THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

Primary Health Care Non-Wage Recurrent Grant and Budget Guidelines to Health Centre II, III and IV, and General Hospitals

Financial Year 2020/21

FOREWORD

The Health Facility Guidelines are issued by the Ministry of Health to Health Facilities under the Local Governments and Kampala City Council Authority to provide guidance on the utilisation and accountability of conditional grants under primary health care (PHC) during FY 2020/21.

The guidelines are also tools to guide preparation of accurate work plans and budget estimates for health service delivery in each public and Private-Not-For Profit health facilities accessing the PHC Non-Wage Recurrent Grants and other Grants from Government.They also provide guidance and templates for facility budget performance reporting, and grievance and redress mechanism.

During FY 2020/21 the sector continues to re-prioritize **Health Promotion, Disease Prevention, hygiene and Sanitation** and **30% of Non-wage Recurrent** has been earmarked to undertake community-based activities related to these priority areas across the spectrum. **Thirty percent (30%)** of the Non- Wage Recurrent for each General Hospital and each Lower Level Facility shall be used for this purpose.

The allocations for health facilities are based on a formula that puts in to consideration the parameters of population (including refugee population), infant mortality, population in hard to reach hard to stay and poverty headcount whose details are contained in these guidelines.

All health facility In-charges are required to ensure that comprehensive annual workplans, budgets and performance reports are prepared timely; disbursed funds are utilized and accounted for as per these guidelines.

I look forward to seeing improved health service delivery and user satisfaction at the Primary level.

Dr. Diana Atwine
PERMANENT SECRETARY

Table of Contents

ABBREVIATIONS AND ACRONMYNS

AWP&B	Annual Work Plan & Budget
BFP	Budget Framework Paper
CAO	Chief Administrative Officer
CBO	Community Based Organizations
DDP	District Development Plan
DHO	District Health Office/Officer
EMHS	Essential Medicines and Health Supplies
GH	General Hospital
GoU	Government of Uganda
GRC	Grievance Redress Committee
GRM	Grievance Redress Mechanism
HC	Health Centre
HLG	Higher Local Government
HMB	Hospital Management Board
HMIS	Health Management Information Systems
HSD	Health Sub District
HUMC	Health Unit Management Committee
JMS	Joint Medical Stores
LGFAR	Local Government Finance and Accountability Regulations
LG	Local Government
LLHU	Lower Level Health Unit
PFMA	Public Financial Management Act
M&E	Monitoring an Evaluation
MC	Municipal Council
MoFPED	Ministry of Finance Planning and Economic Development
MoH	Ministry of Health
MoLG	Ministry of Local Government
NMS	National Medical Stores
NWR	Non-Wage Recurrent
OPD	Out Patient Department
PFMA	Public Finance Management Act
PHC	Primary Health Care
PNFP	Private Not for Profit Providers
PPDA	Public Procurement & Disposal of Assets
RDC	Resident District Commissioners
RMNCAH	Reproductive Maternal Neonatal Child & Adolescent Health
TEC	Technical Evaluation Committee
VHT	Village Health Team

PART ONE: INTRODUCTION

Annually, Local Governments (LGs) make a budget provision for Primary Health Care (PHC) Non-Wage Recurrent (NWR) Grant that are transferred directly to health facilities from Ministry of Finance Planning and Economic Development (MoFPED) following the guidance of the Ministry of Health (MoH). The purpose of the PHC NWR Grant is to fund the operational/running costs of health facilities in execution of health service delivery. Facilities may also receive funds and contributions from other sources e.g. Government, Partners, donations or user fees.

These guidelines are issued by the Ministry of Health (MoH) to health facilities under the Local Governments and Kampala City Council Authority to provide guidance to facilities on the policies and principles for budgeting for the PHC NWR funds at the facility level and the various eligible expenditures for the Grant. They also provide guidance and templates for facility budget performance reporting; and grievance and redress mechanism.

1.1 Purpose of the Non-Wage Recurrent (NWR) Grant

The purpose of the NWR grant transfer to facilities is:

- To fund operational costs of managing health facilities
- To fund maintenance of health facilities
- To facilitate measures to improve health according to the policies in place, related in the LG guidelines.

1.2 Allocation of the PHC NWR Grant

The PHC NWR Grant allocations to each LG are based on a formula with weighted variables. The allocation to the public lower level health facilities within each LG is based on a ratio of 4:2:1 (HC IV:HC II:HC II) of the 85% allocation for the district health services NWR budget. The allocation to the PNFP lower level health facilities is 2:1:0.5 of the allocation. Further still all health facilities have a fixed allocation

Table 1: Health Facility Fixed costs

Gov	
HC II	**2,000,000**
HC III	**4,000,000**
HC IV	**8,000,000**
PNFP	
HC II	**1,000,000**
HC III	**2,000,000**
HC IV	**4,000,000**
HC IV (Special)	**50,000,000**

The PHC NWR Grant for hospitals is also allocated based on the weighted variables and fixed allocations as shown in Table-----

Table 2: Hospital Fixed Costs

Gov	
Hospital	**100,000,000**
o/w Highway Hospital	**15,000,000**
PNFP	
Hospital	**50,000,000**
o/w Solo PNFP	**50,000,000**
o/w Tourism PNFP	**100,000,000**

The details of the formulae and the budget allocation for each health facility for the FY 2020/21 are provided in the Sector Grant and Budget Guidelines for Local Governments available the District Health Office or Ministry of Health website www.health.go.ug.

1.3 Mandate of Facilities

1.3.1 The General Hospitals

These provide preventive, promotive, outpatient curative, maternity, inpatient services, emergency surgery, blood transfusion, laboratory services and other general services. They also provide in-service training, consultation and operational research in support of the community based health care programmes.

The General Hospital (GH) funds should be allocated to the following expenditure categories; capital items, domestic arrears, Hospital based Primary Health Care (PHC) activities, maintenance of medical equipment and buildings, training and capacity building, cleaning wards and compounds, utilities, vehicles and generator operation and maintenance, equipment, food supply (including firewood), other supplies, administration, staff allowances, transport and training).

A minimum of 30% of the non-wage should be allocated for community based health promotion, education and prevention programmes to workplaces, schools, vulnerable urban and rural communities. Activities undertaken to include sensitization on Public Health Protocols, environmental health, sanitation and hygiene promotion, family planning, Sanitation Day activities, and other activities.

1.3.2 The Role of Health Centre (HC) IV

The HC IV is responsible for providing the following services;

i. General Out Patient Department (OPD) services including immunizations and antenatal care
ii. Emergency deliveries
iii. Acute admissions
iv. Maternity services
v. Blood transfusion
vi. Ultra sound examinations for abdominal conditions especially obstetric cases
vii. Caesarean sections and lifesaving surgical operations
viii. Basic laboratory services

In addition, a HC IV serves the functions of the basic peripheral unit in the parish where it is located and also serves the function of a HC III, over and above the functions elaborated above. It has a target population of 100,000.

1.3.3 The Role of HC III

A HC III serves the functions of the basic peripheral unit in the parish where it is located while at the same time performing the supervisory function for all the HC IIs in the Sub-county. It has a target population of 20,000.

1.3.4 The Role of HC II

The lowest planning unit of the district/municipal health system is the HC II. This is the health facility that serves as the interface between the health care system and the community at parish level. This arrangement fulfils the principle of "close to client" and enables close collaboration between the health service providers and the community structures like the Village Health Teams (VHTs), Parish Development Committees, Women Councils, Youth Councils and Councils for Disabled Persons. It has a target population of 5,000.

All in all, a well-functioning HC II will take care of around 75% of the health problems for the catchment community.

2 PART TWO: BUDGET REQUIREMENTS AND IMPLEMENTATION GUIDELINES

2.1 Summary of budget and implementation requirements

For each health facility, the following budget and implementation requirements must be adhered to:

Table 3: Summary of implementation requirements for the NWR Grant

Summary of requirements	
i.	The total allocation to lower level facilities (HC II, HC III, HC IV) must be at least 85% of the PHC NWR budget (excluding PHC Hospital NWR Grant)
ii.	Private-Not-For- Profit (PNFP) health facilities should be funded from the window of NWR grant for PHC, but only if they meet the eligibility criteria in Sub-annex III, have been approved by the MoH, and have signed a Memorandum of Understanding (MoU) with the LG.
iii.	Allocations to general hospitals should be at least the value of the NWR grant for hospitals
iv.	Only PNFP (NGO or CBO) hospitals which meet the eligibility criteria in Sub-annex III and have been approved by the MoH should be allocated PHC funds.
v.	A maximum of 15% of the Non-Wage Recurrent Budget (excluding PHC Hospital NWR Grant) can be used for monitoring and management of District/ Municipality health services.

Table 4 shows the eligible and ineligible activities / items when planning and budgeting under PHC NWR Grants by health facilities.

Table 4: Indicative eligible and ineligible activities/items

Indicative positive list (what may be funded)	Indicative negative list (what may not be funded)
• Employee costs (other than wage) • Administrative expenses • Food supply • Medical equipment where not provided by JMS or NMS • Office equipment • Printing and stationery • Operation & maintenance utilities • Cleaning services • Short training courses with direct relevance to function • Fuel, oil and lubricants • Monitoring, supervision and reporting • Property costs • Material supplies and manufactured goods • Security and hygiene expenses • Repair and replacement of furniture • Water and hygiene expenses	• Long courses e.g. Masters, PhDs – the relevant banned items are Scholarships. • Travel abroad, and travel inland, and staff training could also count. • Courses not related to function/post of the beneficiary officers.

2.2 Health Facility Level Budgeting and Implementation Guidelines

Using the guidelines provided by MoH, the LGs are required to prepare health facility budget provisions for NWR Grants that are transferred directly to health facility account using the IFMIS system by Ministry of Finance, Planning and Economic Development (MoFPED) following the guidance of LGs and MoH.

Health facilities may also receive funds and contributions from other sources.

This section provides guidance to health facilities on the policies and principles for budgeting for the PHC NWR grants allocated to the health facility;

2.2.1 Budgeting and Financial Management for Public Health Facilities

Each Health Facility is required to prepare a detailed annual work plan and budget (AWP&B) for the new Fiscal Year by the 31st July. This should be based on the Comprehensive health facility workplan (Operational workplan) developed following the MoH Planning Guidelines for LGs. The AWP&B should show;

i. All planned activities including those supported by Partners.

ii. All expected revenues from all sources

iii. All planned expenditure for the new financial year (FY).

iv. Show funds received and actual expenditures/ activities for the previous FY.

This will help to ensure that there is no duplication of funding for activities in health facilities by government and the off-budget donors.

The Budget and Annual Financial Statement must include funds from a) the previous FY which were not spent b) the NWR grant for the new FY, c) revenue and expenditure funded by donors directly to health facilities and c) all other sources, if any. This includes donations received from well-wishers, both in cash, in kind (values to be imputed), from fundraising efforts, etc. A template has been provided for monthly and annual reporting in Formats 2 onwards, below. For requesting development investments, further templates developed form part of these sub-annexes.

1. Financial Management at health facility level

Health facilities are required to (and specifically the Officer-in-Charge (OIC);

i. Maintain and operate a bank account into which the NWR funds are deposited, and then drawn by the facility as expenditure is required.

ii. As per the LG Financial and Accounting Regulations 2007, the signatories to the GH bank account shall be the Accounting Officer or his/her representative and the other signatories shall be the Medical Superintendent and or other nominees by the Hospital Management Board (HMB).

iii. The Principal signatories to the bank accounts of the lower level public health facilities shall be the health facility in charges and or persons appointed by the Accounting Officer in consultation with the Health Unit Management Committees (HUMCs) and the Sub-counties/ Municipal Divisions/ Town Councils.

iv. Check that the item(s) being procured has/have been provided for in the budget before expenditure is made.

v. Accurately record the actual expenditure in the cash book and conduct monthly bank reconciliations.

vi. Ensure that the Sub-Accountants of Sub-counties/Municipal Divisions/Town Councils will assist the health facility in maintaining the books of accounts (e.g. cash books and bank reconciliations).

vii. Prepare financial reports for the HMB or HUMC meetings, and provide quarterly reports to the District Health Officer (DHO) by the 7th day after end of the quarter.

viii. Display a summary notice of incomes and expenditures on notice boards at the health facility.

2. **Maintaining Health Facility Level Information**

Health facilities are required to prepare and submit returns on a timely basis to the DHO using the financial reporting template in Part 3.

They should ensure the following information is maintained at the facility:

- HMIS Registers/ reports as per the HMIS reporting schedules
- Asset register and reports
- Health Workers Duty Attendance Registers and attendance analysis reports

2.2.2 Budgeting for PNFP Lower Level Facilities (HC IV, HC III & HC II)

Allocations to PNFP facilities will be made as an integral part of the district health services as follows:

a) PNFP health facilities should be funded from the window of non-wage grant for PHC.
b) Only PNFP (NGO or CBO) health facilities which meet the eligibility criteria in Part 3, Subpart 1 and have been approved by the MoH should be allocated PHC funds.
c) All eligible and approved PNFP (NGO or CBO) lower level health facilities must sign a MoU with the respective LG every FY.
d) For each PNFP facility, in addition to the PHC NWR appropriated under the LG grant, additional funding equal to the LG grant funding will be appropriated under MoH and will constitute a medicines credit line facility at Joint Medical Stores (JMS) for FY 2020/21. This is budget should be reflected in the health facility annual workplans as essential medicines and health supplies (EMHS) budget from the Centre but not under the LG NWR Grant.
e) The PNFP health facilities will be required to order for EMHS from JMS based on quarterly budgets and guidelines from JMS and MoH.
f) The activities to be undertaken by the PNFP lower level health facilities are to be integrated in the LGs Budget Framework Paper (BFP) and the Annual Workplan and Budget (AW&B) for the LGs for FY 2020/21.
g) The PNFP facilities are required to comply to the accounting and financial arrangements stipulated in the LGFAR 2007, the PPDA 2005, PFMA 2015 and the LGA Amendment 2008 to guide financial management, reporting and accounting procedures during utilization of the PHC NWR Grant. In addition, Sub-annexes to the guidelines provide specific formats for monthly and annual reporting as well as cash books.
h) For the PNFPs at all levels the principal signatories for the PHC NWR Grant Bank Account shall be the health facility in charges and other signatories shall be appointed by the HUMCs or HMBs of the respective PNFP health facilities in consultation with the Accounting Officer and the Sub-counties/ Municipal Divisions/ Town Councils authorities in the LG.

2.2.3 Budgeting for Hospitals (Public & PNFP)

1) Allocations to GHs should be at least the value of the NWR grant for hospitals.
2) PNFP hospitals should be funded from the window of NWR grant for hospitals.
3) For each PNFP hospital, in addition to the funding appropriated under the LG grant, additional funding equal to the LG grant funding will be appropriated under MoH and will constitute a medicines credit line facility at JMS for FY 2020/21. This is budget should be

reflected in the health facility annual workplans as essential medicines and health supplies (EMHS) budget from the Centre but not under the LG NWR Grant.

4) Only PNFP (NGO or CBO) hospitals which meet the eligibility criteria in Sub-annex III and have been approved by the MoH should be allocated PHC funds.
5) All eligible and approved PNFP (NGO or CBO) hospitals must sign a MoU with the respective LG every FY.
6) The PNFP hospitals will be required to order for EMHS from JMS based on quarterly budgets and guidelines from JMS and MoH.
7) The activities to be undertaken by the PNFP hospitals are to be integrated in the LGs Budget Framework Paper (BFP) and the Annual Workplan and Budget (AW&B) for the LGs for FY 2020/21.
8) The PNFP hospitals are required to comply to the accounting and financial arrangements stipulated in the LGFAR 2007, the PPDA 2005, PFMA 2015 and the LGA Amendment 2008 to guide financial management, reporting and accounting procedures during utilization of the PHC NWR Grant. In addition, Sub-annexes to the guidelines provide specific formats for monthly and annual reporting as well as cash books.
9) For the PNFPs hospitals the principal signatories for the PHC NWR Grant Bank Account shall be the hospital in charges and other signatories shall be appointed by the HUMCs or HMBs of the respective PNFP health facilities in consultation with the Accounting Officer and the Sub-counties/ Municipal Divisions/ Town Councils authorities in the LG.

2.3 Roles and Responsibilities of Officers in Charge and staff

The below list covers transparency, accountability, staff management, grievance and financial management duties. Additional duties may be set out in standing orders or other MoH or LG communication. The OIC, under the oversight of the HMB/HUMC, is required to ensure that;

a) Financial records are maintained and published according to at least the level of detail captured in the formats in Part 3 below. Detailed duties regarding the budget requirements and financial management are set out in Part 3.
b) Each facility publishes a list of staff (and their photographs) specifying all staff on its payroll on the facility notice board or work stations/wards for large facilities.
c) Each facility has a staff attendance register (manual or digital), which must be filled by all staff on a daily basis.
d) Monthly attendance analysis reports are submitted to the District / Municipal Health Officer. This can be effected through the Human Resource Information System (HRIS) or by some other approved means.
e) Health workers follow the Health Services Commission Professional Code of conduct and Ethics and the Code of conduct and Ethics of the Uganda Public Service.
f) Staff who do not comply with the Code of Conduct and Ethics are managed as guided.
g) All staff in the facility are appraised annually.
h) Noticeboards are up to date with respect to displaying the AW&B, quarterly workplans, income and expenditure, quarterly HMIS reports, and grievance channels. Full contents of the noticeboard are listed below.
i) Staff prepare and are present for any supervision, audit and inspection process.
j) Facility supervision reports are discussed with staff and used to recommend corrective actions, and that those actions have subsequently been followed up.

k) Health facility data is analysed, performance reports discussed and actions have been followed up to improve performance.
l) A Quality Improvement Team is in place and action plan (documentation journal) is updated.
m) Safe practices and guidelines or Standard Operating Procedures on management and disposal of medical waste are available and strictly adhered to. This may include for example the 2009 Approaches for Hazardous Waste Management guidelines published here: http://www.health.go.ug/docs/Approaches%20for%20HCWM%202009.pdf or/and any subsequent guidelines.
n) Guidelines, policies, circulars issued by the MoH and other related agencies as disseminated and explained to all relevant staff by the LG or Health Sub-District (HSD).

2.4 Procurement

2.4.1 Procurement

Procurement must be conducted through the structures and procedures that are prescribed by the Public Procurement and Disposal of Public Assets (PPDA) Guidelines. In accordance with the PPDA Act, Regulations and Guidelines, facilities are considered as Procuring and Disposing Entities (PDE) under the MoH. To govern NWR allocations to facilities, the following serves as a guide to the procedures to be followed, to cover all monies handled by the facility.

1) Institutional Arrangements

PDEs are required to establish institutional structures to ensure that all procurement and disposal activities are carried out in accordance with the Act and Regulations, and that these conform with ethical conduct and best practices.

OICs are the Accounting Officers (AOs) in PDEs. The HUMC plays the role of the Contracts Committees (CCs), while the person playing the role of Chief Financial Officer as designated by the HUMC plays that of the Procurement Disposal Unit (PDU). The AO, CC, PDU and User Departments (UDs) in a PDE are required to each act independently in relation to their respective functions and powers.

2) PDE categories and staffing requirements

Procurement and disposal activities in PDEs cover a wide range of items such as:

a) Supplies and services for maintenance, repair and operations;
b) Works for expansion and provision of infrastructure;
c) Consultancy advisory services in a limited scope; and
d) Disposal of unserviceable stores.

In accordance with the PPDA Guidelines 2014, PDEs are classified in categories of small, medium and large depending on their annual budget. For each category, the guidelines set out required numbers for procurement staff to handle procurement activities. The table below summarizes the PDE categories and required levels for procurement staff.

Table 3. Summary of PDE Categories and required levels for procurement staff

Size of Annual Budget	PDE Category	No. of Procurement Staff
Not exceeding UGX 45 million	Small	1
Not exceeding UGX 150 million	Medium	2
Over UGX 150 million	Large	2

3) Procurement Planning for health facilities

i. PDEs are required to prepare a procurement plan based on the facility's approved budget. In practical terms it is likely that, except for some hospitals, health facilities are likely to nominate an officer who does other work.
ii. User departments (UDs) are responsible for identifying their procurement needs which should be submitted to the PDU for consolidation. It is likely than smaller facilities comprise of one department.
iii. The PDU should then integrate the requirements into the annual expenditure plan in order to enhance procurement scheduling, financial predictability, accounting and oversight over procurement budgets.

PDEs should not initiate any procurement proceedings or activities for which funds are neither available nor adequate, except:

a) Where the delivery of goods, services or supplies and consequent payments to provider are anticipated to be effected from subsequent FYs.
b) In the case of framework contracts, funds will be committed at the time of issue of each specific call of order.

Procurement may be initiated in accordance with the PPDA Act 2017 and Regulations, before the receipt of funds, but a contract shall not be awarded before the availability of funds.

4) Choice of Procurement methods, steps and responsibilities

The procurement method to be used should be selected based on expenditure thresholds, time, duration, level of authorization and urgency of the requirements. The table below outlines the procurement methods and corresponding thresholds set out in the PPDA Guidelines 2014.

Table 5. Summary of Procurements methods and corresponding thresholds

Procurement Methods	Conditions/Rules for Use and Thresholds
Open Domestic Bidding	Used where: • The estimated value of the procurement exceeds UGX 20 million

Procurement Methods	Conditions/Rules for Use and Thresholds
	• Open to bidders following a public advertisement of a bid notice. • Bid documents may be issued at a fee and should be recorded using the form in Annex 12 of the PPDA Guidelines, 2014. • A public bid opening to be held
Restricted Domestic Bidding	Used where: • The estimated value of the procurement or disposal does not exceed UGX 20 million and is above UGX 5 million. • Invitation to bid shall be addressed to at least three bidders. • Public bid opening shall be held.
Quotations/Proposals Method	Used where: • There is insufficient time for open domestic or restricted domestic procedure such as in an emergency situation; • The estimated value of the procurement exceeds UGX 500,000, but does not exceed UGX 5 million. Acceptance of a quotation shall be by use of a purchase order. And, a minimum of 3 quotations shall be obtained to facilitate comparison and competition.
Micro Procurement – this includes items procurement using petty cash.	Used where: • The estimated value of the procurement does not exceed UGX 500,000
Direct Procurement	Used where: • There is insufficient time for any other procedure, such as in an emergency situation; • The works, services or supplies are available from only one provider; • Value of the new works, services or supplies does not exceed 15% of the original or existing contract value.

*NB: Please refer to the PPDA Guidelines, 2014 for detailed procedures for each of the above procurement methods.

5) Procurement Steps and Responsible Entity

Table 6. Summary of Procurement Activities

S/N	Procurement Activity	Responsible
1.	Identify procurement needs and prepare procurement plan for user department.	UD
2.	Consolidate and present procurement plan for review and approval.	PDU

S/N	Procurement Activity	Responsible
3.	Review and approve procurement plan, if satisfactory.	AO
4.	Initiate procurement process in line with PPDA Guidelines 5, 2014.	PDU
5.	Advertise/obtain at least three quotations from bidders in line with the selected procurement method and procedural steps outlined in the PPDA Guidelines, 2014.	PDU
6.	Evaluate bids and make recommendations of best qualified contractor(s) in line with the PPDA Guidelines 5, 2014.	EC
7.	Seek approval of award and the draft contract to the contracts committee.	PDU
8.	Issue award to the best evaluated bidder at least ten days before signing the contract.	PDU
9.	Communicate award to successful bidder(s).	PDU
10.	Handover copy of signed contract to the UD	PDU
11.	Manage implementation of contract	UD

6) Reporting on Procurement Activities

Regular reports on implementation of the plan should be prepared by the PDU. The report is to include compliance or variances if any from the plan and the identified courses of such variances for remedial action.

PDEs, which are fully decentralized, shall make their quarterly reports through the CAO / Town Clerk of the district / Municipality.

3 PART THREE: GRIEVANCE REDRESS AND REPORTING FORMATS

3.1 Grievance Redress Mechanism (GRM)

The grievance redress mechanism (GRM) describes avenues, procedures, steps, roles and responsibilities for managing grievances and resolving disputes. Every aggrieved person should be able to trigger this mechanism to quickly resolve their complaints.

The purpose of the grievance redress mechanism is to:

- Provide affected people with avenues for making a complaint or resolving any dispute that may arise during implementation of health facility activities.
- Ensure that appropriate and mutually acceptable corrective actions are identified and implemented to address complaints;
- Verify that complainants are satisfied with outcomes of corrective actions;
- Avoid the need to resort to judicial (legal court) proceedings unless it is warranted.

There are a number of **sources of grievance**, these may include:

- Quality of works delivered by contractors
- Quality of health care
- Misuse of personal data
- Violence against and abuse of patients and co-workers by health workers, staff, contracted labour, NGO affiliated staff and other donated support workers
- Bullying
- Condition of health infrastructure and facilities
- Functioning of the HMB/ HUMC
- Corruption and misuse of funds
- Health Workers absenteeism
- Land issues related to development
- Other issues relating to behaviour of Health staff, HMB/ HUMC and contractors

There are a number of **stakeholders**, who may be the source of grievance:

- Patients
- Health Workers
- Members of the HMB/HUMC
- Members of the surrounding community
- Others – no-one is excluded from examination through the grievance channels.

Wherever possible, the first port of call for grievances should be at the health facility level, but other avenues must also be available to those with grievance and there must be appropriate referral processes.

The main avenues and their purposes are set out in **Format 1** below. **That table, should be displayed on the noticeboard of any administrative officer and the facility.** The local and facility level guidelines should be filled out by the OIC or DHO according to the level at which the display takes place.

3.2 Health Facility Grievance Redress

At the health facility level, the GRM provides avenues for affected persons to lodge complaints or grievances against various stakeholders directly to the Health facility management and also get redress. This, wherever possible and appropriate should be the first point of grievance redress. All health facilities are required to

a) Ensure that there is a systematic process for handling of grievances that arise among various stakeholders within a timely manner.

b) Post information on the different avenues for grievance redress, including the health facility level mechanism and other mechanisms available.

Format 1 is the form that must be posted, along with any other relevant information.

Format 1: Grievance Channels Form

The following notice should be posted on the Facility Notice board, with details specific to the facility and LG completed. OICs should fill in requisite blank sections in the below table themselves and update all sections as and when necessary.

Avenue	Type of Grievance	Contact details
Facility level		
Health facility in-charge	• Quality of works delivered by contractors • Quality of care • Absenteeism • Other issues relating to behavior of staff, HUMC and contractors	Telephone/SMS: Email: Address:
Hospital Board/HUMC	• Corruption and misuse of funds • Absenteeism • Issues referred by OIC	Telephone/SMS: Email: Address:
Local Government level		
Councillor	• Violence against and abuse of children and adults by staff, contracted labor • Selection of health infrastructure not in line with guidelines • Quality of health care and absenteeism	
Health Officer	• Quality of works delivered by contractors • Condition of health facility infrastructure • Quality of teaching • Functioning of the health unit Management Committee • Corruption and misuse of funds	
District land board	• Complaints about land associated with health facilities and health infrastructure	
National level		
Police	• Corruption and misuse of funds • Other criminal activity • Issues regarding protection of children and vulnerable adults	Telephone: 112/999 CP ANTI-CORRUPTION 0717 121 110 CP ANTI HUMAN TRAFFIC MINISTRY OF INTERNAL AFFAIRS 0715 411 677 CP SEXUAL & GBV 0713 534 713 CP SEXUAL OFFENCES 0718 642 477 Email: info@upf.go.ug Address: https://www.upf.go.ug/key-uganda-police-phone-contacts/

Avenue	Type of Grievance	Contact details
Uganda Patients Protection	• Emotional, physical or sex abuse • Human trafficking • Child neglect esp. by parents or guardian	Not currently available.
Uganda Child Helpline	• Emotional, physical or sex abuse • Child trafficking • Child neglect esp. by parents or guardian	Web: http://uchl.mglsd.go.ug/ Phone: 116
NITA Helpline	• Data protection issues	TBC. Legislation just assented.
Uganda Budget Hotline	• Quality of works delivered by contractors • Missing and misuse of funds	Call for free: 0800 229 229 Feedback: www.budget.go.ug Email: budget@finance.go.ug
IGG Hotline	• Corruption and misuse of funds	Report: https://www.igg.go.ug/complaints/ Call: +256 414 347387 Email: kampala@igg.go.ug (other regions addresses at https://www.igg.go.ug/contact/)

4 PART 3, SUBPART 2 – FACILITY REPORTING TEMPLATES AND FORMS

In addition to the financial reporting requirements in these guidelines, health facilities are required to report using the HMIS reporting requirements as per the HMIS manual. If RBF or other formats cover entirely the information collected by the formats below, please use those instead to avoid repetitions.

4.1 Annual Health Facility Report and Budget

Parts A, B, and C should be displayed publicly by 31st July of each FY and then no later than 32 days after the beginning of each quarter through the Government Fiscal Year.

Health facility Name: …… HMIS code: ……

Facility level: …….

Past Financial Year: …… New Financial Year: ……

4.1.1 Format 1: Highlights of Facility Performance and Plans

1.	**PAST YEAR PERFORMANCE**
1.1	Key Achievements
1.2	Challenges Faced by Facility
1.3	Overview of Receipts and Expenditures
2.	**NEW Year PLANS**

2.1	Highlights of Facility Plans for FY
2.2	Overview of Planned Receipts and Expenditures

4.1.2 Format 2: Cashflow Statement

No.	Description	Previous Year		New Year	
		Budget	Actual	Budget	Remarks
1.	**OPENING BALANCE**				
2.	**TOTAL INCOME** (2.1 + 2.2 + 2.3)				
2.1	**PHC Grant from Government**				
	PHC Grant Allocation (from MoFPED)				
	Additional Resources from LG				
2.2	**Grant from NGOs/Donor**				
	NGO/donor name:				
	NGO/donor name:				
2.3	**Other revenue sources**				
	Fundraising				
	Contributions from local associations				
	Other (please specify):				
3.	**TOTAL EXPENDITURE (from Part C)**				
4.	**EXPLAINED BALANCE** (1 +2- 3)				
5.	**VARIATIONS** (between closing balance and explained balance)				
6.	**CLOSING BALANCE** (4 + 5)				

4.1.3 Format 3: Annual Expenditure and Budget Report

A separate table should be provided for in-kind costs

No	Description	Previous Year			New Year			
		Budget	Actual Expenditure	Description (Purchases, source of funds etc.)	Estimated Expenditure	Source of Funds		Description (Purchases, source of funds etc.)
						PHC Grant	Other	
1.	VHT related costs							
2.	Administration related costs							
3.	Costs for health service related materials							
4.	Costs for community activities							
5.	Communication costs							
6.	Transport (running motorcycles, travel costs)							
7.	Procurement of services e.g. for staff not on payroll							
8.	Minor equipment and facility maintenance							
9.	Staff development costs							
10.	Health & sanitation							
11.	Utilities							
12.	Security expenses							
13.	Bank Charges							
14.	Other (specify):							
	Total							

Format 4: FACILITY IMPROVEMENT - PROGRESS REPORT AND PLANS

No.	Issue to be addressed	Previous FY			New FY
		Planned Activities	Actual performance	Comments	Plans
1.					
2.					
3.					
4.					
5.					
6.					

4.1.4 Format 5: Health Facility Asset Register and Requirements Checklist

Facility name: ……. District: …….

Financial Year: …… Month checked: ……

	Medical Buildings							Staff houses	Equipment
	Out Patient Department	**Drug Store with HSD Office**	**Operation Theatre**	**General Ward**	**Maternity Ward**	**Mortuary**	**Placenta Pit and Medical Waste Pit**		
Existing Facilities									
No. Existing Facilities									
Description of condition facilities									
Planned routine maintenance									
Facilities Required									
*No. facilities requiring **rehabilitation***									
*No. **new** facilities required*									
Justification									

Prepared by:……..

Verified by:……..

Approved by:……..

Signature:……..

Signature:……..

Signature:……..

4.2 Monthly and quarterly Report formats

Formats 6 and 9 only need to be updated every quarter

4.2.1 Format 6: Quarterly overview

Facility Name: …… HMIS code: …… .

Facility level: ……..

Financial Year: …… Past Quarter End Date: ……

1.	**PAST Quarter PERFORMANCE**
1.1	**Key Achievements**
1.2	**Challenges Faced by Facility**
1.3	**Overview of Receipts and Expenditures**
2.	**NEW QUARTER PLANS**
2.1	**Highlights of Facility Plans for Quarter**
2.2	**Overview of Planned Receipts and Expenditures**

4.2.2 Format 7: Cashflow Statement

Financial Year: …… Month: ……

No.	Category	Annual Budget	Actual to end of Previous Month	Actual in Month	Actual by end of Month	Remarks
1.	**OPENING BALANCE**					
2.	**TOTAL INCOME** (2.1 + 2.2 + 2.3)					
2.1	**PHC Grant from Government**					
	Basic PHC Grant Allocation (from MoFPED)					
	Additional Resources from LG					
2.2	**Grant from NGOs/Donor**					
	NGO/donor name:					
	NGO/donor name:					
2.3	**Other revenue sources**					
	Fundraising					
	Contribution from local Associations					
	Other (please specify):					
3.	**TOTAL EXPENDITURE (from Part C)**					
4.	**EXPLAINED BALANCE** (1 +2- 3)					
5.	**VARIATIONS** (between closing balance and explained balance)					
6.	**CLOSING BALANCE** (1 +2- 3)					

4.2.3 Format 8: Monthly Expenditure

Financial Year: …… Month: ……

No.	Expenditure Category	Annual Budget	Expenditure to end of previous Month	Expenditure in Month	Expenditure by end of Month	Source of Funds		Description (Purchases, source of funds etc.)
						PHC Grant	Other	
1.	VHT related costs							
2.	Administration related costs							
3.	Costs for health service related material							
4.	Costs for community activities							
5.	Communication costs							
6.	Transport (running motorcycles, travel costs)							
7.	Procurement of services e.g. for staff not on payroll							
8.	Minor equipment and facility maintenance							
9.	Staff development costs							
10.	Health & sanitation							
11.	Utilities							
12.	Security expenses							
13.	Bank Charges							
14.	Other (specify):							
	Total							

4.2.4 Format 9: Quarterly Facility Improvement - Progress Report and Plans

Financial Year: …… Quarter……

No.	Issue to be addressed (incl. from inspection)	Previous quarter			Next quarter
		Planned Activities	**Actual performance**	**Comments**	**Plans**
1.					
2.					
3.					
4.					
5.					
6.					

4.2.5 Format 10: Monthly Financial Statement

Financial Year: …… Month……

No.	Description	Annual Budget	Actual to end of Previous Month	Actual in Month	Actual by end of Month	Remarks
1.	**OPENING BALANCE**					
2.	**TOTAL INCOME** (2.1 + 2.2 + 2.3)					
2.1	**PHC Grant from Government**					
	Basic PHC Grant Allocation (from MoFPED)					
	Additional Resources from LG					
2.2	**Grant from NGOs/Donor**					
	NGO/donor name:					
	NGO/donor name:					
2.3	**Other revenue sources**					
	Fundraising					
	Contribution from local associations					
	Other (please specify):					
3.	**TOTAL EXPENDITURE (from Part C)**					
4.	**EXPLAINED BALANCE** (1 +2- 3)					
5.	**VARIATIONS** (between closing balance and explained balance)					
6.	**CLOSING BALANCE** (1 +2- 3)					

4.2.6 Format 11: Cashbook

Cashbook Name: …….

Date opened: …….

Date closed: ……...

Date	Description	Voucher Ref	Income/ Expense Category	Income Shs	Expense Shs	Balance Shs

4.2.7 Public display format for facilities

The display should consist of printed or legible hand-filled copies of the following:

- The latest available facility-level budget, in the Format above, by 31st July each year.
- Quarterly overview, and Facility improvement progress report and plans, using the Format above, within a month of the beginning of each quarter – ie by 31st July, 31st October, 31st January, and 30th April.
- Latest cashflow statement and monthly expenditure statement in the format above, no later than two months from the end of the month reported.
- Format 1 – the grievance channels table – should also be displayed, including LG-specific data to be written onto the form by the health facility.
- Attendance registers – monthly summaries should be displayed, including the number of staff assigned to each facility in total, the number of days of absence (days attended minus the number of assigned staff), where any part-of-day absence is counted as a whole day, and for bigger health facilities, per department. Attendance should be displayed no later than 14 days after the last day of the reporting month.
- Any other material to promote accountability with no sensitive data under the Data Protection Act 2018 under the directive of the HUMC and/or LG.
- Relevant Formats in the Health LG level guidelines should also be displayed if upgrading application(s) has been made. Public meetings concerning facilities upgrades should be announced widely and no later than 10 days before the proposed time.
- Format 5 on facility infrastructure (if prepared) should also be made available on written or verbal request at the facility.

This material should be displayed in a position accessible to the general public within normal working hours of the facility. Size of text should be at least as large as presented in these guidelines when printed in A4 format. Display *cannot* be inside a private office, cupboard, or an office, if any other weatherproof space is available. The noticeboard should be displayed in a high-patient-traffic part of the facility.

Information on non-wage recurrent grants per health facility are available from the Local Government pages and home pages of the budget website budget.go.ug