even if they are of lower priority, and a minimum level of expenditure is necessary to keep them functioning. At all levels, it is essential to raise salaries to increase health workers' morale and productivity, to ensure a minimum supply of drugs and consumables (about US$16 million per annum), and to make provision for building and vehicle operations and maintenance. The Government hopes to meet some increased recurrent expenditure through the formalization of user charges in the sector (paras 5.47-5.49). Increued recurrent spending from the budget will be necessary in addition, however, at least at the primary level. It is clear that local governments do not have adequate resources to pay even a slimmed-down primary health work force. This may mean rethinking the present block grant concept from the Ministry of Local Government to the districts; at present there is no block grant component for health while there is for other expenditure categories like education; alternatively, if ministerial responsibilities are reorganized (para 5 .50), it could be done through the Ministry of Health's budget. 9
5.43 Similarly, for development expenditure, the priority should be the primary subsector, including the maintenance of effective vertical programs, the expansion of the family planning and AIDS programs, and the rehabilitation and construction of health centers and lower level facilities in areas not well served by NGOs and the private sector. This means especially the North and Rakal district. Hospitals also require rehabilitation but this-should proceed slowly until primary facilities are adequate and until provision has been made to cover their recurrent costs. The rehabilitation of Mulago beyond those basic work: currently funded is not a high priority, whereas the provision of primary facilities for the rapidly expanding Kampala area is critically important.
Cost Recovery and Efficiency
5.44 Cost Recovery. The Government intends to introduce user charges throughout the public ' health system; it did so for private hospital patients in March 1990. No timetable has yet been established for introducing charges. As there is de facto charging in many, if not most, public health facilities at present, the formal introduction of charge: will to a very large extent represent a rationalization of existing practice. Present thinking among those preparing for the introduction of formal charges is that general charges will be levied for all curative outpatient and inpatient services on a sliding scale according to the level of the facility. Documents under discussion in early 1990, for instance, suggested a general outpatient charge at a health center of U Sh 200 compared to U Sh 300 at a district hospital and U Sh 500 at a general referral hospital; a similar scale was under consideration for inpatients. Outpatient reattendances wodld be charged at one half - the rate for a first attendance. Preventive servieec such as immunizations would be free, as would

all services for children under 5 years of age and reattendances for the treatment of certain
communicable diseases such as tuberculosis. There will be exemptions for those unable to pay;
these will be granted by the Resistance Committee: at local level following general guidance from
the center.

5.45 Increasing charges at higher levels of the system will encourage patientsto first ’s eek’ .
treatment at lower levels of the health system. The Government intends to charge those re ferred
to higher level facilities only the differencebetween the fee levied at the first facilit y and that for
a first attendance at the second facility. The levels of charges under consideration for outpatients
are said to be determined as 20 percent of the estimated costs of personnel, drugs and ma intenance
at each facility. Yet this is an arbitrary percentage; moreover, in general such cost dat a do not
exist at the facility level. Similarly, without cost data, it is hard to assess the possi ble levels of
inpatient charges relative to costs. No decisions have been taken on the utilization of r evenues
from charges but a likely scenario is that 50 percent of them will be utilized for staff ’welfare’
(i.e. to increase salaries), 30 percent to imprOVe the health facilities themselves, 10 p ercent for a
common fund at the district level, and 10 percent to cover the administrative costs of op erating the
user charge system. Health expenditure financed from general revenue: is nOt to’ be reduc ed as
. a result of charges being introduced which will thus supplement existing resources.
5.46 Comprehensive revenue projections based on the proposed charges have not been drawn
up. In general they are expected to approximately quadruple health center employees’ earn ings
and triple those of hospital workers. Reviewing the likely revenue: was beyond the scope of the
public expenditure mission. However, several observations are relevant. First, the intent ion to
introduce charges is a sensible one, from the perspective of both the overall level of re sources in
the sector and the allocation of those resources Swond, more thought might be given to ch arging,
including a prepaid capitation fee, at the community level for basic primary services. Th ird,
without a systematic study of household budgets, it is impossible to estimate whether or not the
poor will be able to pay even the fairly low charges under consideration and thus it will be
important that the exemption system be operated very flexibly until such data are obtaine d.
Alternatives could include exemptions determined by the local RC5, or using proxies for i ncome
such as ownership of land, livestock, etc. Fourth, given that more people already seek tr eatment
from NGOs. which charge for their services, than do from the public sector, it is possibl e that the
introduction of charging throughout the system will divert more people to the NGOs. Filth , the
fees now in place for private patients are clearly too low to even cover costs and should be raised
as quickly as possible and then regularly revised to keep up with inflation; this should be done even
in advance of the wider introduction of_ user charges as there is no case for private pat ients being
subsidized by public ones. Sixth, on the basis of experience in other countries, the Gove rnment
would be advised to delay the introduction of charging until it is certain that it has pr oper systems
set up for collection of fees (including the exemption of those unable to pay) and referr al of
patients and until thelsupply of drugs and consumables is in good shape. Seventh, the all ocative
eliiciency goal of the system is somewhat offset by the charge proposed for referrals; to encourage
people to enter the system at the lowest level, referrals should be free. Finally, chargi ng at all .

facilities may be attractive in terms of raising health workers' income but it both raises questions
of wage equity with other parts of the public service and avoids concentrating cost recovery on the
three areas where costs are highest: drugs/consumables, hospital inpatients, and private patients.
' The Government may wish to start with charging for these services and only later move to more
general consultation fees. The most expensive hospital inpatient services, which are largely utilized
by relatiVely more affluent urban dwellers, should be the ones where future cost recovery is .
focused. These include particularly the 'hotel' functions such as food. Once such charges were
in place, a greater portion of hospitals' recurrent costs would be funded and their rehabilitation
would be more justified. It would be advisable also u soon as possible to introduce a separate
charge for drugs in order both to recover some portion of costs and to deter overprescription which
at present appears to be widespread.

M
5.47 Cost Effectiveness. ’Health’ as an outcomeyis not readily measurable in any country. In other countries, however, it is possible to measure the Cost of intermediate outputs sueh as number of patients and number of days, although these do not reflect quality. _In Uganda, howeve r, the collapse of the health information system means that even such intehnediate output data a re not available. A limited amount of data was collected in Hoima and Mbale districts which sugg ests that the unit cost per outpatient visit at a public health center is lower than that at a private or NGO clinic. However this does not at all mean that the public facility is more efficient; rat her it pays very low salaries to its workers and, unlike the private unit, usually has no support ser vices such as a laboratory. When the data are corrected for quality, therefore, and when labor is pr operly shadow priced, it may well be that the private facility is more efficient. More work is n eeded in this area. It will nOt be useful, however, until the underfunding of recurrent expenditur es is corrected.

5 .48 Given the perceived quality of NGO services, however, the Government should experim ent with contracting with NGOs to provide not only for-fee curative services but also free pr eventive services. Very close monitoring of such experiments would provide useful information to g uide the future provision of such services; would be necessary in order to prevent NGOs from b ecoming . overloaded and losing effectiveness; and would be essential to protect the poor.

Institutional Issue:

5.49 Overall planning and policy work is the clear responsibility of the Ministry of Heal th. Its planning unit is weak, however, as evidenced by the hrst draft of a health plan through t he year 2000 which takes account neither of disease priorities nor of likely resource availabilit ies but rather consists of a very mechanical projection of facility and personnel needs. The unit should be strengthened through the assignment of skilled Ugandans supported by external assistance. Over time, the unit could move not only to provide planning services at the national level but also to assist districts with planning. At present only a very few districts have any sort of hea lth plan. NGOs could possibly also provehelpful in sector planning at the district level and the ex periment currently underway in Masindi should be closely monitored. ,

5.50 Both budgeting and implementation are impeded by the complex organization of the sec tor, discussed in paragraph 5.6. Not only are the Ministries of Health and Local Government, M ulago Hospital, districts and municipalities engaged in service delivery, their budgets are con sidered separately from each other. Mulago became semi-autonomous of the Ministry of Health in 19 86; while this is very desirable in terms of giving it operating autonomy, it has also result ed in the Ministry of Finance considering the Hospital’s budget quite separately from that of the M inistry of Health. They should be considered together. Similarly, as Mulago currently perfoims pr imary and secondary as well as tertiary functions, it would be advisable to comdinate decisions concerning it with those of other agencies involved in service delivery in the kampala ar ea i.e. the Ministry of Health and the Kampala City Commission. The financial year for local governme nts

runs from October-September, or three months different from that (or central government, which
makes financial coordination very difficult. District and municipal budgets are submitted to the
Ministry of Local Government for review but no special attention is paid to the health sector, even
though it is usually the largest single component after "general administration". This is probably
because there is little direct funding of local health services by the Ministry of Local Government,
except for development expenditure.

v__
98 Unpter 5: Hum,
5.51 Over time, it would be desirable to focus all health activities on the district ahd, for the .
large towns, the municipality. This would involve a major change, however, including
strengthening district health management and giving it control of all health resources, including for
h05pitals, spent in the district. ’lhe’Government may wish to consider moving toward such a
pattern, ultimately reducing the role of the Ministry of Health to one concerned with national
guidance and functions such as training that require economies of scale, and integrating the vertical
programs at the district level. Pending such a reorganization, or a similar one, urgent steps are
needed to increase the coordination of activities at the district level. The Government may wish
to experiment with this in a few _districts.
y 5.52 The process of budgeting is similar in the Ministry of Health, Mulago and the Ministry of
Local Government. Basically, individual departments submit ’wish lists’ to the central part of the
ministry which then cuts them back largely by comparison to the previous year’s budget. There
is no forward budgeting. There is no systematic basis for estimating counterpart requirements for
donor funds under the development budget. Relative allocations in most budgets tend to look like
those of the year before with only minor variations, preserving a historical pattern of spending and
making change very difficult. There is almost no program budgeting, although the Minisz of
Health does use six semi-programmatic budget heads e.g. Hospitals, Training, etc. To further
complicate, budgeting, recurrent budgets are reviewed by the financial sections of the ministries
whereas development budgets are reviewed by the planning sections. There is thus no scope for
integrated budgeting. No evaluation techniques are used to determine the effectiveness of particular
programs. Once budgets are approved, they are not fully implemented because the Ministry of
Finance suspends the greater part of them, as discussed in paragraph 5.23.
5 .53 Accounting in the Ministry of Health is of reasonable quality but very delayed because of
a lack of simple computer equipment. It was,- for example, difficult for the mission in March to
obtain results for the first half of the current fiscal year i.e. July-Decembet. The Ministry has
submitted the accounts for FY 88/89 to the Auditor-General who is responsible for auditing them
as for the rest of the’public sector. The Auditor-General is well behind in doing so; the latest audit
received by March 1990 was for FY86/87. Accounting has virtually broken down at the local level
where there are almost no up-to-date records; as noted, this is one reason why donors are loath to
decentralize financial aspects of vertical programs. Accounting was not examined at either Mulago
or the Ministry of Local Government.

mm 5.11: Total Public Expenditure on Hum. by From, Loal/Foreign Expenimre d Fin Sontag. M 1933/39 (U Sh million)
Secondary
Tania
Cenml
Administration
Clpital 5
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Secondary
Tani:
CcntrIJ
Administration