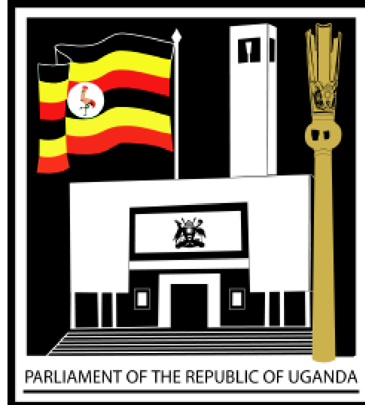

REPORT OF THE COMMITTEE ON HEALTH

ON

THE MINISTERIAL POLICY STATEMENT

AND

THE BUDGET ESTIMATES FOR THE HEALTH SECTOR

FOR THE FY 2013/2014

30 AUGUST 2013

1. INTRODUCTION

In accordance with Rule 177 of the Rules of Procedure of Parliament, the Committee on Health examined the Policy Statement on the Health Sector for the Financial Year 2013/2014. In addition, the Committee examined, critically, the recurrent and capital budget estimates for the health sector for the financial year 2013/2014. The Health Sector comprises the following Votes:

- Vote 014 Ministry of Health
- Vote 114 Uganda Cancer Institute
- Vote 115 Uganda Heart Institute
- Vote 116 National Medical Stores
- Vote 134 Health Service Commission
- Vote 151 Uganda Blood Transfusion Services
- Vote 161 Mulago National Referral Hospital
- Vote 162 National Butabika Referral Hospital
- Vote 501-850 Local Governments – Primary Health Care
- Votes 163 – 176 covering 14 Regional Referral Hospitals (namely Arua, Fort portal, Gulu, Hoima, Jinja, Kabale, Masaka, Mbale, Soroti, Lira, Mbarara, Mubende, Moroto and Naguru Hospital).

Arising from the examination of the policy statement and budget estimates of the Health Sector, the Committee made observations and recommendations that are intended to guide the House in its appropriation process.

2.0 TERMS OF REFERENCE

In examining critically the budget estimates for the health sector, the Committee was guided by the following terms of reference:

- Identify the steps and plans that the leadership of the health sector has enacted to deliver effective health service delivery envisaged under the Constitutional provisions on the citizens rights to health and medical care;

- Examine the extent previous recommendations of Parliament on the health sector, particularly the recommendations made on the health sector budget framework paper were addressed in constructing the health policy and budget estimates for the FY 2013/2014.

- Examine the extent the expenditure plans in the health sector are geared towards addressing strategic health concerns such as disease prevention;

- Propose recommendations on what needs to be done in terms of the policy initiatives and health resource envelope to improve the health care delivery in Uganda.

3.0 METHODOLOGY

In conducting the above mentioned assignment with a view of obtaining the relevant information, the Committee adopted the following methodology:

1. Reviewed the policy statement and budget estimates for the health sector; the Auditor General's report on the accounts of the Agencies in the health sector; Previous Parliamentary Recommendations on the ministerial policy statements and Budget Framework in regard to the sector.

2. Interacted with the Ministers and technical heads of the Ministry of Health, Mulago National Referral Hospital; Butabika National Referral Hospital; Uganda Heart Institute; Uganda Cancer Institute; Uganda Blood Transfusion Services; National Medical Stores; National Drug Authority; 14 Regional Referral Hospitals; and the Health Service Commission.

3. Interacted and received submissions from a coalition of over 40 CSOs, the Uganda Medical and Dental Practitioners Council, and the Uganda Parliamentary Forum for Youth.

4. The Committee also received critical information from the Ministry of Finance, Planning and Economic Development, and the Drug Monitoring Unit in State House.

5. The Committee would like to report that it received maximum cooperation from the Ministry of Health in all the meetings with the sector, where at least a Minister of Health was in attendance.

4.0 PAST BUDGET PERFORMANCE

Table 1: Sector Budget Performance Excluding Taxes, Non Tax Revenue (AIA) and Arrears

Figures in Billion UGX		Approved Budget FY 2012/13	Released by End May 2013	% of Budget Released FY 2012/13
Vote	**Institution**			
14	Health	264.992	**399.167**	151%
114	Uganda Cancer Institute	5.3	**4.68**	88%
115	Uganda Heart Institute	3.16	**1.472**	47%
116	National Medical Stores	208.291	**182.285**	88%
134	Health Service Commission	3.586	**3.409**	95%
151	Uganda Blood Transfusion Service (UBTS)	3.674	**2.193**	60%
161	Mulago Hospital Complex	32.226	**19.039**	59%
162	Butabika Hospital	18.232	**11.28**	62%
163-176	Regional Referral Hospitals	58.341	26.746	46%
501-850	Local Governments	245.375	**187.205**	76%

Source : **Health Sector Ministerial Policy Statement for Financial year 2013/14**

From Table 1 above, it can clearly be observed that Ministry of Health had the greatest budget release performance in the sector of 151% of the approved budget. This was as a result of a supplementary in the non wage budget by UGX 5.4 billion and external financing over performed at 170%. On the other hand, regional referral hospitals had the least release performance at 46% of the approved budget in the sector. This performance is attributed mostly to the poor performance of the development budget of these hospitals which on average was below 40% of the approved budget. The committee was informed that the poor development budget release performance was due to the revenue shortages in the country that led to no 4th quarter releases for the development budget last financial year.

It is important to note that in the sector, the committee had received only data of Ministry of health on actual release and expenditure for Fiscal year 2012/2013 by the time of writing this report. Out of UGX 38.89 billion approved by Parliament and later a supplementary of UGX 5.39

billion for the recurrent budget, UGX 37.695 billion was released and UGX 34.483 billion was spent by the Ministry. This represents an 85% release performance based on the revised budget and absorption of 91% of the released funds. On the other hand, with regard to the development budget, the committee had not received data on external financing at the time of writing this report and is only reporting on Government of Uganda Funds. While Parliament approved UGX UGX 19.716 Billion for development expenditure, UGX 14.799 billion was released of which UGX 14.141 billion was spent by the end of the financial year. This represents a 75% release performance and 96% absorption of the released funds.

5.0 Snapshot of the Financial Allocation to the Health Sector in FY 2013/14

Table 2: Financing of the Health Sector in the Medium Term excluding taxes and NTR(AIA)

Figures in Billion Shillings	**Approved Budget FY 2012/13**	**Proposed Budget FY 2013/14**	**Projected Budget FY 2014/15**	**Projected Budget FY 2015/16**
Total Health Subsector Allocation excluding external financing	630.775	**710.660**	760.502	822.448
External Financing	221.431	**416.668**	162.625	74.002
Total Health Subsector Allocation including external financing	852.206	**1,127.328**	923.128	896.451

Source: Health Sector Ministerial Policy Statement and Draft Estimates of Revenue and Expenditure FY 2013/14

It can clearly be observed from table 2 above that the health sector Government of Uganda allocation is projected to increase over the medium term. However, external financing to the sector is projected to decline in the over the medium term. Overall, the total budget to the health sector is projected to decline in the medium term unless Government increases its allocation from what is projected above.

In the FY 2013/2014, UGX 1,127.3 Billion will be invested in the health sector which is 8.7% of total national budget, a one percentage point increase (1%) from 7.8% in FY 2012/13. Of the total allocation to the sector, UGX 707.02 Billion will be Government of Uganda funding, and UGX 416.67 Billion will be donor funding which is 37% of total proposed funding to the sector.

Table 3: Budgetary Allocation to Health Sector Institutions over the medium term excluding taxes and NTR (AIA)

	Financial Year	Approved Budget FY 2012/13 in Billion UGX		Proposed Budget FY 2013/14 in Billion UGX		% change in Proposed Budget	
Vote	**Institution**	**Excluding External Financing**	Including External Financing	**Excluding External Financing**	Including External Financing	**Excluding External Financing**	Including External Financing
014	Health	48.947	264.992	**45.97**	**462.64**	-6.1%	74.6%
107	Uganda Aids Commission(Statutory)	5.475	5.475	**5.45**	**5.45**	-0.4%	-0.4%
114	Uganda Cancer Institute	5.300	5.300	**6.48**	**6.48**	22.3%	22.3%
115	Uganda Heart Institute	3.160	3.160	**5.11**	**5.11**	61.7%	61.7%
116	National Medical Stores	208.291	208.291	**217.62**	**217.62**	4.5%	4.5%
134	Health Service Commission	3.586	3.586	**3.58**	**3.58**	-0.2%	-0.2%
151	Uganda Blood Transfusion Service (UBTS)	3.674	3.674	**4.06**	**4.06**	10.5%	10.5%
161	Mulago Hospital Complex	32.226	32.226	**37.99**	**37.99**	17.9%	17.9%
162	Butabika Hospital	12.847	18.232	**9.61**	**9.61**	-25.2%	-47.3%
163-176	Regional Referral Hospitals	58.341	58.341	**71.35**	**71.35**	22.3%	22.3%
501-850	District NGO Hospitals/Primary Health Care	17.195	17.195	**17.19**	**17.19**	0.0%	0.0%
501-850	District Primary Health Care	220.03	220.03	**274.45**	**274.45**	24.7%	24.7%
501-850	District Hospitals	5.943	5.943	**5.94**	**5.94**	-0.1%	-0.1%
501-850	District Health Sanitation Grant	2.208	2.208	**2.21**	**2.21**	0.1%	0.1%
122	KCCA Health Grant	3.554	3.554	**3.64**	**3.64**	2.4%	2.4%
	SUB-TOTAL HEALTH	630.775	852.2055	**710.66**	**1,127.33**	12.7%	32.3%

Source: Health Sector Ministerial Policy Statement and Draft Estimates of Revenue and Expenditure FY 2013/14

From table 3 above, it can clearly be observed that the total health sector budget is projected to increase by 32% from UGX 852.2 Billion in FY 2012/13 to UGX 1.127 Trillion in FY 2013/14. Ministry of Health has the greatest budget increment in the sector of 75% due to a 75% increase in external financing which is UGX 200.6 Billion. On the other hand, Butabika Hospital has the greatest decline of of its budgetary allocation by 47% in the sector. It is important to note that with regard to PHC, the budget increment is only in the wage bill. However, the non wage bill is projected to remain at UGX 41.185 billion while the development budget; which is responsible for the construction of theaters, Maternity and General wards, Staff houses, OPD; is projected to decrease by 14% from UGX 34.814 billion Last FY to 30.084 Billion this FY. It is important to note that last FY, this figure was projected to be UGX 52.43billion. However, the committee was informed that lack of a unit cost by the Ministry of Health was hindering increased funding to PHC.

According to the National Health Accounts(March 2013), the total health expenditure per capita for Fiscal Year 2009/10 was USD 11 as opposed to the USD 44 recommended by the WHO yet donors and NGOs shouldered 36% of the total health expenditure. In addition, the out of pocket expenditure was at 42% of the total health expenditure though the committee was informed that currently it is 54% which justifies the need for health Insurance. The Committee believes that more funding to the health sector is crucial and it should be used efficiently to translate to improved service delivery. However, more can also be achieved if the available resources were used on high impact interventions in the health sector.

6.0 OBSERVATIONS AND RECOMMENDATIONS

6.1 Medicines and Supplies

For the last 10 years, Uganda Parliament has consistently advocated for better health care delivery. The 8th Parliament addressed the hitherto perennial shortage of drugs in the public health facilities by allocating the entire medicines budget for all public health facilities under the National Medical Stores which is charged with the procurement, storage and distribution of drugs and other medical supplies to public health facilities. However, the committee was informed that some facilities had challenges with regard to proper requisition of drugs to NMS.

The Committee would like to commend the Parliament and the Executive for working together to prescribe the solution to the problem of medicine and human resources for health, although a lot still needs to be done in the area of recruitment, retention and motivation of health workers as shall be elaborated later in the report.

The committee recommends that capacity on requisition of drugs by health workers be built to avoid unnecessary drug shortages. In addition, the capacity of Health management committees should be enhanced to increase monitoring supply and demand of drugs in the communities.

Lastly, the committee recommends strict adherence to guidance to essential drugs management to avoid wastage of drugs due to over prescription.

6.2 Prioritization of Preventive Health Care

Again, consensus has now emerged between Parliament and the Executive on the need to focus on preventive health care through health promotion and disease prevention. Parliament has consistently recommended that more investment be shifted to the disease prevention and health promotion strategy to halt the ever escalating curative budget. Consequently, the Government expressed its commitment to primary health care in the Health Sector Strategic Investment Plan (HSSIP), the 2011 NRM Manifesto, Vision 2040, and National Development Plan. Also, H.E. the President Y.K. Museveni, during his delivery of the State of the Nation Address on 6 June 2013, informed the Country that through disease preventive measures, the total disease burden eliminated can amount to 80%. This suggests that PHC, which is the institutional framework for disease prevention, is the priority area of investment. What now remains to be done is to walk the talk.

However, the Committee observes that the proposed expenditure plans for the FY 2013/2014 are not geared towards PHC as a priority. As the House may wish to recall, under the Local Government Act, districts and municipal councils are responsible for medical and health services including: Hospitals except regional referral hospitals; all health centres; maternal and child health services; communicable disease control, especially Malaria, HIV/AIDS, TB; ambulance services; vector control; environmental sanitation; health education; quality monitoring of water supplies; supervision and monitoring of private sector health services; immunization campaigns; health promotion; reproductive health including family planning, etc. Despite the huge health mandate vested with local governments, only 27% of the health sector budget equivalent to UGX 41.185 Billion is appropriated to 137 local governments, 56 general hospitals, 61 PNFP hospitals and 4,205 lower level health units. 40 percent of the health budget is spent at the Centre.

The Committee was informed by the Ministry of Health that Government was committed to increasing the PHC funds, and was developing a unit cost for funding health sector facilities as a justification for more PHC allocations in the FY 2014/15.

The Committee recommends that more funds and energy be expended in primary health care to facilitate the local governments and lower health facilities including PNFPs to deliver on their health-related mandate.

In addition, the committee recommends that Ministry of health prioritizes the development of a unit cost for funding health sector facilities in FY 2013/14 so as to facilitate the provision of additional resources for PHC.

6.3 Human Resources for Health

In an effort to improve healthcare service delivery in lower health facilities, Parliament pushed and Government accepted to avail extra UGX 49.5 Billion to recruit health workers in HCIIIs and HCIVs. The funds were meant to: meet the cost of recruitment of 10210; pay salaries of the recruited staff and pay retention allowances to doctors in HC IVs (UGX 2.5 Million).

The outcome was as follows: 8,078 health workers were appointed. Of these, 6,839 reported to work, and by 30 June 2013, only 5,039 recruited staff had accessed the payroll.

The Committee also learnt that the recruitment exercise did not attract adequate critical cadres such as doctors, dispensers, midwives, anesthetic officers, theatre assistants, public health dental officers and nurses, etc. With respect to midwives, the Committee learnt that enrolled comprehensive nurses who had applied to be midwives had been offered appointment letters on trial for three years. However, Ministry of Health had been advised to work with Ministry of Education to ensure that these officers are retrained. In addition, the committee was informed that 10 categories of critical carders still require retention package and to enhance their salary by 50% would require UGX 43.179 Billion

The Committee further learnt that some doctors who had been recruited and reported for work left stations because they took long to access the payroll, their appointment letters did not show the promised retention allowance, others left because of lack of accommodation. The Committee was informed that a second recruitment was to be carried out to fill the gaps.

The committee observed that some doctors left general hospitals as a result of the wage enhancement and were recruited to work in HCIV`s and HCIIIs creating a gap which would cripple the referral system. In addition, the committee was informed by the Uganda Medical and Dental Practitioners Council that in FY 2012/13, 94 doctors left the country to seek jobs or study abroad (a figure that excludes those who left for South Sudan since it doesn`t require a certificate of good standing from the council); implying that motivating the health workers remains very critical.

Furthermore, the Committee observed that the decentralization policy seemed to promote sectarianism as some local Governments had decided to recruit their own, implying that the districts that had few of their own in the medical field were left to suffer.

Another observation was that medical officers were offered scholarships and as a result bonded for a specific time; however, upon completion of the studies there were no jobs as envisaged in the bonding agreement. As a result, the Ministry had offered some contracts to these officers without the knowledge of Health Service Commission. On the other hand, the districts to which the officers are bonded were not aware of these bonded officers.

In addition, the committee observed that there was lack of harmonization between the Ministry and Health Service Commission with regard to the officers due for retirement.

The Committee recommends that:

i. ***The Ministry expedites the second recruitment fill the vacant positions with priority in those who were not attracted. In addition there should be harmonization of recruitment by government and that carried out by development partners.***

ii. ***Ministry of health, Health Service Commission and Ministry of Public Service should work together to develop a retirement plan that should feed into the recruitment plan so as to avoid unnecessary Vacancies in health facilities.***

iii. ***Process of Recentralization of the recruitment of health workers be expedited.***

iv. ***In order to fully functionalize HC IVs and HCIIIs, Government should enhance the wage of the 10 critical cadres at these health centers who include among others Midwives, nurses, Anesthetists officers and Anesthetists assistants, Laboratory technicians. The Committee recommends that UGX. 43.179 Billion be allocated for the enhancement of the wages of the 10 critical cadres by 50% as retention allowances.***

v. ***The ministry develops a deployment plan for all bonded students and ensures that the local governments and health service commission are aware of it.***

vi. ***Government carries out a study on the possibility of bonding all Government Sponsored graduates in health courses (Specifically undergraduates) for at least one year to address the staffing shortages in health facilities especially the critical cadres.***

vii. ***Ministry of Health must ensure that all comprehensive nurses are retrained in midwifery.***

viii. ***The Ministry of Public Service should urgently ensure that all the recruited health workers access the payroll, and retention allowance is paid to the beneficiaries and reflected in their appointment letters.***

6.4 Under-grading and under-paying certain health cadres

The Committee learnt that the recent recruitment of health workers for HC III and HC IVs did not attract adequate number of critical cadres, as the table below shows.

Cadre of Health workers	**No. required**	**No. recruited**
Anaethetic Officer	170	45
Public Health Nurses	170	35
Ophthalmic Clinic officers	170	40
Theatre Assistants	170	25

The Committee learnt that one of the reasons for failing to attract the above critical cadres was the de-motivating payment that was not commensurate with their advanced and specialized training. An Anaesthetic Officer in Uganda receives the same salary as a Nursing Officer (Salary Scale U5). Yet, an anaesthetic officer first trains as a nursing officer, and then trains anaesthetism for 2 years. The same applies to Public Health Nurse who must be double trained both in General Nursing and Midwifery all at Salary Scale U5, and then undergoes further training in public health, and comes back at Salary Scale U5. An Opthalmic Clinic Officer first trains as a Clinic Officer at salary scale U5, after which studies opthalmology for 2 years, only to graduate and stay at salary scale U5! With this state of affairs, the officers are not motivated to pursue further studies.

The Committee recommends that Anaesthetic Officers, Public Health Nurses and Opthalmic Clinic Officers should be upgraded from salary scale U5 to salary scale U4 as a way of increasing the numbers of these cadres.

6.5 Functionalization of Village Health Teams

The Committee asserts that Government's effort to functionalize lower health facilities will not yield maximum benefits until community participation in health matters is strengthened. One

way of facilitating community participation is through revamping village health teams. The preventive health care stands to achieve success through well facilitated and supervised resident community mobilisers or community health workers or village health teams -VHTs).

The Committee was informed that Ministry of Health had already established 51,724 VHTs in 52 districts but only 39,947 are active due to poor motivation. However, the Committee wishes to observe that the effectiveness of VHTs will continue to deliver sub-optimal performance due to: (a) Composition and size (b) Recruitment criteria (c) Motivation (d) Supervision (e) lack of political and administrative anchorage (f) Supplies.

Among other roles, VHTs are supposed to carry out the following roles:

- *i) Registering and mobilizing pregnant mothers to seek ante-natal care and deliver at health facilities;*
- *ii) Mobilizing communities for routine immunization services, HIV testing and treatment, ABC prevention programmes;*
- *iii) Distributing health commodities such as insecticide treated nets and mama kits;*
- *iv) Collecting information from community members on strange diseases for onward reporting to health workers and local leaders;*
- *v) Encouraging sick people to seek medical attention from health facilities; and*
- *vi) Registering traditional birth attendants and herbalists in the community;*
- *vii) Providing a link between community members and health facilities and public health assistants*

The Committee recommends for the enactment of a policy defining, among others, the composition of the Village Health Teams; the selection criteria of the team members; the remuneration and or facilitation of the team members; the reporting procedures and accountability of VHTs vis a vis village local councils, HC IIs and public health nurses or assistants.

The Committee further recommends that Secretaries for Health and Education at the Local Council I and Local Council II levels should be utilized to enhance community level coordination of VHTs.

VHTs should be rolled out to the remaining districts and in addition to bicycles; Government should provide a motivational allowance. Furthermore, VHTS should be sensitized on nutrition to enable them sensitize community members on importance of balanced diets to address the malnutrition problem.

6.6 Eradication of Malaria

The Committee noted that malaria remains the major cause of death in Uganda with approximately 70,000 to 100,000 Ugandans dying annually, from this disease and 50% of inpatient deaths among children under five (U5) being attributed to malaria. In addition, through direct cost of medical care and reduced productivity of malaria sufferers and their caretakers, malaria negatively significantly affects the economy. The budget on anti-malarial drugs is on the increase. There are several indirect costs due to malaria like inpatient costs of admission and blood for malaria-induced anaemia in children and pregnancy (50% and 30% of all blood demand is for child health and maternal health respectively). Yet, malaria is preventable and treatable.

The Committee learnt that Government piloted indoor residual spraying (IRS) in Lango, Kanungu and Acholi sub regions and the results were very good. The good news received from the pilot districts was that the uptake of anti-malarial drugs budget and the number of malaria induced admissions in health facilities has drastically reduced.

The Committee was informed that Government of Uganda would require close to USD 76 Million (equivalent to UGX 188.3Billion) to roll out IRS across the country and it should be done every six months. The committee was further informed that WHO recommends that IRS should be sustained for at least 3 years translating to an annual cost of UGX 376.6 billion and a total of UGX 1129.8 Billion for the three years. However in FY 2013/14 the committee was informed that thirteen districts are projected to have IRS.

The Committee recommends that Indoor Residual Spraying should be prioritized as an effective way of eradicating malaria-induced deaths as compared to other measures such as larviciding and the use of insecticide treated mosquito nets that are being funded and promoted by the donors.

The committee recommends that the Ministry carries out a long term cost benefit analysis of all the various methods being used in Malaria eradication with a view of using the most efficient method of eliminating malaria. Among others, the cost of collecting blood should be one of the costs involved in this analysis given the fact that 50% of blood in Uganda is used for treating children with severe anaemia largely due to Malaria and 50% of inpatient deaths among children under five are attributed to malaria induced anaemia according to Uganda Blood Transfusion Service.

6.7 Revamping Immunization Programme

In spite of huge investments in immunization programmes especially by the donors, the statistics about immunization remain disturbing. About 52% of children under five are fully immunized, making Uganda the poorest performer in immunization coverage in East and Southern Africa region, only better than Somalia with 45% of children fully immunized[1].

The Committee was informed that declining immunization coverage started in 2006 when GAVI funds were misappropriated and the support was subsequently terminated. The coverage dropped from 90% to the current miserable coverage. The Committee was assured that the GAVI funds are to begin to flow in Uganda, and the situation would improve. In addition, new modalities have been crafted to ensure a revitalized immunization agenda, such as streamlining the procurement, storage and distribution of vaccines from UNEPI to National Medical Stores; introduction of key cost effective interventions such as Reach Every District/Reach Every Child; periodic intensified routine immunization and Child Health Days. The Committee was also informed that the recently recruited health workers would facilitate the delivery of immunization programmes, although the exercise did not recruit cold chain assistants vital to propel immunization activities. The Committee also noted that Government was to introduce Rotavirus vaccine (against diarhhoea), scale up the Human Papilloma Virus vaccine countrywide. However, these two vaccines are provided by GAVI for a period of two years and there after Government is expected to take over.

The Committee commends the Ministry of Health for the immunization revitalization plan and finally accepting that routine immunization as opposed to expensive national immunization campaigns.

6.8 Family Planning Services

The Committee observed that family planning services influence the quality of maternal health in a significant way. However, availability and accessibility of family planning services in Uganda remain a big challenge. For instance, the contraceptive prevalence rate among married women stands at 30%. Secondly, the unmet need for family planning among married women stands at 34%, while unplanned pregnancies in Uganda stand at 1.1 million.

The Committee observed that family planning services in Uganda are heavily donor dependent. Moreover, most of the services and or commodities do not meet the needs of the rural clients hence leading to poor absorption of the services. In addition, long term or permanent methods

[1] Ministry of Health. *Uganda Demographic and Health Survey Report 2011*. Kampala, Uganda

of family planning are not accessed by the rural clients mainly because of lack of specialized skills at lower health facilities to carry out the procedures.

The Committee recommends that funding for family planning services be increased. In addition, there should be an increase in skills training of health workers in the lower health facilities on family planning methods especially the long term methods.

Furthermore, the committee recommends that in order to increase efficiency in the provision of Family Planning Services, there should be a mechanism to induce demand for the services.

6.9 Nutrition and health

Malnutrition and stunting are slowly but surely undermining Uganda's health defence system with serious negative consequences on the children's physical and cognitive development. According to the Uganda Demographic Health Survey 2011, one third of children in Uganda suffer from stunting and 300,000 children under five suffer from severe acute malnutrition, five out of ten children are anemic and 15% of children are born with a low birth weight. Moreover, according to the recent Government/WFP report, the cost of malnutrition to Uganda is UGX 1.8 trillion annually, equivalent to 5.6% of GDP.

The Committee noted that Uganda Government is conscious about the threat of malnutrition. In response, the Government enacted the Uganda Nutrition Action Plan, costed at UGX 15.4 Billion. The objectives of this plan are to: 1) Improve access to and utilization of services related to maternal, infant, and young child nutrition; 2) Enhance consumption of diverse diets; 3) Protect households from the impact of shocks and other vulnerabilities that affect their nutritional status; 4) Strengthen the policy, legal, and institutional frameworks and the capacity to effectively plan, implement, monitor, and evaluate nutrition programmes and; 5) Create awareness of and maintain national interest in and commitment to improving and supporting nutrition programmes in the country. However, the Committee learnt that the plan remains un-implemented due to lack of resources.

The Committee recommends that the Nutrition Plan be funded and implemented, and aggressive sensitization and behavioural change communication be conducted targeting the mothers and youth on basics of good nutrition.

6.10 Non Communicable Diseases

The Committee observed that Non-Communicable Diseases (NCDs) and their risk factors are now an emerging problem in Uganda although the focus has been directed to infectious diseases to a greater extent. NCDs include hypertension, cardiovascular diseases, diabetes, chronic respiratory diseases, mental illness, cancer conditions, injuries as well as oral diseases.

According to the World Health Organization, "most Non Communicable Diseases are the result of four particular behaviours (tobacco use, physical inactivity, unhealthy diet, and the harmful use of alcohol) that lead to four key metabolic/physiological changes (raised blood pressure, overweight/obesity, raised blood glucose and raised cholesterol)."

The Committee was informed that Ministry of Health initiated the process of conducting a national NCD baseline survey on risk factors and magnitude of non-communicable diseases in the country so as to provide baseline data on the prevalence of NCDs and their risk factors.

The committee recommends that the ministry expedites the process of availing data on the prevalence of NCDs and their risk factors so as to guide the NCD policy.

In addition, the Committee recommends that Government should increase funding to sports and physical activities.

Furthermore, Diabetic test kits and functional blood pressure kits should be provided at all lower health facilities. In addition, Periodic cancer screening should be carried out at HC IIIs.

6.11 Drugs, Alcohol and substance Use

The Committee observed that there is currently easy access to drugs and alcohol. For example, alcohol was being sold cheaply in sachets at as low as UGX 1,000/=, and some drugs, such as kuba, were being sold in supermarkets. In addition there is a new lifestyle of taking *Shisa*. However, according to the British Heart Foundation, one session of *Shisa*, which normally lasts an hour, is equivalent to smoking more than 100 cigarettes. Moreover, the continued use of *Shisa* could encourage the cigarette market to shift from the direct to indirect consumption of tobacco thereby increasing cancer cases and shifting the tobacco market from formal industries to the informal market.

The Committee recommends that the Bill on drugs and other substances be expedited to regulate the use of alcohol and drugs, which seem to be on the increase. In addition, a study should be carried out on the likely impact of *Shisa* use on tax revenue.

6.12 HIV/AIDS Funding

In order to contain the increasing HIV prevalence rate and new infections, last FY, the Committee recommended, among others, that:

- The health sector brings back the HIV prevention strategies (ABC) on the national arena through adequate funding of HIV prevention campaigns and strategies.

- Government needs to step up efforts in ensuring universal access to ARVS by all, including the rural and urban poor. A conditional grant on HIV/AIDS treatment and a Maternal and Child Health Care grant should be established for local governments.
- The Committee further recommended that Government scales up the application of the following interventions that have previously proved to be effective: EMCTS; condom use; safe male circumcision; Ant-Retroviral treatment, behavior change interventions; HIV counseling and Testing; Post exposure prophraxis (PEP); Pre-exposure prophraxis (PREP).

The Committee observes that more funding is required if the above valid recommendations are to be implemented.

The Committee further noted that in June 2013, WHO released new guidelines on HIV treatment whereby any person tested and found HIV positive with CD4 count of 500 or less should be immediately enrolled on ART. This means that more Ugandans will need to be enrolled on treatment. However, donors remain the main funders of the HIV/AIDS programmes in Uganda, a situation that is risky and unsustainable.

Furthermore, the committee observed that most HIV positive people are also TB positive yet the TB units and HIV/AIDS units operate independently. Also the distance between HIV positive people or students travel long distances either to the treatment centres or schools respectively yet some of these students cannot afford proper meals as demanded by the ARVs.

The Committee recommends that an HIV/AIDS Trust Fund be established to take care of the financial needs for the country's HIV/AIDS strategic plans and programmes. In addition, Universal HIV testing should be encouraged.

In addition, Government should collaborate with HIV/AIDS units and TB units so as to establish the number of people who are both HIV/AIDS and TB positive so as to ensure that both conditions are addressed at the same time.

Lastly, Government should ensure that there is adequate availability of condoms in the country.

6.13 Referral System

a: Improving internal referral system

Last FY, the Committee observed that the current 7 tier referral system in Uganda may be less cost-effective and ultimately, un-sustainable. Moreover, the purpose for which referral system may have been established may not have been achieved since even the national referral hospitals such as Mulago remain over-congested and continue to operate as general ordinary

hospitals. The Committee recommended that the referral system in Uganda be reviewed with a view of creating shorter referral mechanisms and reducing on the tiers thereby reducing on costs.

The Committee further observed that the criteria for funding regional referral hospitals were not clear. For example, some referral hospitals such as Moroto Hospital which did not have the required critical staff such as senior medical officers, were referring patients to district, mission hospitals or other regional referral hospitals that had them; while other referral hospitals such as Mbarara Regional Referral Hospital was receiving patients form other regional referral hospitals yet its budget for drugs at NMS was maintained with that of other referrals creating a drug shortage in this hospital.

In addition, the Committee observed that the policy of upgrading health facilities from one service level to another was not clear and popularized. Some districts were upgrading some health centre IIIs to HC IVs without the knowledge of the Ministry. The Committee was informed that efforts to improve the referral system have been launched and a policy to guide referrals was being drafted by the ministry.

The Committee recommends that the policy on referral system be expedited and made through a transparent and participatory manner.

In addition, the process of establishing the regional referrals in Kampala to decongest Mulago hospital should be expedited.

The Committee also recommends that the Ministry should sensitize local governments on the guidelines of upgrading Health facilities from one level to another so as that there is strict adherence to guidelines of upgrading health centers given the financial implications.

The Committee further recommends that affirmative action be taken to bring Moroto regional referral hospital to the status of other regional referral hospitals to avoid situations of RRH referring to a general hospital.

b: Reduction of Referrals Abroad

For the past two years, the Committee on Health has been calling for the review of referrals abroad; first, to build a super specialized facility in Uganda to handle cases that are normally referred abroad; second, to consolidate all funds budgeted for treatment abroad from all government departments and place them in one centre such that they can be accessed by all deserving cases whether the beneficiaries are employed in the public sector or not; third, to

strengthen our national referral facilities and super specialized institutes, such as the Cancer Institute and the Heart Institute.

The Committee was informed that Government was in the process of constructing a specialized facility at Mulago to handle cases hitherto referred abroad for treatment.

The Committee was also informed that efforts to transform Uganda Heart Institute Ltd into a semi-autonomous public body were in advanced stages.

The Committee recommends that efforts to build a super specialized hospital and transform the Uganda Heart Institute Ltd into a public body and to strengthen the capacity of specialized institutes with more resources be expedited.

6.14 Ambulance system

The Committee observed that the manner in which ambulance system is designed and offered in the health facilities was not satisfactory. First, there seems to be no clearly articulated policy on ambulance system in the country. Second, the manner in which ambulances are procured, distributed and managed leaves a lot to be desired. Third, a number of ambulances are grounded in most of the health facilities. Yet, an effective ambulance is an asset in the reduction of maternal mortality and an important determinant of an effective referral system.

The Committee recommends that a policy be enacted to guide ambulance system in Uganda.

In addition, new ambulances should be prioritized for hard to reach areas.

Lastly, special consideration should be made for mountainous and water areas in the distribution of ambulances.

6.15 Public health Inspection

The Committee observed that if preventive health care is to be delivered, public health inspection has to be prioritized. However, the cadre of public health inspectors and midwives is not prioritized and facilitated. Yet, this cadre defines the secret of countries like Sri Lanka which have managed to register excellent health care to their citizens. The Committee was informed by the MOH that the health inspectors are provided for in the local government establishments and specifically at the district and the HC IV level only.

The Committee recommends that health inspectors be facilitated to do their work as a priority area and as a means of promoting preventive health care.

6.16 Revamping the Medical/Professional Councils

The Committee noted with concern the raising cases of quack and unethical doctors and mushrooming quack health training institutions. To address this vice, last FY, the Committee recommended that the licensing of private health training institutions should be done by the Ministry of Health, and the current licences should be reviewed; supervision of nursing training institutions should be undertaken by the MOH rather than the Ministry of Education since the former has more relevant technical competence than the latter; training curriculum of health training institutions should be expanded to include training on ethics and customer care; a register of genuine traditional healers should be established with the support of the traditional healers association to weed out quack healers; the traditional healers bill be expedited to regulate the traditional medicine; the Medical Council should be facilitated to supervise and discipline unethical medical practitioners. The Committee observed that the above recommendations were not implemented.

In addition, the committee observed that the use of alternative and complementary medicines was on the increase yet there seemed to be no regulation of these drugs.

The Committee reiterates the above mentioned recommendations as a way of weeding out quack and unethical doctors and quack health training institutions.

In addition, the committee recommends that Government should urgently regulate the use of alternative and complementary medicines.

6.17 Health Insurance Scheme

The Committee noted that the speed to establish a national health insurance scheme had reduced. However, the Committee was informed that the Bill on health insurance scheme was in advanced stages of development, and that remaining discussions were on the financial implications of the Bill.

The Committee recommends that the Bill should be expedited since it has the potential to improve access to healthcare and reduce out of pocket spending in Uganda.

6.18 Maternal Death Audits

The Committee noted the efforts made by Government to improve maternal health through measures such as the recruitment of health workers at lower HC IIIs and HC IVs. The Committee was assured that as a result of the interventions, maternal mortality will reduce from the current level of 438/100,000. The Committee was also informed that an audit is conducted on every maternal death that occurs, and a report is compiled. However, it would appear that recommendations in maternal audit reports are not acted upon in a timely manner at the

central and facility level. Nor is there effective oversight and monitoring to ensure that recommendations are acted upon given the fact that monitoring of the health sector is the least funded vote function (its 0.2% of the ministry of health budget in FY 2013/14) even when it comes to release of funds, it had 35% of the approved budget released in FY 2012/13.

On a happy note, the Committee observed that maternal death audit was being effectively done at Mbarara Regional Referral Hospital and findings of the audit being acted upon. As a result, maternal death had drastically reduced at the facility.

The Committee recommends that maternal death audits be strengthened and best practice from Mbarara Regional Referral Hospital be benchmarked by other health facilities.

In addition, the Ministry of Health should compile data on all maternal death audits in all health units in the country, both public and private, and submit an annual report to Parliament with actionable recommendations.

6.19 Sanitation and Hygiene

The Committee observes that sanitation and hygiene are the pillars of any disease prevention strategy. It is a well known fact that most disease outbreaks in Uganda are waterborne, and water washed, diseases. These include dysentery, typhoid, diarrhea and cholera, ringworms, pediculosis, bedbugs, jiggers, dental decay, eye infections, candida, genital infections. In spite of these, consolidated attention to sanitation and hygiene as primary health issues has been lacking or at best uncoordinated. For example, there is no policy statement and budget allocation on the matter under VOTE 014 for the FY 2013/14.

The Committee notes that aspects of water sanitation and hygiene are handled in the water sector and education sector; but these are not coordinated and guided by the ministry in charge of the overall health in the country.

The Committee recommends that sanitation and hygiene should be given the due attention through policy and budget support in order to mitigate the unwarranted deaths of Ugandans through waterborne diseases.

The Committee further recommends that the four ministries of health, water, education and local government under the guidance of the Office of the Prime Minister develops a harmonized position, strategy, policy on sanitation and hygiene.

6.20 Utilities in Hospitals

The Committee observed that health facilities that are connected to NWSC and UMEME services were perennially grappling with utility bills arrears and, had always had the services disconnected by the utility providers. The Committee observed that to run a hospital without water and electricity is a disaster.

The Committee noted the efforts being made by the Ministry to ensure that public health facilities have access to water and electricity. Such efforts include: negotiating with Ministry of Finance to clear the utility areas and providing solar panels to some health facilities.

The Committee recommends that strategic and innovative ways should be designed to ensure that health facilities have water and electricity, through schemes such as water harvesting, gravity water schemes, negotiating subsidies or affirmative action from utility providers.

6.21 Uganda Cancer Institute

The Committee noted the tremendous work registered by the Uganda Cancer Institute. However, the Committee learnt that the genuine cost of cancer treatment – chemotherapy was not known to the majority of the people, including the patients, thereby creating space for unscrupulous people to cheat patients. The Committee was informed by the Director Uganda Cancer Institute that chemotherapy treatment was free of cost, except that patients were charged 30,000 for the bed per night.

The Committee recommends that the Uganda Cancer Institute revamps its public relations and information sharing to keep the public informed about the services they offer and the associated costs.

6.22 National Drug Authority

a: Unpaid fees for inspection of donor supplied drugs

The Committee noted that NDA does not receive appropriations from Parliament. Instead, it raises its operational funds from inspection fees, which is at 2% of the value of imported medicines and other supplies.

The Committee was informed that Government of Uganda receives huge supplies of drugs and other supplies from a number of donors. However, these donors are not willing to pay the cost of inspection to NDA, yet the drugs have to be inspected to ensure their efficacy. Consequently, the Ministry of Health has been requesting NDA to inspect the donor supplied drugs on the promise of future re-imbursement. To this end, Ministry of Health owes NDA UGX 3 Billion, which has been outstanding for a long time. The Committee learnt that the cost of verification of some of the drugs such as ARVs was very expensive.

The Committee recommends that UGX 3 Billion should be cleared as domestic arrears.

Secondly, the National Drug Authority should be given a VOTE so that Parliament can appropriate funds for its operations.

b: National Drug Authority Board

The Committee noted that for the last two years, the NDA has not had a board. The Members appointed to the Board in March 2013 by the former Minister of Health, Hon Christine Ondoa have never assumed office. The Committee was informed that the names were submitted to Cabinet for endorsement. The Committee was further informed that the absence of the Board had hampered the work of the NDA. For example, the certification of NDA laboratory could not proceed without the duly appointed laboratory officer, who can only be appointed by the Board. The Committee observed that Cabinet had taken long to endorse the Board members.

The Committee recommends that the National Drug Authority Board should be constituted urgently to enable the Authority function properly.

6.23 PHC Grants to Local Governments

The committee was informed that some local governments were diverting the funds that are allocated for Primary Health Care for their own priorities. As a result, health facilities do not spend the funds appropriated to them though the sector budget funds are spent at the end of the financial year.

The committee recommends that Ministry of Health ensures that all health facilities open bank accounts in Fiscal year 2013/14 to enable Ministry of Finance send PHC transfers directly to the health facilities and hence control district reallocations.

6.24 Legal Status of Uganda Heart Institute

Parliament had observed that several conflicts and challenges were emerging in terms of ownership of assets, finances and management of human resources at the Uganda Heart institute as it was found to be a limited company. The offices of the Auditor General, Attorney General and First Parliamentary Counsel, the Health Committee and the Budget Committee had pronounced themselves on this matter advising the Ministry of Health to initiate a legislation to transform Uganda Heart Institute limited into a statutory body. The committee was informed that Uganda heart Institute was now owned by Government and the Ministry was working on the relevant legislation to transform the Institute into a public entity owned by Government of Uganda. Attached is the evidence tendered by the Minister of Health.

7.0 GOVERNANCE CHALLENGES IN THE HEALTH SECTOR

7.1 The Charged PS/Accounting Officer

The political leadership of the Ministry was changed with the appointment of Hon Dr Ruhakana Rugunda, Hon Dr Tumwesigye and Hon Sarah Opendi. The Committee is optimistic that the team will provide effective stewardship of the health sector. The Committee also noted that the hitherto Acting Permanent Secretary, Ministry of Health, Dr Asuman Lukwago was recently appointed as a full Permanent Secretary in the same Ministry. However, at the time of his appointment, the said Asuman Lukwago had been charged by the Director of Public Prosecution with a number of criminal offences. The sanctioned charge sheet is attached.

The Committee recalled that Parliament had expressed reservation on the continued stay in office of the charged Permanent Secretary of Ministry of Health. The Committee observed that a Public Service Standing Orders 2010 provide for the interdiction of a public officer if criminal proceedings are being instituted against him or her. The Committee also reliably informed that the officer responsible for interdicting a Permanent Secretary is the Head of Public Service/Secretary to Cabinet.

In light of the foregoing controversy, the Committee recommends that the Appointing Authority appoints a new Accounting Officer for VOTE 014, Ministry of Health.

In addition, administrative measures should be undertaken on the charged accounting officer in line with laws and regulations that govern public officers.

7.2 The Assistant Commissioner Support Services claimed to be a hindrance of effective healthcare delivery at Mulago National Referral Hospital

The Committee received reports that one Kantarama Alison, Assistant Commissioner Support Services at Mulago Hospital was misusing her office. The Committee was informed that the officer, who has worked at Mulago Hospital for about 20 years, was renting institutional houses meant for health workers to private persons for personal gain. The Committee was also informed that the said officer was using the hospital laundry for private ends, and had turned a DAYCARE CENTRE built with public funds, a loan from African Development Bank, into a private asset. The Committee learnt that each child in this Day Care Centre pays approx 600,000/= but these funds are not declared to the hospital administration. The Committee also learnt that the officer was insubordinate to the leadership of the Hospital, and had also rented out hospital land to private persons. The allegations have direct bearing on the Non-Tax Revenue collection and effective health service delivery.

The Committee recommends that the Ministry of Health takes immediate action on the matter in order to prevent paralysis of service delivery at Mulago National Referral Hospital. The Minister of Health should report to Parliament on measures taken within two months.

In addition, the committee recommends that a value for Money audit be carried out at Mulago Hospital complex by the Auditor General's office.

7.3 Mapping and coordination of health interventions in the country

The Committee noted with concern that there were a lot of players in the health sector including CSOs whose interventions are not well coordinated. There is a lot of resources with CSOs, private sector, religious foundations if well-coordinated and directed would put an end to duplications and add value towards a fully functional primary health care systems in Uganda.

The Committee recommends that Ministry of Health conducts a comprehensive mapping exercise of all health players aimed at profiling who does what, where and with what resources and identifies under-served areas, regions, districts for corrective measures.

7.4 Fragmentation of health service delivery

Last year, the Committee observed that health services continue to be delivered to the citizens by so many actors and in most cases in an un-coordinated and synchronized manner. There is also the challenge of supervision and reporting. For example, in the public sector, the following Ministries play a role in the health sector: Ministry of Health (policy and planning); Ministry of education (in charge of health training institutions); Ministry of Local Government and Local Governments (health promotion and disease prevention through primary health care service delivery, supervision of hospitals and health centres below the level of regional referral hospitals; semi-autonomous regional referral hospitals and national health institutes; the Health Service Commission (recruiting for upper health institutions/hospitals) and the District Service Commissions (recruiting for lower health institutions).

The Committee recommends that the current institutional framework for delivering health services be reviewed with a view to enhancing effective coordination and supervision.

7.5 Donor dependency of the sector and parallel structures

The Committee observed that the health sector receives a lot of off - budget support from a number of donors/agencies. Some of these donors have established parallel staff structures to implement health programmes, and some of these staff are based in public health facilities.

However, there are many negative un-intended consequences of this practice. First, the donors are recruiting from public health facilities since they pay more than government. Second, the public health workers who work at the same station with donor-recruited health workers feel de-motivated due to the discrepancy in the salaries. Moreover, some of these well paid donor recruited workers are supposed to be supervised by the government's poorly paid health workers. Third, the sustainability plan for these donor recruited staff is not evident. Consequently, this practice seems to have induced the projectization of healthcare delivery, with its attendant negative consequences.

The Committee recommends that Government critically studies the implication of off –budget support to the health sector and the projectization of healthcare delivery on the long term healthcare delivery progress in Uganda.

7.6 Planning for Human Resource for Health

The Committee observed that one of the challenges to the recruitment, motivation and retention of health workers was the absence of long term strategic planning for human resource in general and human resources for health, in particular. For example, scholarships in public universities and for studies abroad did not seem to be aligned with the strategic health needs of the country. There seems to be no human resource master plan to guide on training, deployment, motivation, retirement and replacement. As a result, in the health sector, there was uncoordinated training and recruitment of health workers. There was limited interface between the Ministry of Education, Ministry of Health, Health Service Commission, Ministry of Public Service, National Planning Authority to work out the number of trained health workers required at any given time and place.

The Committee also observed that the human resources function in the health sector institutions was weak as only 8 hospitals had human resources officers.

The Committee recommends that a strategic human resource planning be conducted to enable the formulation of a human resource master plan.

8.0 Recommended Re-allocations within the Health Sector

After critically analyzing the proposed recurrent and development budget estimates of the health sector, the Committee recommends re-allocations within the sector as follows:

1. The funds earmarked for the purchase of the vehicle for the senior presidential advisor (UGX 150 Million) under Vote 014-MOH should be reallocated to purchase mattresses for general Hospitals, to be purchased by the NMS. The justification is that the Ministry of Health is not the one responsible for purchasing vehicles for presidential advisors.

2. UGX 100 Million under Vote 014-MOH for purchase of specialized machinery and equipment should be reallocated to NMS for the purchase mattresses for general Hospitals. The Justification is that Government runs an activity based budget and this item has no inputs, planned output and activities to deliver Outputs.
3. UGX 499.6 Million under VOTE 162 Butabika Hospital for purchase of drugs should be reallocated to VOTE 116 National Medical Stores since it is the latter Vote that is charged with the responsibility of drug procurement, storage and distribution to all hospitals.
4. UGX 1 Billion being part of funds earmarked by Vote 176 Uganda-China Friendship Hospital Naguru should be reallocated to NMS for purchase of mattresses for all general hospitals. The justification is that the funds are meant for construction yet the Hospital has not yet identified the land on which to build houses for staff.

Justification for Mattresses

In the FY 2011/12, National Medical Stores set aside about UGX 16 Billion to purchase beds and mattresses for all health facilities in the country. However, the fourth quarter release for NMS was cut off hence failure to procure beds and mattresses. Most of the beds and mattresses in the health facilities remain in a sorry state. The committee was informed that no provision has been made this fiscal year for Beds and Mattresses and it would cost USD 8.6 Million equivalent to UGX 22.49 billion to ensure that all health facilities have them. The committee was informed that this cost involved delivery costs. However, General Hospitals would require USD 1.683 Million (equiv. UGX 4.376 Billion). The reallocated funds realized could not provide both beds and Mattresses and so the committee settled for only mattresses to ensure that patients don`t sleep on the floors.

9.0 Performance Contracts

The Committee noted that health indicators in Uganda remain disappointing in spite of the progressive increase in funding to the health sector over the years. For example, malaria induced deaths remained high; there was increased HIV prevalence and reported new infections; maternal mortality had also increased; immunization coverage had declined; and malnutrition was on the increase. The Committee observes that resource allocation should translate into the reduction of these disturbing health indicators/figures.

As the way forward, the Committee recommends that leadership of the health sector should be given performance contract to the effect that this Financial Year's health budget to the tune of 1.2 trillion should, at the minimum, yield the reduction of maternal mortality ratio from the current 438/100,000 to 300/100,000 and improve immunization coverage from the current the 52% to at least 75%.

10. Conclusion

Subject to the recommendations advanced above, the Committee on Health urges the Committee of Supply to supply to the following Votes under the Health Sector the following Revised recurrent and development budgets for the FY 2013/14.

Vote	Institution	Recurrent "000s"	Development "000s"
14	Health	33,078,033	440,913,339
114	Uganda Cancer Institute	3,282,208	4,200,000
115	Uganda Heart Institute	5,431,047	2,530,000
116	National Medical Stores	219,374,587	-
134	Health Service Commission	3,236,603	646,799
151	Uganda Blood Transfusion Service	3,704,084	400,000
161	Mulago Hospital Complex	39,965,046	5,220,000
162	Butabika Hospital	7,699,770	1,888,141
163	Arua Referral Hospital	4,186,757	821,000
164	Fort Portal Referral Hospital	4,677,840	836,360
165	Gulu Referral Hospital	3,977,440	1,201,000
166	Hoima Referral Hospital	3,294,969	1,520,000
167	Jinja Referral Hospital	4,646,124	1,251,000
168	Kabale Referral Hospital	3,396,927	1,150,000
169	Masaka Referral Hospital	3,836,737	748,436
170	Mbale Referral Hospital	5,503,362	587,700
171	Soroti Referral Hospital	3,614,373	1,620,000
172	Lira Referral Hospital	3,484,929	600,000
173	Mbarara Referral Hospital	4,757,141	950,000
174	Mubende Referral Hospital	2,535,459	1,192,000
175	Moroto Referral Hospital	2,040,410	1,413,000
176	Naguru Referral Hospital	5,868,192	3,850,684

Source: Draft Estimates of Revenue and Expenditure FY 2013/14 and Recommendations of the Committee.

I beg to report.

MEMBERS OF THE COMMITTEE ON HEALTH THAT ENDORSED THE REPORT OF THE COMMITTEE ON THE HEALTH SECTOR MINISTERIAL POLICY STATEMENT AND BUDGET ESTIMATES FOR THE FY 2013/14

No	Name	Constituency	Party	Signature
1	Hon Dr. Omona Kenneth	Kaberamaido	NRM	
2	Hon Iriama Margaret	Moroto	NRM	
3	Hon Lematia Ruth Molly	Maracha	NRM	
4	Hon Anite Evelyn	Youth	NRM	
5	Hon Kabasharira Noame	Ntungamo	NRM	
6	Hon Dr. Bitekyerezo Medard	Mbarara Muni	NRM	
7	Hon Dr. Twa-twa Mutwalante. J	Iki-Iki	NRM	
8	Hon Khainza Justine	Bududa	NRM	
9	Hon Dr. Chris Baryomunsi	Kinkizi East	NRM	
10	Hon Barumba Rusaniya	Kiruhura	NRM	
11	Hon Egunyu Nantume Jennifer	Buvuma	NRM	
12	Hon Dr. Patrick Mutono Lodoi	Butebo	NRM	
13	Hon Dr. Michael Bayigga Lulume	Buikwe South	DP	
14	Hon Femiar Wadada	Sironko	FDC	
15	Hon Betty Aol Ochan	Gulu	FDC	
16	Hon Betty Amongi Ongom	Oyam South	UPC	
17	Hon Rhona Ninsiima	Kabale Mun	Indep	