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PERFORMANCE AUDIT REPORT

of the

AUDITOR-GENERAL

on

TRANSPORT OPERATION IN THE MINISTRY OF HEALTH

GHANA AUDIT SERVICE
MR. EDWARD DUA AGYEMAN
AUDITOR-GENERAL OF GHANA

MEMBERS OF STAFF OF GHANA HEALTH SERVICE AND
GHANA AUDIT SERVICE PRESENT AT THE EXIT CONFERENCE
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Ref. No. AG.01/109

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September 2004

Dear Sir,

REPORT OF THE AUDITOR-GENERAL
ON TRANSPORT OPERATION IN THE MINISTRY OF HEALTH

I have the honour to submit to you for presentation to Parliament my seventh performance audit report in pursuant to Article 187(5) of the 1992 Constitution and Section 13(e) of the Audit Service Act, Act 584. The Audit Service Act, which came into force in October 2000, gives me the authority to audit programmes and activities of public offices to ensure economy, efficiency and effectiveness in the use of resources.

2. Performance auditing is currently being introduced at Ghana Audit Service as part of a capacity building project funded by the European Union as part of Public Financial Management Reform Programme and managed by the National Audit Office (U.K.) in partnership with the Swedish National Audit Office. The team that carried out the audit comprised Messrs A.R.K. Boadu (Leader), A.N. Aboagye-Attah and Eugene Mwinvi under the supervision of Mr. R.K. Anaglate, Chairman, Performance Audit Management Committee, Mr. A.R.K. Boadu, Acting Director of Performance Audit and Mrs. Z. Martey, counterpart in the capacity building project.

3. Performance audits are carried out by teams of professional staff, which if required may also include specialists such as architects, legal experts and engineers. Depending on the extent of the coverage and complexity, it normally takes between six months and one year to complete a performance audit, thus, making it more
expensive than the traditional financial audit. Effective performance audits can lead to better use of resources by public bodies and provide support to democratic government by bringing about accountability and transparency, improved operations and better decision-making.

4. This report to Parliament is the seventh out of eight reports prepared by 22 staff who have been professionally trained in conducting performance audits to internationally recognised standards to supplement the traditional financial audits.

5. This seventh report is on Transport Operation in the Ministry of Health. The audit included identifying and analysing problems as well as giving recommendations in order to enhance economy, efficiency and effectiveness in the transport services.

6. I would like to thank my staff for their assistance in the preparation of this report and the staff of MOH and Ghana Health Service (GHS) for assistance offered to my staff during the audit.

7. I trust that this seventh performance audit report would meet the approval of Parliament.

Yours sincerely,

EDWARD DUA AQYEMAN
AUDITOR-GENERAL

THE RT. HON. SPEAKER
OFFICE OF PARLIAMENT
PARLIAMENT HOUSE
ACCRA
PERFORMANCE AUDIT REPORT OF THE AUDITOR-GENERAL ON
TRANSPORT OPERATION IN THE MINISTRY OF HEALTH

EXECUTIVE SUMMARY

In 1993, the Ministry of Health (MOH) implemented a transport programme to improve the operation and management of transport services to support health care delivery. The Ministry's strategic objective is to ensure that availability and reliability of transport services translate into improved health care.

2. The purpose of this audit was to examine transport services in support of health care delivery in Ghana, with focus on acquisition, allocation, fleet maintenance and management. The audit was based on interviews, inspection, review of documents and analysis of statistical data from MOH and the different levels of Ghana Health Service (GHS) in five regions.

3. The audit shows that the objectives of the ministry have not been fully met. Transport acquisition does not meet estimated needs and the replacement policy cannot be followed. There is a shortage of some vehicles by type and poor functioning ones. Vehicles have not been allocated according to the policy and vehicles are unevenly distributed among health institutions. The Planned Preventive Maintenance (PPM) Scheme is not carried out as intended and the ministry's workshops are not functioning efficiently.

4. Our conclusions are that:
   - The policy and planning for transport replacement are unrealistic and ineffective and the ministry is unable to meet its most important needs independent of donors;
   - If the Transport Model is relevant, then there is an inefficient allocation of vehicles in the country;
   - MOH workshops are not well patronised and the PPM Scheme is not functioning as it should; and
   - It is difficult to manage acquisition and disposal efficiently.
Acquisition of transport

5. Due to lack of resources and insufficient supply of vehicles by donors the replacement policy cannot be followed by the ministry. Transport replacement is always behind schedule and the existing fleet is over-aged. It is unrealistic and the planning process is ineffective. Some vehicles are already due for replacement even before they are procured. The estimated amount (2001) to cover replacement needs and new vehicles is approximately 40 times higher than the expenditure between 1999 and 2001.

6. From 1997 to 2002, the ministry never provided a budget for transport acquisition and could therefore not meet its most important transport needs without relying on donor support.

7. In order to improve the acquisition of transport, we recommend that the ministry should:
   - establish its own budget and review the policy on replacement. The real condition of vehicles should be taken into account.
   - seek authorisation from the Ministry of Finance and Economic Planning to use proceeds from auction of vehicles for acquisition and rehabilitation of vehicles.

8. The inventory in 2002 showed a fleet of 895 vehicles, an apparent excess of 160 vehicles (22%) above the minimum requirement according to the ministry’s Standard Transport Model. The model has not been used for allocation as stipulated in the Policy.

9. To improve the allocation of vehicles among regions and other institutions, we recommend that the ministry should:
   - analyse and assess the type and distribution of vehicles among regions and other institutions; and
   - review the procedures for allocation of vehicles.
Fleet maintenance

10. The PPM Scheme is not functioning as it should. Many health facilities do not implement the scheme at the ministry's workshops, resulting in under-utilisation of the facilities. The workshops have problems in terms of equipment, training of personnel, technical expertise and availability of spare parts. These problems were identified in a specialist report in 1998, but the ministry has not fully taken action on the recommendations in the report. We noted that some spare parts allocated to health facilities have not been paid for.

11. To improve the maintenance of vehicles and the efficient use of resources, we urge the ministry to:

- review the PPM Scheme including determining whether the scheme is more cost effective than other sources of supply and

- either resuscitate or abandon it. If the PPM Scheme is to be well implemented, then the workshops should be properly equipped, staffed and managed.

Transport management

12. The ministry has an elaborate transport management system set out in its Transport Management Handbook. However, staff who are supposed to use the Handbook, do not have a thorough knowledge of the administrative procedures and requirements for documentation of data. Ultimately the quality of decision-making is affected.

13. In addition, auction sales have not been properly managed by the ministry. There are outstanding debts to be paid by auctioneers. Health institutions have not paid monies from auction sales into the Consolidated Fund as required by Financial Regulations.

14. In order to improve transport management, we recommend that the ministry:

- train staff in the ministry's procedures and regulations;

- test drivers regularly;
improve the system of reporting on the fleet of vehicles;
- take preventive action aimed at reducing theft of motorcycles;
- improve the management of auction and disposal of vehicles; and
- recover all outstanding monies from auctioneers and account for auction proceeds.

15. Management assured us of its recognition of and readiness to address the various issues raised by this report to enhance transport operation in MOH and GHIS.
Reasons for the audit

Ministry of Health (MOH) provides preventive, curative, restorative and promotional health care at the regional, district, sub-district and community levels.

2. One crucial component of health service delivery in MOH is transportation. It is used to convey logistics, run administrative errands, provide outreach services and carry out patient referrals. In 2001 MOH was operating 884 four wheeled vehicles, 1,397 motorcycles and 15 motorboats across the country. Large sums of money are committed for the provision of transport services in MOH and Ghana Health Service (GHS). The donor community provides substantial funds for the acquisition of new vehicles to support the delivery of health services in Ghana. The capital investment in the transport services in MOH/GHS requires careful supervision and management.

3. In accordance with Section 13(e) of Audit Service Act, Act 584 of 2000, the Ghana Audit Service commissioned a performance audit. The audit focused on transport acquisition, allocation, management and fleet maintenance in MOH/GHS to find out if transport resources are utilised efficiently and effectively to achieve value for money and MOH/GHS objectives.

Purpose and scope

4. The purpose of the audit was to examine the acquisition, allocation, management and maintenance of transport resources in support of health care delivery in Ghana. This includes identifying and analysing problems as well as giving recommendations in order to enhance economy, efficiency and effectiveness in the transport services. The audit covered the period 1997 to 2001. However, the fleet inventory of 2002 has also been used and analysed.

Method and implementation

5. During the audit we interviewed senior officials from MOH and GHS to obtain their views on acquisition, allocation, management and maintenance of vehicles. We also compiled and analysed statistics and information from various policy documents and
reports at MOH and GHS. The audit assessment was based on policy and regulations in the MOH Transport Policy, Transport Management Handbook and Regulations 48 (1) – (2) and 110 of the Financial Administration Regulations (FAR), L.I. 1234 of 1979.

6. In order to cover the situation in different parts of the country, the following five regions were selected.
   - Greater Accra Region, which is the hub of all MOH/GHS activities;
   - Volta Region, represents the Southern Zone;
   - Ashanti Region, represents the Central Zone;
   - Northern Region, represents the Northern Zone; and
   - Upper West Region, which has a well established mechanical workshop.

7. We interviewed Directors of Health Services, District Directors of Health, Medical Officers, Health Service Administrators, Transport Officers, Workshop Superintendents, Mechanics/Artisans and Drivers on the allocation, operation and management of transport resources in their respective regions, districts and health facilities. Case studies were carried out at the two Teaching Hospitals of Korle-Bu and Okomfo Anokye, three Regional Hospitals, five Regional Health Administrations, four District Hospitals and six District Health Administrations. On-site inspections were carried out at five mechanical workshops at Ho, Wa, Tamale, Tema and Accra to study the operations of the workshops. The list of places visited during the audit is annexed to this report as Appendix A.

**Structure of the audit report**

8. Chapter 2 gives a detailed description of the processes of acquisition, allocation, management and maintenance of transport resources in the MOH/GHS. This is done in terms of goals and objectives, current development, key players and their main activities. Chapter 3 presents the findings, while chapter 4 provides a summary of findings and conclusions of the audit. In chapter 5 recommendations are made in order to improve the efficiency and effectiveness of the transport services in MOH and GHS.
CHAPTER TWO
DESCRIPTIVE CHAPTER

Historical background

9. Ghana Health Service (GHS) is the institution that implements the programmes and policies of Ministry of Health (MOH). GHS was established by Act 525 of 1996. The mission of the health sector in general is to improve the health status of all people living in Ghana, through development and promotion of proactive policies for good health and longevity, and the provision of quality health services that are affordable and accessible.

10. In the early 1990’s many studies were conducted in Ministry of Health. These studies identified inefficient transport support and operation as a barrier to the delivery of health services. The Ministry was operating 32 different types of vehicles. Both the Ministry and the donor community had expressed concern at the seemingly endless requirement for new vehicles without being able to measure the impact of such vehicles. Donors had spent large sums of money on the provision of vehicles and motorcycles but health care statistics had not shown any significant improvement. The donor community was therefore unwilling to provide more vehicles. In 1992 a transport working group was established to develop a transport policy and improve the operation and management of transport within the Ministry.

11. In 1993 MOH implemented a transport programme, funded by Department for International Development (DFID) of U.K. (then Overseas Development Agency) and with technical assistance provided by Save the Children (U.K.). A basic transport management system was implemented, backed up by a programme of transport capacity building. The programme included training of managers, health workers, drivers, riders, mechanics and administrators. TRANSAID Worldwide (U.K.) and Riders for Health were involved in the development of the transport system and training of personnel. This programme of assistance ended in 1997.

12. A study to determine the key components of a cost effective transport system to support the delivery of primary health services in Sub-Saharan Africa was conducted in 2001 by the World Health Organisation (WHO), Bill and Melinda Gates Children’s Vaccine Programme and others. The study concluded that MOH had implemented an effective system of transport management. This was demonstrated by:

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Report of the Auditor-General on Transport operation in the Ministry of Health
good knowledge of the need for transport management;
- data availability;
- vehicle availability and utilisation;
- transport considerations that are integrated into management decision making; and
- investment in the professional development of the transport staff.

13. Based on the implementation of the Transport Management Programme, donor confidence in the transport management system has grown and donors, particularly DFID and Danish International Development Agency (DANIDA), have been supporting the planned replacement of some of the four-wheeled fleet, and have made a major investment in additional motorcycles.

14. Table 1 shows the size of the fleet of health service vehicles from 1998 to 2001.

<table>
<thead>
<tr>
<th>Years</th>
<th>Number of four wheeled vehicles</th>
<th>Number of Motorcycles</th>
<th>Number of Boats</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>894</td>
<td>1,400</td>
<td>12</td>
</tr>
<tr>
<td>1999</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2000</td>
<td>877</td>
<td>1,341</td>
<td>14</td>
</tr>
<tr>
<td>2001</td>
<td>884</td>
<td>1,397</td>
<td>15</td>
</tr>
</tbody>
</table>

N/A = Not Available. Report and figures for 1999 were not provided.


**Goals and objectives**

15. Transport exists in the Ministry primarily to provide spatial mobility for staff to deliver critical services to the population and to ensure timely positioning of health logistics for health provision. It also contributes towards the achievement of other strategic objectives of MOH and GHS. The Ministry’s primary objective for the transport services is to ensure availability and reliability of transport as an essential logistic for delivery of health services, and to do this in the most cost effective and efficient manner. This is done to enhance health services delivery through excellence in transport management.
16. The strategic objective of the Ministry is to ensure that the availability and reliability of transport resources translate into improved health outputs. The strategic objectives of the transport services are to:

- ensure easy access to the population by health staff;
- ensure a lower average fleet running cost;
- contribute to quality of care by the timely positioning of health resources; and
- increase vehicular resources by ensuring high vehicle availability and reliability.

**Current development**

17. One of the most important changes taking place is that the Replacement Policy is being reviewed by MOH/GHS, as a result of difficulties in having to replace vehicles after 5 years and motorcycles 3 years of acquisition. Also, MOH has established a spare parts revolving fund to improve the availability of spare parts for the maintenance of vehicles.

**Key players and main activities**

18. The main aspects of transport services in MOH/GHS are acquisition, allocation, management and fleet maintenance. The key personnel involved are MOH, Co-operating Partners and GHS. The key players and their functions are summarised in Table 2. For details, see Appendix B. Appendix C provides the Organisational Structure of MOH/GHS.

**Table 2: Key players and their functions**

<table>
<thead>
<tr>
<th>Key Player</th>
<th>Main Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Health</td>
<td>Policy formulation, co-ordination and supervision</td>
</tr>
<tr>
<td>Co-operating partners</td>
<td>Provision of vehicles</td>
</tr>
<tr>
<td>Ghana Health Service</td>
<td>Acquisition, allocation, management and maintenance of vehicles etc.</td>
</tr>
</tbody>
</table>

**Needs assessment**

19. To determine transport needs in MOH/GHS, the Transport Management Unit at GHS Headquarters adopts the following methods.

- The Unit maintains a national database on vehicles. It includes the fleet inventory, which shows the distribution, location, age and condition of the
vehicles. This information is used in assessing vehicular needs of the various health institutions in the country.

- By the Ministry’s Replacement Policy, vehicles should be replaced five years and motorcycles three years after acquisition. The needs assessment is based on key performance indicators such as percentage fleet due for replacement, the average age of vehicles etc. The Policy helps in procurement planning.

- Use of information about new health programmes, which are of immediate public concern, establishment of new offices and any other health institution that is without a vehicle.

20. The requests from the districts are sent through the Regional Health Administrations to GHS Headquarters for inclusion in the procurement plan.

**Procurement of vehicles**

21. MOH and GHS prepare their annual procurement plans based on the needs assessment. MOH in 1995 signed a Memorandum of Understanding (MOU) with its Co-operating Partners or Donors. This allows the Ministry to present its procurement plans regarding its transport and other needs to the Co-operating Partners, namely: DFID, DANIDA, USAID, WHO, UNICEF etc. The Co-operating Partners then pledge their support in terms of loans and grants towards the acquisition of vehicles. These pledges are channelled through the Donor Pooled Fund also known as Health Fund or Programme Fund, managed by MOH and Earmarked Fund, which is controlled by the donors. Between 1998 and 2001 DFID supplied the bulk of the Ministry’s vehicles. Crown Agents (U.K.) procure the vehicles on behalf of DFID for MOH and GHS.

22. The Director of Stores, Supplies and Drugs Division, in an interview informed us that the Ministry on the average receives US$30 million annually for all its programmes, including provision of transport. Sixty per cent (60%) of this amount is in the form of grants and 40% credits.

23. Until recently MOH had standardized on Nissan, Toyota and Mitsubishi vehicles and Yamaha AG.100 motorcycle in the procurement of new vehicles and motorcycles.
Where donors are not able to supply the standard vehicles due to procurement constraints, other types and models are accepted provided there would be technical training for MOH/GHS maintenance staff and spare parts support for three years. This applies to bulk procurement of non-standardized vehicles. As a result of donor demand, the Ministry has now de-standardized its vehicles, making the market wider and more competitive.

24. According to the Policy, all vehicles to be procured for MOH/GHS shall be new and in current production. The procurement method used for vehicle acquisition shall ensure value for money and selection of the most suitable vehicles for MOH/GHS operations. The following factors shall be considered during the procurement of new vehicles:

- purpose for which the vehicle is required;
- specific operational conditions and requirements;
- existence of a local dealership;
- legal requirements of the country;
- availability of technical consumables and spare parts; and
- previous experience with respect to the vehicles operational performance.

25. The procurement of used vehicles shall not be encouraged. However, if it becomes essential to acquire one, written approval must be sought from the Regional-Director in the case of the regions and the Director-General, in the case of Headquarters. Chart 1 shows how transport resources are obtained, used and disposed of in the Ministry.
Chart 1: Transport resource inflow - outflow in MOH/GHS

Source: Ghana Health Service
Transport inflow

26. The Ministry's Co-operating Partners supply the bulk of vehicles in the Health Sector. The vehicles are distributed to Teaching Hospitals, GHS Headquarters, Regional, District and Sub-District Health Administrations, Regional and District Hospitals and Sub-District Health Centres for their operations.

27. The Ministry of Finance at times procures vehicles for MOH. However, Government of Ghana vehicles are mostly for its political appointees.

28. Corporate bodies like UNILIVER periodically make vehicle donations to MOH/GHS. Certain health programmes also receive vehicles directly from their sponsors and some health facilities use their Internally Generated Fund to acquire vehicles.

Transport outflow

29. MOH and GHS, however, lose vehicles and motorcycles through accidents, theft, disposal auction and transfer of vehicles to other departments.

Allocation and management of transport resources

30. The Headquarters Transport Management Unit, using the national database, presents proposals on allocation/distribution of vehicles to the Director of Health Administration and Support Services for discussion and vetting. The distribution list is then submitted to the Director-General, GHS, for another vetting. The list is finally submitted to the Minister for approval and distribution to health institutions in the country.

31. The Regional Health Administrations do reprioritization before distribution to the health institutions in the regions.

32. The right type/model of vehicles are to be allocated to areas of most need. Priority for allocation of transport resources shall be given to districts and sub-districts. For the period under review, vehicles should be allocated according to the Standard Transport Model. The Model specifies the minimum number of different kind of vehicles each type of health facility should have. However, in March 2003, the Ministry published a new

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3 MOH Transport Policy, revised May 2001, page 3-4.
Transport Policy. This Policy includes a revised standard model, indicating the minimum requirement for different health institutions. However, according to this Policy allocation of vehicles is also going to be guided by the following:

- institutions with a good transport management system in place;
- institutions without vehicles;
- institutions having only an ambulance;
- deprived regions, districts and specialties;
- fleet age (replacement burden);
- current organisational size (number of health facilities, size and population of area);
- activities carried out;
- level and trend of running cost of existing vehicle(s);
- opportunities for vehicle pooling;
- new or prioritised programmes and projects; and
- any other national priorities.

33. To ensure operational efficiency, motorcycles shall be assigned to an individual rider. Such a rider shall be the primary rider. However, other trained riders shall have access to the use of the motorcycle for service delivery. Direct responsibility shall rest with the rider in case of any accident. Bicycles shall primarily be allocated to the sub-districts to support service delivery at the community level.

34. According to the Policy, the Director-General and his deputy, Headquarters Directors, Regional Directors, Medical Directors of Regional Hospitals and Specialized Hospitals shall be allocated duty post vehicles, preferably a saloon car, to facilitate the performance of their official duties.

4 MOH Transport Policy of March 2003.
35. Cross-country vehicles shall not be used as duty-post vehicles. Unit and Programme Heads, who by the nature of their work would need transport, shall be allocated saloon cars or pick-ups. All vehicles (with the exception of duty-post vehicles) shall be allocated to vehicle pools to enhance vehicle availability and operational efficiency. Where a vehicle has been assigned to any individual or programme, other officers and programmes/projects shall have access to it, when not in use.
CHAPTER THREE

FINDINGS

36. The objectives of MOH are to ensure availability and reliability of transport as an essential logistic for delivery of health services, and to do this in the most cost effective and efficient manner through excellence in transport management. However, these objectives have not been fully met.

37. The audit revealed a replacement burden, lack of budget and low transport acquisition, uneven allocation of vehicles, ill equipped workshops, lack of qualified and experienced technical staff to undertake inspection and quality assurance and non-adherence to the planned preventive maintenance of vehicles. The operational management of vehicles is also not efficient. The above factors have given rise to inefficient transport services in MOH and GHS.

Problems of transport services in MOH/GHS
Chart 2 outlines the content of this chapter and shows the relationship between the various aspects of transport services in MOH/GHS.

<table>
<thead>
<tr>
<th>Transport services - needs not met</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Quantity/type of vehicles</td>
</tr>
<tr>
<td>• condition of vehicles</td>
</tr>
<tr>
<td>• distribution of vehicles</td>
</tr>
</tbody>
</table>

Acquisition

38. The Ministry bases its transport needs assessment, projection, procurement planning and fleet management on its Replacement Policy. According to this Policy vehicles should be replaced five years after acquisition, and motorcycles after three years.
Officials interviewed at MOH and GHS regard the Policy as useful for vehicle needs assessment and projection, and for procurement planning and management of a large fleet.

39. The audit shows that the Replacement Policy is not followed by the Ministry, mainly because of lack of financial resources and insufficient supply by donors. Since the replacements are falling behind schedule, the need for new vehicles and motorbikes is increasing year by year. The existing fleet is also getting older and older, which among other things, has consequences for running costs and the use of existing vehicles. Some vehicles are due for replacement, even before they are procured.

40. The Replacement Policy does not represent actual needs. Many of the old vehicles are still functioning well. About two thirds of vehicles between 6 and 10 years are in a good or fair condition. Even for vehicles older than 10 years, one third are still in good/fair condition.

41. There is a large difference between estimated needs and the number of vehicles and motorcycles actually received or procured. The estimated amount to cover replacement needs and for new vehicles is approximately 40 times higher than the expenditure incurred between 1999 and 2001.

42. The rest of this section deals with:
   ☑ Replacement Policy not followed;
   ☑ Many vehicles supposed to be replaced are functioning well; and
   ☑ Inadequate funding.

**Replacement Policy not followed**

43. Acquisition of new vehicles falls far short of the Ministry’s estimated transport needs and the Replacement Policy is, for that reason, not followed. Instead, the estimated needs increase year by year and create an increasing replacement burden. The existing fleet has also become over-aged. This situation has implications for running and maintenance costs of the fleet. It will also affect the relative availability of existing vehicles and put pressure on the few newer vehicles.
44. Table 3 shows that the number of both vehicles and motorcycles needing replacement has been increasing year by year, while the number procured or received has been far below the estimated needs.

Table 3: Vehicles and motorcycles needing replacement between 1998 and 2001

<table>
<thead>
<tr>
<th>Year</th>
<th>Vehicles</th>
<th></th>
<th></th>
<th>Motorcycles</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number needing replacement</td>
<td>Number procured or received</td>
<td>Received in % of needs</td>
<td>Number needing replacement</td>
<td>Number procured or received</td>
<td>Received in % of needs</td>
</tr>
<tr>
<td>1998</td>
<td>526</td>
<td>67</td>
<td>12.7%</td>
<td>198</td>
<td>268</td>
<td>135.4%</td>
</tr>
<tr>
<td>1999</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2000</td>
<td>548</td>
<td>101</td>
<td>18.4%</td>
<td>720</td>
<td>168</td>
<td>23.3%</td>
</tr>
<tr>
<td>2001</td>
<td>576</td>
<td>70</td>
<td>12.2%</td>
<td>930</td>
<td>151</td>
<td>16.2%</td>
</tr>
</tbody>
</table>

N/A = Not Available
Source: MOH Annual Transport Management Reports 1998 to 2001

45. The percentage of vehicles received from 1998 to 2001 ranged between 12.2% and 18.4% of the estimated needs. In 1998, the ministry received many motorcycles, making it possible to increase the fleet over and above the estimated need for replacement. However, after three years these motorcycles reached the age needing replacement – according to the Policy. Since the level of acquisition of motorcycles could not match up with this replacement need, it dropped to the same level as that of vehicles. In 2001, the Ministry received only 16.2% of the estimated needs for motorcycles.

46. Since the need for replacement has not been met, the existing fleet is getting older. The audit disclosed that there were 576 vehicles aged between 6 and 20 years, and 930 motorcycles four years or older at the end of 2001, apparently due for replacement. Table 4 shows the number of vehicles and motorcycle in different age blocks.
Table 4: Number of vehicles and motorcycles in different age blocks 1998 to 2001

<table>
<thead>
<tr>
<th>Vehicles</th>
<th>Age Block</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 – 5 years</td>
<td>259</td>
<td>N/A</td>
<td>329</td>
<td>308</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6 – 9 years</td>
<td>348</td>
<td>N/A</td>
<td>236</td>
<td>242</td>
<td>over aged</td>
</tr>
<tr>
<td></td>
<td>10 years and above</td>
<td>178</td>
<td>N/A</td>
<td>312</td>
<td>334</td>
<td>Fleet</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>785</td>
<td>N/A</td>
<td>877</td>
<td>884</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Motorcycles</th>
<th>Age Block</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 – 3 years</td>
<td>706</td>
<td>N/A</td>
<td>621</td>
<td>467</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 – 5 years</td>
<td>143</td>
<td>N/A</td>
<td>599</td>
<td>546</td>
<td>over aged</td>
</tr>
<tr>
<td></td>
<td>6 years and above</td>
<td>55</td>
<td>N/A</td>
<td>121</td>
<td>384</td>
<td>Fleet</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>904</td>
<td>N/A</td>
<td>1,341</td>
<td>1,397</td>
<td></td>
</tr>
</tbody>
</table>

N/A = Not Available
Source: MOH Annual Transport Management Reports

47. The average fleet age rose from 6.3 years in 1997 to 8 years at the end of 2001. According to MOH Transport Management Reports for 2000 and 2001 the average percentage of vehicles due for replacement rose from 65% in 2000 to 69% in 2001 and for motorcycles from 52% in 2000 to 60.8% in 2001.

48. Some health institutions use their internally generated revenue to buy partly used vehicles. While the Policy requires vehicles to be replaced after five years, some institutions purchased vehicles that were already too old. We found that the Korle-Bu Teaching Hospital bought five over-aged vehicles. Eight other health institutions also expended $1.7 billion from their Internally Generated Fund to acquire second hand vehicles aged between 10 and 15 years. Besides being a violation of the Policy, only $318.9 million or 18.8% of the expenditure was disclosed in the ministry’s financial statements. In addition, the following examples of procured old vehicles were noted during our field visits.
Examples of procured old vehicles

<table>
<thead>
<tr>
<th>Date of purchase</th>
<th>Institution</th>
<th>Type of vehicle</th>
<th>Cost (cedis)</th>
<th>Age at purchase</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/9/2000</td>
<td>Accra Metropolitan Health Administration</td>
<td>Toyota Hiace</td>
<td>47,000,000</td>
<td>10 years</td>
</tr>
<tr>
<td>21/9/2001</td>
<td>Nurses Training College, Pantang</td>
<td>Toyota Hiace</td>
<td>57,000,000</td>
<td>11 years</td>
</tr>
<tr>
<td>12/2001</td>
<td>Nurses Training College, Korle-Bu</td>
<td>VW Taro D/C Pick-up</td>
<td>55,000,000</td>
<td>12 years</td>
</tr>
</tbody>
</table>

Many vehicles supposed to be replaced are functioning well

49. We noted that many of the old vehicles are still functioning well. For the regions and GHS Headquarters, about 2/3 of the vehicles between 6 and 10 years are in good or fair condition. Even for vehicles older than 10 years, one third of them are still in good/fair condition. This means that out of the 555 vehicles in Table 5 that are due for replacement (according to the Policy) 267 vehicles (48%) are in a good or fair condition. In addition, some of the vehicles classified as “serviceable” are most likely to be in fair condition.

Table 5: Age and condition of vehicles in the regions and GHS Headquarters in 2002

<table>
<thead>
<tr>
<th>Age group</th>
<th>Good</th>
<th>Fair</th>
<th>Serviceable</th>
<th>Weak</th>
<th>Unknown</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>216</td>
<td>20</td>
<td>14</td>
<td>6</td>
<td>4</td>
<td>260</td>
</tr>
<tr>
<td>6-9</td>
<td>75</td>
<td>89</td>
<td>21</td>
<td>63</td>
<td>1</td>
<td>249</td>
</tr>
<tr>
<td>10 and above</td>
<td>13</td>
<td>90</td>
<td>34</td>
<td>165</td>
<td>4</td>
<td>306</td>
</tr>
<tr>
<td>Unknown</td>
<td>-</td>
<td>1</td>
<td>4</td>
<td>-</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>304</td>
<td>200</td>
<td>73</td>
<td>234</td>
<td>9</td>
<td>820</td>
</tr>
</tbody>
</table>

Source: Compiled from GHS 2002 fleet inventory. Data is missing for 33 vehicles in MOH Headquarters and 42 vehicles in the two Teaching Hospitals.

Footnote: The above statistics may underestimate the real number of vehicles in weak condition. The classification of the condition of vehicles in the inventory is not consistent. In Ashanti, the classification “Serviceable” is used to refer to both vehicles in fair and weak condition. The condition of 9 vehicles was not also known.

Inadequate funding

50. The main reason why transport replacement is falling far behind schedule is that available resources are not enough. Besides, we also noted that 70 vehicles and 151
motorcycles, which were procured or received in 2001, were actually meant for the 2000 procurement period and activity, indicating delays in the procurement system.

51. Our review of financial statements disclosed three sources of funding transport acquisition in the Ministry: the Donor Pooled Fund, Government of Ghana Support and Internally Generated Fund. From 1999 to 2001 the sum of €4.2 billion was used to procure vehicles, motorcycles and spare parts. Out of this figure, the sum of €3.1 billion or 73.2% came from the Donor Pooled Fund, 19.1% or €795.6 million was from Government, whilst internally generated revenue amounted to €318.9 million or 7.7%.

52. The vehicles provided by Government were procured by Ministry of Finance and were mostly for political appointees. Our review of financial records at MOH Headquarters disclosed that from 1997 to 2001, the Ministry of Health never provided a budget for transport acquisition and replacement. Neither was revenue generated by health institutions and used for procurement of vehicles captured in the Ministry’s budget, contrary to financial regulations\(^5\).

53. This means that the ministry relied almost totally on donor support for acquisition of vehicles and motorcycles. The Head of Transport Management Unit said in an interview that in 2002 donors agreed to supply the Ministry with 300 out of 500 Pick-Ups it had planned for. The ministry needed 353 Pick-Ups but only 218 (62%), were supplied, resulting in an overall shortfall of 135 Pick-Ups (38%). It is clear that donors are unable to meet all of the demand and that there is an over reliance on donor support.

54. The financial records from 1997 to 2001 also showed that there was no Depreciation Reserve Account to cater for the annual depreciation provision on vehicles to ensure their replacement. However, the new Transport Policy of March 2003 requires that Budget Management Committees make a provision for vehicle replacement in their annual budget. This shall be taken as the annual depreciation cost of vehicles and shall be used as a fund to replace older vehicles.

55. The Transport Management Bulletin, Issue 2 of January 2002 disclosed that it would take an average of 180 vehicles (all types) over the next five years to catch up with

\(^5\) Regulation 48 (1) and (2) of L.I. 1234 of 1979.
the pace of replacement. In 2001, it was projected that not less than US$20 million would be needed to meet the demand for both replacement and new vehicles. This is 40 times more than the £4.2 billion spent between 1999 and 2001.6

**Transport allocation**

56. MOH/GHS allocate vehicles to regional directors for onward distribution to districts and other health institutions. It is the Ministry’s policy that the right type of vehicles are acquired and allocated to areas where they are most needed. Priority for allocation of transport resources shall be given to districts and sub-districts. For the period under review, vehicles were to be allocated according to the Standard Transport Model, which specifies the minimum requirement for each type of health facility.7

57. The audit showed that the Transport Model was not used to allocate vehicles as intended in the Policy, and no other clear and generally accepted criteria had been used for the allocation. Furthermore, analysis during the audit indicated that the number of vehicles exceeded the minimum requirement by 22%. There were three times as many People Carriers as stipulated in the Transport Model and at the same time, a shortage of other types of vehicles and motorbikes. However, since approximately one third of the fleet was in a weak condition, there was a shortage of well functioning vehicles; only approximately 85% of the minimum requirement was covered by vehicles in a good or fair condition.

58. Existing vehicles were not evenly distributed; there were big differences in the number and condition of vehicles among the regions and other institutions, compared to the Transport Model. While the number of vehicles in Ashanti Region, GHS Headquarters and the two Teaching Hospitals was only approximately 90% of the minimum requirement, the ratio was twice as high in Northern and Upper West Regions. While 83% of the vehicles in Upper West region were in good or fair condition, Northern Region had only 54%. GHS Headquarters, the two Teaching Hospitals, Brong-Ahafo and Western Regions (and most likely Ashanti Region) have less than the average of 85% of the minimum requirement of vehicles in good or fair condition. This places these institutions at a disadvantage in the performance of their duties. Upper East and Upper West Regions

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6 (US$20 million x £8,600 = £172 billion) / £4.2 billion = 40.95 times more. It should be noted though that this is a comparison in nominal figures, based on the forex bureau rate in July 2003.

7 In March 2003 MOH published a new Transport Policy that, in addition to a revised model for the minimum requirement, specifies criteria for allocation of vehicles (see chapter 2.4.3).
have more serviceable vehicles than the minimum requirement. In the latter case the reason is that one donor, DANIDA, had concentrated its resources in the Upper West Region.

**Number and type of vehicles**

59. The Transport Model indicates the minimum transport resources needed to operate every health institution efficiently. We observed that vehicles were distributed without regard to the Transport Model. The Head of the Transport Management Unit indicated in an interview that the guidelines in the Transport Model were not used in the allocation process because the existing vehicles were fewer than required. Some health programmes also received vehicles directly from their sponsors. This was often not known to Headquarters.

60. According to the Transport Model, the minimum requirement of vehicles should be 735 but the national fleet inventory in 2002 showed a total of 895 vehicles, thus, exceeding the minimum requirement by 22% or 160 vehicles as shown in Table 6.

**Table 6: Existing number of vehicles 2002 compared with the Transport Model**

<table>
<thead>
<tr>
<th></th>
<th>Existing number</th>
<th>Standard number</th>
<th>Existing number as % of standard number</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 Regions</td>
<td>735</td>
<td>571</td>
<td>129%</td>
</tr>
<tr>
<td>HQ Total</td>
<td>118</td>
<td>118</td>
<td>100%</td>
</tr>
<tr>
<td>- MOH</td>
<td>33</td>
<td>26</td>
<td>127%</td>
</tr>
<tr>
<td>- GHS</td>
<td>85</td>
<td>92</td>
<td>92%</td>
</tr>
<tr>
<td>2 Teaching Hospitals</td>
<td>42</td>
<td>46</td>
<td>91%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>895</td>
<td>735</td>
<td>122%</td>
</tr>
</tbody>
</table>

Source: Compiled from GHS 2002 fleet inventory.

61. For motorcycles, the minimum fleet size should have been 2,561 but there were only 1,397 in the system, indicating a shortage of 1,164. In other words, the number of existing motorcycles is short of the minimum requirement, according to the Standard Transport Model, by 45%.
62. We also noted differences in the various types of vehicles. There was an excess of Pick-Ups, Trucks, Buses and especially People Carriers. On the other hand, Ambulances, Saloon cars, Vans and Motorcycles were in short supply, as shown in Table 7.

**Table 7: Different types of vehicles in 2002, compared with the Transport Model in the regions and MOH/GHS Headquarters**

<table>
<thead>
<tr>
<th></th>
<th>Existing number</th>
<th>Standard number</th>
<th>Existing number as % of standard number</th>
</tr>
</thead>
<tbody>
<tr>
<td>People Carrier</td>
<td>143</td>
<td>46</td>
<td>311%</td>
</tr>
<tr>
<td>Pick-Up</td>
<td>507</td>
<td>385</td>
<td>132%</td>
</tr>
<tr>
<td>Truck</td>
<td>45</td>
<td>39</td>
<td>115%</td>
</tr>
<tr>
<td>Bus</td>
<td>68</td>
<td>59</td>
<td>115%</td>
</tr>
<tr>
<td>Ambulance</td>
<td>54</td>
<td>99</td>
<td>55%</td>
</tr>
<tr>
<td>Saloon Car</td>
<td>24</td>
<td>35</td>
<td>69%</td>
</tr>
<tr>
<td>Van</td>
<td>12</td>
<td>14</td>
<td>86%</td>
</tr>
<tr>
<td>Motorcycle</td>
<td>1,397</td>
<td>2,561</td>
<td>55%</td>
</tr>
</tbody>
</table>

Source: Compiled from GHS 202 fleet inventory. Vehicles in the two Teaching Hospitals are not included in the comparison, since data is missing on their 42 vehicles.

**Shortage of good vehicles**

63. Out of 820 vehicles in the regions and GHS Headquarters, 234 (29%) were classified as weak (see Table 5) because of major breakdowns, high average running costs, low availability and high number of days spent at workshops. It is likely that some of the vehicles classified as “serviceable” also would have been classified as weak, had there been a consistent classification in the inventory.

64. Table 8 shows that approximately two thirds of the vehicles, excluding vehicles in Ashanti Region and MOH Headquarters, were in good condition. A combination of review of inventory data and interviews indicated that approximately half of the fleet in the two Teaching Hospitals (22 out of 42) was classified as weak. At the Korle-Bu Teaching Hospital 13 out of 23 vehicles were in weak condition, according to the inventory list for the Hospital. According to the Transport Officer at Komfo Anokye Teaching Hospital, 9 out of 19 vehicles were also weak.
<table>
<thead>
<tr>
<th>Place</th>
<th>Standard number</th>
<th>Total existing vehicles</th>
<th>Existing in % of standard number</th>
<th>Vehicles in good or fair condition</th>
<th>% of existing vehicles in good or fair condition</th>
<th>Good or fair vehicles as % of standard number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashanti</td>
<td>84</td>
<td>73</td>
<td>87%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Brong Ahafo</td>
<td>50</td>
<td>55</td>
<td>110%</td>
<td>41</td>
<td>75%</td>
<td>82%</td>
</tr>
<tr>
<td>Central</td>
<td>59</td>
<td>65</td>
<td>110%</td>
<td>54</td>
<td>83%</td>
<td>92%</td>
</tr>
<tr>
<td>Eastern</td>
<td>67</td>
<td>96</td>
<td>143%</td>
<td>58</td>
<td>60%</td>
<td>87%</td>
</tr>
<tr>
<td>Greater Accra</td>
<td>83</td>
<td>95</td>
<td>114%</td>
<td>75</td>
<td>79%</td>
<td>90%</td>
</tr>
<tr>
<td>Western</td>
<td>56</td>
<td>83</td>
<td>148%</td>
<td>47</td>
<td>57%</td>
<td>84%</td>
</tr>
<tr>
<td>Northern</td>
<td>52</td>
<td>93</td>
<td>179%</td>
<td>50</td>
<td>54%</td>
<td>95%</td>
</tr>
<tr>
<td>Upper East</td>
<td>31</td>
<td>45</td>
<td>145%</td>
<td>33</td>
<td>73%</td>
<td>106%</td>
</tr>
<tr>
<td>Upper West</td>
<td>25</td>
<td>45</td>
<td>180%</td>
<td>35</td>
<td>78%</td>
<td>140%</td>
</tr>
<tr>
<td>Volta</td>
<td>64</td>
<td>85</td>
<td>133%</td>
<td>58</td>
<td>68%</td>
<td>91%</td>
</tr>
<tr>
<td>All Regions(^1)</td>
<td>571</td>
<td>735</td>
<td>129%</td>
<td>451(^2)</td>
<td>68%(^2)</td>
<td>93%(^2)</td>
</tr>
<tr>
<td>MOH Headquart.</td>
<td>26</td>
<td>33</td>
<td>127%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>GHS Headquart.</td>
<td>92</td>
<td>85</td>
<td>92%</td>
<td>62</td>
<td>73%</td>
<td>67%</td>
</tr>
<tr>
<td>2 Teaching Hosp.</td>
<td>46</td>
<td>42</td>
<td>91%</td>
<td>20</td>
<td>48%</td>
<td>43%</td>
</tr>
<tr>
<td>Grand Total(^2)</td>
<td>735</td>
<td>895</td>
<td>122%</td>
<td>533(^2)</td>
<td>68%(^2)</td>
<td>85%(^2)</td>
</tr>
</tbody>
</table>

\(^1\) “Serviceable” vehicles in Western and Upper East Regions have been considered good/fair, since that classification seems to be used instead of “fair” in the inventory. For Ashanti Region and MOH Headquarters, “Serviceable” seems to refer to both weak and fair vehicles, which means that the number of their vehicles in good/fair condition could not be calculated. For classification of the condition “Weak”, see footnote to Table 5.

\(^2\) Sums in the three last columns exclude Ashanti Region and MOH Headquarters, since the number of their vehicles in good/fair condition could not be determined.

Source: Compiled from GHS 2002 Fleet Inventory.

65. The Table shows that only 85% of the minimum requirement, according to the Transport Model, is represented by vehicles in good or fair condition. There is therefore a shortage of well functioning vehicles in the health system.

Uneven distribution of vehicles
66. Neither the Transport Model nor any other clearly defined and generally accepted criteria have been used to allocate vehicles to different regions and institutions. The audit showed that compared to the Transport Model, vehicles were unevenly distributed among the regions and other institutions. There were also big differences in the condition of
vehicles in the regions. Furthermore, there were complaints from some health managers about the distribution.

67. The audit showed that there are differences in the distribution of vehicles in the regions, compared to the Transport Model. While Ashanti Region, the two Teaching Hospitals and GHS Headquarters have only approximately 90% of the minimum requirement, five regions have more than 140%. Northern and Upper West Regions have the highest ratio, exceeding the Transport Model by 79% and 80% respectively. However, only 68% of existing vehicles were in good or fair condition as shown in Table 8.

68. If only vehicles in good or fair condition are considered, GHS Headquarters, the two Teaching Hospitals, Brong-Ahafo and Western Regions (and most likely Ashanti Region) have less than the average of 85% of the minimum requirement. This places these institutions at a disadvantage in the performance of their duties. Upper East and Upper West Regions have more vehicles than the minimum requirement.

69. There were also complaints about the distribution of vehicles from some health managers. MOH Annual Transport Report for 2000 disclosed that newer and stronger vehicles were concentrated at the Regional Offices and Headquarters, while transport in deprived rural communities was inadequate to support service delivery. The Northern Regional Director of Health Services, complained about the discretionary nature of allocation of vehicles in the Ministry. He indicated that the size of an administrative area and the topography or nature of the terrain were not taken into account in the distribution of vehicles. This view was echoed in the 2000 Annual Transport Report of the Upper West Region. Some districts also complained about wrong vehicles being sent to them. For instance, it was claimed that Nissan Pick-Ups and Mitsubishi Pajeros are not suitable for the Upper West and Northern Regions.

Fleet maintenance

70. The audit showed that the Planned Preventive Maintenance (PPM) Scheme is not carried out as intended. MOH workshops are far away from health facilities, the quality of work done by the workshops is low and there is a lack of spare parts and an insufficient maintenance budget. MOH/GHS have not paid proper attention to the workshops. Problems identified in a specialist report in 1998 still remain unresolved. The workshops
are not properly equipped, staffed and managed. In most of the regions visited, health facilities choose to use third party garages instead of the workshops, leading to under utilization of the resources at the workshops. Further, the Spare Parts Revolving Fund is not functioning as expected, due to high prices and reluctance to enforce payment.

**Planned Preventive Maintenance**

71. The Ministry has developed a scheme whereby its vehicles are to be regularly serviced and repaired at periodic intervals at its regional mechanical workshops. The objective is to ensure that the vehicles are available for health care delivery. This scheme is referred to as Planned Preventive Maintenance (PPM).

72. The PPM is a proactive system that requires regular inspection and maintenance of vehicles and ensures timely replacement of parts. Under unplanned maintenance\(^7\), however, components are not replaced until they are totally worn out (fail). Failure to invest in the PPM system could lead to greater costs later in the life of the vehicle. The PPM is expected to increase availability, reduce costs and ensure a predictable expenditure pattern.

73. Our visits to the Regional Health Administrations and their workshops at Ho, Wa, Tamale, Kumasi, Tema, Accra, Korle-Bu and Komfo Anokye Teaching Hospitals revealed that with the exception of Wa in the Upper West Region, the other regions did not implement the PPM as they should. The non-adherence to the PPM is attributable to the following:

- location of the workshops from health facilities;
- low quality of work done at the workshops; and
- lack of spare parts and insufficient maintenance budget;

---

\(^7\) Unplanned maintenance was not covered during the audit
Location of workshops

74. Most health facilities in the districts and sub-districts are remotely located from their regional capitals where the mechanical workshops are situated. Health facilities at the district and sub-district levels, which have few vehicles, find it difficult therefore to carry out the PPM, as the demand for their vehicles is high. The release of these vehicles to undergo PPM at the regional mechanical workshops therefore poses a challenge and is difficult to comply with.

75. This results in non-adherence to the PPM Scheme and lack of patronage of the regional mechanical workshops by the health facilities at the lower levels.

Poor quality of work done

76. Interviews with users of the workshops revealed that the quality of work done at the ministry’s workshops is poor. Inferior spare parts are said to be used in refixing non-functioning parts on vehicles brought for minor repairs and servicing. Mechanics recruited to the workshops are not provided with continuous training after their employment. In fact, they do not receive any training at all. The personnel at the workshops cannot be said therefore to have the requisite competence to handle the ever-changing technology in modern vehicle repairs and servicing.

77. These factors discourage patronage of the workshops by the health facilities in carrying out their PPM, compelling them to do the PPM at local filling stations instead. By so doing, the other aspects of the PPM (inspection, regular checking for faulty parts and minor repairs undertaken at MOH workshops) are ignored.

Lack of spare parts and insufficient maintenance budget

78. Availability of fast moving vehicle parts such as oil filters, fan belts and timing belts is a prerequisite for effective implementation of the PPM Scheme. To implement the PPM effectively spare parts and lubricants must be available in sufficient quantities to meet the demand for them.

79. However, the five regional mechanical workshops visited during the audit had very low stock levels of these vital vehicle parts needed for effective PPM. Minor parts and lubricants necessary for carrying out the scheme were not planned and budgeted for and so
they were not always available. Budgetary provisions for undertaking the PPM have also often been insufficient. Interviews with users and operators of vehicles revealed that maintenance schedules for some vehicles are postponed due to lack of funds. Instead, faulty parts in some vehicles are allowed to totally break down and only replaced upon availability of funds.

80. One cause of the problems is that MOH/GHS have paid little attention to the operations of the workshops, thus impeding effective implementation of the PPM. (See section 3.3.2). However, the rising costs of inputs pose constraints for MOH/GHS in their implementation of the scheme.

81. The Head of the Transport Management Unit indicated that a comprehensive maintenance proposal is being drafted to re-develop the maintenance system. He said that if the PPM scheme is facing any challenges, there is no other option but to rectify the problems and improve upon, since abandoning the PPM will lead to the eventual collapse of the entire Transport Management System.

Mechanical workshops

82. Facilities at MOH workshops are to be used for routine servicing and simple repairs only. The Ministry has established mechanical workshops in all the regional capitals except Kumasi. The Tema Mechanical Workshop is the biggest with a Fleet Engineer as the head. The workshops are to be equipped with basic tools, personnel and materials such as spare parts that will enable them perform their functions. Complex repairs are to be carried out at accredited private workshops. Standard MOH/GHS contracts are executed with accredited workshops. Monitoring and evaluation of work done in the private workshops are to be carried out by MOH technicians.

83. In 1998, a study sponsored by DFID for the Ministry, was carried out on the Re-Establishment of the Central Mechanical Workshop by a Vehicle Fleet Management Specialist from U.K. The report has since not been fully implemented by MOH/GHS.
84. During the audit, we inspected the Central Mechanical Workshop at Tema. The inspection showed that many of the problems raised in the Specialist report still existed.

- The Workshop is still not equipped to properly perform its role of undertaking PPM and minor repairs of a fleet in excess of 310 vehicles and 70 motorcycles. The regional workshops we visited also lacked basic tools for their work.
- The appraisal of the staff members by the Specialist disclosed absence of training for staff, particularly in the basic principles of automotive engineering. This problem is still outstanding and no training needs assessment has yet been conducted.
- The Specialist recommended restructuring the labour force of the Workshop and estimated the optimum labour force to be between 11 and 13. During our inspection of the Workshop in May 2003, the labour force was still 25.
- The Specialist observed lack of sound technical management at shop floor level (little or no technical direction) when the Fleet Engineer is absent. This problem still remains.
- The Specialist observed lack of qualified and experienced technical staff to undertake PPM inspection and quality assurance. This problem has not yet been resolved.

85. The Head of the Transport Management Unit indicated that these aspects of the specialist’s report have not been implemented:

- Training was conducted for all mechanics at the Central Mechanical Workshops on new workshop procedures in 2002.
- A new title “Fleet Engineer” to reflect the job purpose of the Mechanic Engineer was adopted.
- Transfer of staff was carried out to distribute skills and ensure equity.
- A revolving fund was established which has helped sustain the operations of the workshop since 1999.
An appreciable level of tooling and equipping has been provided since the submission of the report.

Renovation has been carried out at the workshop. However, the major outstanding issue has been the physical re-designing of the shop floor, which entails an appreciable level of capital outlay, which is yet to be sourced.

86. Out of the five workshops visited during the audit, it was only the workshop in Wa that was busy. The reason is that there are no good private workshops in Wa, so other Ministries use the MOH workshop in Wa. The other workshops did not have much to do. Most health institutions patronised third party workshops not only for major repairs, but for the PPM as well. It was observed that the intended vehicle inspection and exercise of quality assurance on third party work were not done at the MOH workshops. Also, vehicle repairs at third party garages were mostly not examined or diagnosed by the workshops before award of contracts.

Spare Parts Revolving Fund

87. In 1998, the Ministry established a Spare Parts Revolving Fund (SPRF) with a seed money of €20 million for vehicles to be centrally managed at the Workshop at Tema. Parts are stockpiled for servicing of vehicles. The value of parts in stock as of 28 February 2003 stood at €231.8 million. The regions purchased their parts from the Workshop at Tema.

88. The Ministry, with the assistance of DfID, procured Yamaha AG.100 motorbike parts amounting to US $189,000 for distribution to the regions. The parts were to be sold to the districts. The proceeds so accrued were to be kept in the Transport Account as seed capital for the operation of the Fund. The Regional Directors were to ensure that all essential parts were replaced regularly to ensure “zero break down” of the bikes. The parts were quoted in US Dollars and Directors were to convert them to Cedis at the prevailing exchange rate in order to withstand any depreciation of the Cedi, which might lead to decapitalisation of the SPRF.
89. The SPRF has not functioned as expected, due to the high pricing of the items in Dollars and reluctance on the part of the Directors to enforce payment for supplies and services.

90. Health facilities were not able and willing to pay for parts allocated to them. The facilities preferred buying from the local markets since they claimed that the Ministry’s parts were more expensive. A top bearing which sold at €7,000 in the local market at Wa, was for example, priced at €45,000 at the Ministry’s workshop. It was also claimed that some of the parts were of low quality since they were acquired from sources other than the manufacturers.

91. The Regional Directors did not enforce payment by health institutions. Our review of SPRF records revealed an indebtedness of €471.2 million in respect of non-payment by health institutions for services rendered and parts supplied to them. Table 9 shows amounts owed by health institutions to the Central Mechanical Workshop, Tema, Wa and the other Regional Health Administrations where we conducted our audit. Details are annexed to this report as Appendix D.

**Table 9: Non payment by health institutions for parts supplied and services provided**

<table>
<thead>
<tr>
<th>To whom payable</th>
<th>Amount €</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Mechanical Workshop, Tema</td>
<td>256,825,953</td>
<td>18 February 2003</td>
</tr>
<tr>
<td>Technology Workshop, Wa</td>
<td>150,230,911</td>
<td>August 2002</td>
</tr>
<tr>
<td>Northern Reg. Health Admin.</td>
<td>52,669,000</td>
<td>August 2002</td>
</tr>
<tr>
<td>Ashanti Reg. Health Admin.</td>
<td>11,443,970</td>
<td>August 2002</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>471,169,834</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source: Review of SPRF records by team during audit provided by client

92. Non-payment for supplies affected the operation of the Fund. The absence of essential spare parts did not enable MOH and GHS to undertake the PPM and minor repairs to enhance their transport operations.
Transport management

93. Regarding transport operation, the audit revealed differences between the situation on the ground and the regulations in the Transport Management Handbook; there was non-compliance with operational procedures; inadequate reporting on fleet performance; irregular monitoring; and a lack of training of transport staff. Furthermore, MOH/GHS did not manage accident cases well, were not able to prevent substantial theft of motorbikes and did not manage auction/disposal of vehicles efficiently.

Transport operation

94. The operational management and use of vehicles are regulated by the Transport Policy of the Ministry. The Transport Management Handbook provides details of the management structure, operational procedures, authorisation, documentation, planning and scheduling as well as control measures. According to the Handbook, health managers and transport officers at the facility levels should ensure that:

- vehicle use is planned, controlled and solely used for health activities;
- administrative procedures governing vehicle use are followed;
- fleet performance is measured and monitored; and
- stakeholders involved in transport are trained annually.

95. The audit revealed differences between the situation on the ground and the regulations in the Handbook. Staff who are supposed to use the Handbook, do not have a thorough knowledge of the administrative procedures and requirements for documentation of data. Operational procedures governing the use of vehicles were not complied with and data on the performance and effective use of transport were not properly recorded (poor record keeping, lack of authorisation and documentation and inadequate reporting on fleet performance). The policy on pooling of vehicles was not followed. Furthermore, monitoring and feedback were not functioning as intended and there was a lack of training of transport staff.

Record keeping

96. According to the Transport Management Handbook, a file should be opened for each vehicle. The file should contain the vehicle registration documents, maintenance records and any other correspondence relating to that vehicle.
97. During the audit files at 19 health institutions/districts were examined. None of these had maintenance records nor any official correspondence relating to their vehicles on the files. Interviews and reviews conducted confirmed that the files did not contain the relevant data on the history of activities on the vehicles. This lapse did not leave any audit trail or records on the activities and expenditures made on each vehicle. For example, it was not possible to get cost analysis for vehicles of the various age groups in the system. Health managers complained about the high expenditure incurred in the running and maintenance of old vehicles and yet these complaints could not be verified due to the absence of such records.

98. Vehicle log books were found not to be completed in full. Full details of journeys undertaken and their purpose were not recorded as required. Typical examples were entries such as “local running” and “to town and back”. In addition, most of the officers who used the vehicles failed to authenticate the trips undertaken by not signing the log sheet. Interviews showed that some users do not attach much significance to the vehicle log books. This behaviour is more pronounced where the drivers are illiterate, such as in the Northern Region where 80% to 90% of drivers can neither read nor write. This omission led to improper completion of log books, poor data recording, and lack of information on vehicle use.

99. Furthermore, the forms for reporting the use of vehicles did not allow for full disclosure of information about transport operating costs. The emphasis was only on fuel and maintenance/repair costs. The cost of lubricants, tyres and batteries, for instance, were not included in the calculations. Transport planning and budgeting were adversely affected by this omission.

Authorisation and documentation

100. There are administrative procedures regarding authorisation and documentation to control the use of vehicles. Accordingly, users should fill in vehicle request forms. Fuel coupon control forms should also be used to control fuel usage and journeys undertaken should be recorded in the vehicle log book.

101. We observed that vehicle request forms were not regularly used while fuel coupon control forms were not used at any of the places we visited with the exception of the
Ashanti Regional office. In the Upper West, the Transport officers were not even involved in the issue of fuel to vehicles let alone reconciliation of fuel accounts. Besides health managers at four of the regions visited did not have knowledge about the fuel coupon control form (Form 8). These conditions could result in misuse of resources.

102. We also noted that apart from Programme vehicles, none of MOH vehicles had Road Worthiness Certificates, as required by the Policy. In addition, most of the vehicles did not have basic tools, seat belts or fire extinguishers to ensure the safety of users as required by the Transport Policy.

**Fleet performance measurement and information management**

103. The operational management system ensures the measurement of key performance indicators such as kilometres travelled, percentage utilisation and availability and kilometres per litres. Our audit revealed that about 60% of the vehicles in the five regions visited did not have working odometers, consequently the measurement of key performance indicators such as kilometres travelled was estimated instead of measured, leading to poor data recording, which ultimately affects the quality of decision-making.

104. Vehicle reporting forms which are to be completed by all Transport Officers form the basis for the compilation of national statistics on the operations of the vehicles. Our review disclosed that some institutions failed to submit returns, whilst others submitted theirs irregularly. The two Teaching Hospitals have consistently failed to file their returns over the years, whilst Brong Ahafo and Upper East Regions did not submit any reports in 2001. With the exception of Greater Accra Region, every other region failed to report correctly. The regional variation was between 5% and 37% in 2001. All the five Regional Transport Officers interviewed expressed concern about the irregular, late or non-submission of returns by the district health administrations, which affects the timeliness and completeness of information needed at Headquarters. The situation is the same for motorcycles.

**Transport pooling**

105. Transport pooling entails putting all means of transport under one authority, so that they can be made available for everyone for planned activities. According to the Ministry’s policy, transport must be pooled in all health institutions.
106. The policy on transport pooling was, however, not being observed at the Headquarters. We noted that Programme Vehicles were mostly under the control and management of Programme managers, who also controlled the budget for the running and maintenance of such vehicles, and for which reasons the managers were unwilling to put them in the pool.

107. This situation creates parallel ownership of the vehicles in the Ministry; resulting in difficulties in the allocation, use and maintenance of the vehicles. For example, programme names are still written on some programme vehicles in violation of the Ministry's pooling policy.

**Monitoring and feedback**

108. As part of the reporting procedure, Transport Officers are required to complete and submit returns to the next higher level within a specified time. For example, Transport Officers at the facilities/institutions are to submit returns to the District Transport Officer, who in turn submits them to the Regional Transport Officer for submission to the Head of the Transport Management Unit at Headquarters. The audit noted that whilst MOH Headquarters provided feedback to the Regional Transport Officers, the latter did not provide any feedback to the districts and institutions on the performance of their fleet. The Transport Officers at the districts and institutions also failed to provide feedback to the drivers of vehicles. Interviews with Regional Transport Officers disclosed that Transport Officers at the district and sub-district levels were not only untrained but did not stay for long due to transfers, resignation, vacation of posts, etc. This situation made it difficult for them to properly complete the vehicle returns.

109. Regular monitoring will enhance effective and efficient transport operations. The Transport Policy provides a framework for monitoring, evaluation and feedback within the transport management system. The Transport Management Unit at Headquarters is to conduct monitoring visits to the regions whilst the Regional Transport Officers are to monitor the activities at the district and sub-district levels. We observed that Headquarters and the Regions could not adequately perform their monitoring roles. The Transport Officers in an interview complained about lack of funds to enable them undertake the monitoring tasks. The 2001 Transport Management Report disclosed that the National Office conducted one monitoring and evaluation visit that year to selected districts and
institutions in the 10 regions and that Regional Office monitoring to the districts was low, a situation attributed to lack of funds. The Regions used joint monitoring teams with integrated checklist encompassing all programmes. Though this joint monitoring helps to reduce the cost of monitoring, it may sacrifice details. Effective technical monitoring is critical to ensuring effectiveness and efficiency of the transport system.

Training of Transport Officers, Drivers and Mechanics
110. According to the Transport Policy, adequate capacity should be built for all key stakeholders involved in transport. The main stakeholders are managers, transport officers, drivers and mechanics. People management involves training (both technical and managerial) as well as budgeting and planning.

111. We noted the absence of regular capacity building or training for transport officers, mechanics and drivers. Our interviews with five Regional Transport Officers showed that lack of senior management’s commitment and understanding of transport management issues contributed to this state of affairs. In other words, health managers consider transport issues as auxiliary and are therefore unwilling to commit funds for refresher or training courses.

112. The Head of the Transport Management Unit was of the view that regular training programmes should be organised by the Regional Health Directorates with support from Headquarters.

Accident prevention
113. Accidents involving health vehicles sometimes result in the death or injury of health personnel and others and destruction of vehicles, thereby depleting the stock of vehicles. We noted that 100 vehicles and 25 motorcycles were involved in traffic accidents from 1998 to 2001, which resulted in 87 injuries and 19 deaths. Eight accident vehicles were written off during that period, since they were beyond economic repair. We noted that non-professional drivers drove three of the vehicles that were involved in accidents in 1998. Table 10 shows the number of accidents, injuries and deaths during the period.
Table 10: Number of traffic accidents from 1998 to 2001

<table>
<thead>
<tr>
<th>Year</th>
<th>Vehicles</th>
<th>Motorcycles</th>
<th>Injuries</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>23</td>
<td>3</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>1999</td>
<td>24</td>
<td>8</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2000</td>
<td>24</td>
<td>8</td>
<td>45</td>
<td>7</td>
</tr>
<tr>
<td>2001</td>
<td>29</td>
<td>6</td>
<td>36</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>25</td>
<td>87</td>
<td>19</td>
</tr>
<tr>
<td>Average</td>
<td>25</td>
<td>6</td>
<td>29</td>
<td>6.3</td>
</tr>
</tbody>
</table>

N/A = Not Available.
Source: MOH Annual Transport Management Reports.

114. There is a policy for reporting on all accidents involving health vehicles. According to the transport policy, all accidents must be reported to the police and investigated for causes of the accidents to be determined. The Regional Transport Officer of the MOH/GHS is informed and within a week Headquarters is also informed on the nature of accident, on whom liability/culpability is placed. The Attorney-General and Ministry of Finance are also informed where insurance claims are made on the State. Where causes of the accidents are traceable to drivers’ carelessness or recklessness, they are to be sanctioned according to regulations.

115. We noted on the contrary that accident cases were not well managed by MOH and GHS. Accident cases reported to the police were not followed up to conclusion to determine the cause, parties involved, liability and remedial action to forestall future accidents. The following instances of unresolved accident cases were observed in four regions:

**Outstanding accident cases from 1996 to 2001**

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of outstanding accident cases</th>
<th>Period Outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashanti Regional Health Administration</td>
<td>23</td>
<td>2 – 7 years</td>
</tr>
<tr>
<td>Upper West Regional Health Administration</td>
<td>10</td>
<td>3 – 5 years</td>
</tr>
<tr>
<td>District Health Administration, Ho</td>
<td>1</td>
<td>Up to 3 years</td>
</tr>
<tr>
<td>Regional Hospital, Ho</td>
<td>1</td>
<td>Up to 2 years</td>
</tr>
<tr>
<td>Korle Bu Teaching Hospital</td>
<td>3</td>
<td>2 – 5 years</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>38</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source: Compiled by team during audit from records provided by client
116. The cost of replacing vehicles destroyed, repairs, downtime and payments for medical treatment is a problem for the Ministry. Specialists also have to be paid for services not rendered as a result of such accidents.

117. Management explained that it is frustrated in its attempts to have accident cases resolved early, as it requires the cooperation of the Police, Attorney-General’s Department and the Judiciary. The Head of the Transport Management Unit proposed the creation of a legal Unit in MOH/GHS to address such legal issues.

Stealing of motorcycles

118. Motorbikes are purchased to enable health workers in the rural areas get to the hinterlands to provide health service to the people. We noted that from 1998 to 2001, 177 motorcycles belonging to the Ministry were stolen, out of which only nine were retrieved. Thus, 168 motorcycles costing US$453,600 or £3.3 billion were lost during the period, as shown in Table 11. The Ministry’s own Transport Management Reports for 2000 and 2001 disclosed that the stealing of motorcycles has been rising and the number increased from seven bikes in 1998 to 74 bikes in 2000. The retrieval rate for 2000 was 6.8% and 6.9% for 2001. In effect, if 100 bikes are stolen only about seven may be retrieved.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number stolen</th>
<th>Number retrieved</th>
<th>Net loss</th>
<th>Cost US Dollar</th>
<th>Cedis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>7</td>
<td>-</td>
<td>7</td>
<td>18,900</td>
<td>132,300,000</td>
</tr>
<tr>
<td>1999</td>
<td>38</td>
<td>-</td>
<td>38</td>
<td>102,600</td>
<td>718,200,000</td>
</tr>
<tr>
<td>2000</td>
<td>74</td>
<td>5</td>
<td>69</td>
<td>186,300</td>
<td>1,341,360,000</td>
</tr>
<tr>
<td>2001</td>
<td>58</td>
<td>4</td>
<td>54</td>
<td>145,800</td>
<td>1,095,500,000</td>
</tr>
<tr>
<td>Total</td>
<td>177</td>
<td>9</td>
<td>168</td>
<td>453,600</td>
<td>3,285,360,000</td>
</tr>
</tbody>
</table>

Source: Annual Transport Management Reports.

119. A newspaper report indicated that the theft of motorbikes has continued to be a serious problem in 2002. More than 14 Yamaha motorbikes belonging to the Ministry of Health in the Northern Region were stolen from the personnel in 2002.

120. We were informed that the modes of theft are as follows:

- motorcycles are taken away from riders at gun point;

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8 Page 5 of the Mirror No.2514 of Saturday, February 6, 2003.
motorcycles are ridden away when found unlocked;

- motorcycles are bundled into waiting vehicles and driven away; and
- riders colluding with others.

121. A particular motorcycle, Yamaha AG 100 attracts thieves. We were also informed that the stolen bikes were transported across the borders to Burkina Faso and Northern Togo. Others were sold in parts to private riders and some dismantled for Yamaha Outboard Motors for marine use:

122. The regions in Table 12 have been the worst affected areas over the years.

Table 12: Regions worst affected by theft of motorcycles

<table>
<thead>
<tr>
<th>Region</th>
<th>Number stolen</th>
<th>Number retrieved</th>
<th>Net loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern</td>
<td>28</td>
<td>2</td>
<td>26</td>
</tr>
<tr>
<td>Eastern</td>
<td>24</td>
<td>-</td>
<td>24</td>
</tr>
<tr>
<td>Greater Accra</td>
<td>24</td>
<td>1</td>
<td>23</td>
</tr>
<tr>
<td>Ashanti</td>
<td>25</td>
<td>3</td>
<td>22</td>
</tr>
<tr>
<td>Brong Ahafo</td>
<td>19</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>Central</td>
<td>17</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>137</td>
<td>9</td>
<td>128</td>
</tr>
</tbody>
</table>

Source: Compiled during audit from data by client

123. MOH and GHS are aware that some of the thefts are caused by some health workers through carelessness and/or collusion with the thieves. MOH and GHS have reported these thefts to the police and other security agencies. In certain cases arrests and prosecutions have been made. It was claimed that some riders did not exercise due care in the use of the motorcycles. These concerns, however, have been expressed in every annual report since 1998, but no action has been made to address these concerns and the problems still persist.

124. The stealing of motorcycles is not only a threat to life and property but is seriously affecting health delivery as the personnel are unable to reach the people in the remote areas. For fear of their lives, resulting from the stealing of motorbikes and also rough terrain, some women health workers in the Ashanti Region are no longer using motorbikes for their fieldwork.
Disposal/auction

125. Our discussions and review of disposal procedures and records revealed that in view of the replacement burden confronting the Ministry, vehicles which were auctioned in 1995/96 were not replaced. In addition, the disposal system was not well managed and is fraught with irregularities. Our interviews with auctioneers and officials of the Ministry brought to light the problem of political and official interference, leading to abuse in the disposal/auction of vehicles, long delays and/or non-accountability of auction monies.

126. According to financial regulations all monies collected by Government Departments shall be paid promptly into the Consolidated Fund. The Controller and Accountant-General may then authorise disbursement from the Fund upon proper application by the spending officer.

127. We noted that health institutions in violation of the financial regulations used auction monies on other activities. Our review at GHS Headquarters revealed that between 1998 and 28 February 2002 there was no evidence that auction proceeds of ₺102.3 million were paid into the Consolidated Fund. Auction proceeds realised in Greater Accra, Brong-Ahafo, Central, Eastern and Upper East Regions were not available. Appendix E provides details. The visits to Ashanti and Northern Regional Health Administrations showed that they are yet to pay into the Consolidated Fund the sum of ₺124.6 million in respect of auctions conducted between 1995 and 2002. Details are shown in Table 13.

Table 13: Amounts owing to the Consolidated Fund

<table>
<thead>
<tr>
<th>Office</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashanti Regional Health Administration</td>
<td>34,502,790</td>
</tr>
<tr>
<td>Northern Regional Health Administration</td>
<td>90,090,000</td>
</tr>
<tr>
<td>Total</td>
<td>124,592,790</td>
</tr>
</tbody>
</table>

Source: Accounting recorded Ashanti and Northern Regional Offices

128. We noted that due to the lukewarm attitude on the part of management to ensure timely accountability of auction sales, two auctioneers are owing the sum of ₺37.9 million in respect of auction sales they conducted in Tamale in 1997 and March 2002 as detailed in Table 14.

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10 File No.MOH/TFMUGF.GF.9Vol.1.
Table 14: Outstanding amount from auction of vehicles, cedis

<table>
<thead>
<tr>
<th>Date of auction</th>
<th>Name of auctioneers</th>
<th>Items auctioned</th>
<th>Net amount&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Amount paid</th>
<th>Outstanding amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>Mr. Issah Alhassan,</td>
<td>10 vehicles</td>
<td>12,040,000</td>
<td>5,000,000</td>
<td>7,040,000</td>
</tr>
<tr>
<td></td>
<td>Tamale</td>
<td>92 motorcycles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>March 2002</td>
<td>Mali-Bi-Vilura,</td>
<td>21 vehicles</td>
<td>115,952,000</td>
<td>85,090,000</td>
<td>30,862,000</td>
</tr>
<tr>
<td></td>
<td>Tamale</td>
<td>24 motorcycles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>10 generators</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>127,992,000</strong></td>
<td><strong>90,090,000</strong></td>
<td><strong>37,902,000</strong></td>
</tr>
</tbody>
</table>

Source: "Net amount was arrived at after deducting the auctioneers’ 7% commission and other charges from the gross amount.

129. We observed in all the five regions where we conducted our audit that some vehicles have been parked and left at the mercy of the weather for periods of up to eight years awaiting disposal action. Delay in disposal results in further deterioration and also reduces the realisable value of the vehicles and parts in the long run. Table 15 shows the number of vehicles that had been grounded in the places we visited for periods up to eight years, without disposal action.

Table 15: Unserviceable vehicles requiring disposal action

<table>
<thead>
<tr>
<th>Workshop</th>
<th>Number grounded</th>
<th>Number listed for disposal</th>
<th>Period grounded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volta Region, Ho</td>
<td>10</td>
<td>8</td>
<td>1 – 8 years</td>
</tr>
<tr>
<td>Upper West Region, Wa</td>
<td>4</td>
<td>4</td>
<td>Up to 1 year</td>
</tr>
<tr>
<td>Northern Region, Tamale</td>
<td>3</td>
<td>-</td>
<td>1 – 6 years</td>
</tr>
<tr>
<td>Ashanti Region, Kumasi</td>
<td>11</td>
<td>11</td>
<td>1 – 8 years</td>
</tr>
<tr>
<td>Korle-Bu Teaching Hospital</td>
<td>7</td>
<td>7</td>
<td>1 – 8 years and above</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>35</strong></td>
<td><strong>30</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source: Compiled during audit

130. The inclusion of these unserviceable vehicles in the inventory creates the impression that those centres have more vehicles than they actually have.

131. Our review of records also disclosed that quantities of new vehicle parts for Bedford (7 tonner), Mitsubishi Fuso Truck and Kawasaki Motorcycles became obsolete when MOH standardized on Toyota, Nissan and Mitsubishi vehicles. These parts remained in stock for more than 20 years at the Central Mechanical Workshop, Tema, without being disposed of until July 2001 when they were auctioned.
CHAPTER FOUR
SUMMARY OF CONCLUSIONS

132. The objectives of the Ministry of Health to ensure availability and reliability of transport in the most cost effective and efficient manner have not been fully met. Transport acquisition does not meet estimated needs and the Replacement Policy is not followed. On the whole, there are more vehicles than the minimum requirement, but there is a shortage of well-functioning vehicles. There is also a shortage of some vehicles by type (e.g. ambulances), whilst others are in excess (e.g. People Carriers). The policy on allocation of vehicles has not been followed, and vehicles are unevenly distributed among health institutions. Planned Preventive Maintenance (PPM) Scheme is not carried out as intended. The Ministry’s workshops are not properly equipped, staffed, managed and fully patronised. Transport management is also not efficient.

133. Our conclusions are that:

❖ The Replacement Policy is unrealistic and inappropriate, which means that the planning process for vehicle replacement is equally ineffective.

❖ In the absence of a budget for vehicles, the Ministry cannot even meet its most important transport needs, independent of donors. Should donor fatigue arise, transport services would suffer greatly and this would affect health care delivery in the country.

❖ If the Transport Model is relevant, the big differences among regions and other institutions imply that the allocation of vehicles is not efficient.

❖ The PPM Scheme is not working as it should and there is the need to resuscitate or abandon it.

❖ The present system makes it difficult to manage transport acquisition and disposal efficiently.

134. In spite of the issues raised in this report, MOH and GHS have good transport systems and procedures in place which can even be replicated by other Ministries and Agencies. What is required is effective and efficient implementation of those systems and procedures to enhance the Ministry’s transport operation, which this report seeks to achieve.

Report of the Auditor-General on Transport operation in the Ministry of Health
Acquisition of transport

135. The audit shows that the Replacement Policy is not followed by the Ministry, mainly because of lack of resources and an over reliance on donors who cannot meet all demands. Since replacement is always behind schedule, the need for new vehicles and motorcycles increases year by year. The existing fleet is also getting older, which among other things, has consequences for running costs and the use of existing vehicles. There is a large difference between estimated needs and the number of vehicles and motorcycles actually received or procured.

136. Moreover, the Replacement Policy is both unrealistic and inappropriate. This also means that the planning process for transport replacement, which is based on the Replacement Policy, is unrealistic and ineffective. Some vehicles are already due for replacement even before they are procured. The estimated amount to cover replacement needs and new vehicles is approximately 40 times higher than the expenditure between 1999 and 2001. Further, the Policy does not represent actual needs, since it does not consider the condition of the vehicles. Many of the "old" vehicles are still functioning well. About two thirds of vehicles between 6 and 10 years are in a good or fair condition. Even for vehicles older than 10 years, one third are still in good/fair condition.

137. We observed that in 2001, 37.8% (334 vehicles) of the fleet of 884 vehicles were aged between 10 and 20 years. The use of such "old" vehicles in health care delivery has implications on high running and maintenance costs, frequent break down, difficulties in getting spare parts, pollution and health hazards.

138. We found that MOH never provided a budget for transport acquisition. The Ministry relied totally and inappropriately on donor support for the purpose. Non-provision of budget leaves gaps in procured transport resources urgently needed for service delivery. The Ministry thus loses its ability to prioritise vehicular needs; a decision solely in the hands of donors. For example, whilst the Ministry requires a minimum of 99 Ambulances, only 54 have been acquired. At the same time, there is an excess of other types of vehicles. Similarly, out of a minimum number of 2,561 motorcycles required for effective service delivery, the Ministry had a shortfall of 45.5%. Should donor fatigue arise, transport services would suffer greatly and this would affect health care delivery in the country.
Transport allocation

139. The Transport Model, MOH and GHS require a minimum of 735 vehicles for their operations. The fleet inventory in 2002 showed a fleet of 895 vehicles; an apparent excess of 160 vehicles (22%) above the Model. We noted, however, that only approximately two thirds of the fleet is in good condition. Compared with the Model, this indicates a shortfall of 15% (110) well-functioning vehicles.

140. There are three times as many People Carriers as stipulated in the Transport Model and at the same time a shortage of other types of vehicles (Ambulances, Saloon Cars and Vans) and motorcycles. It has not been possible to establish the cause for this discrepancy in the study. There are three possible explanations:

- The Transport Model is not fully relevant;
- The Ministry does not use the Transport Model in estimating transport needs for presentation to donors; or
- The Ministry has not been able to enforce its priorities in relation to donors.

141. The audit also shows that the Transport Model has not been used to allocate vehicles as intended by the Policy, and no other clear and generally accepted criteria have been used for the allocation. There are significant differences in the number of vehicles and their condition between regions and other institutions. Compared to the Transport Model, existing vehicles are not evenly distributed.

142. According to the Ministry, the reason why the Transport Model has not been used for allocation of vehicles is that there are not enough vehicles to meet the needs. It is not likely that it is appropriate to strictly follow a Model like the Transport Model; it can probably only be used as a guide or service reference. However, if the Transport Model has any relevance, it is difficult to understand the big differences between the Model and the reality on the ground regarding type of vehicles, distribution of vehicles between regions and distribution of vehicles in good or fair condition. It also implies that the transport allocation is not efficient.
Fleet maintenance

143. The PPM Scheme is not carried out as intended. Many health facilities do not implement the Scheme at the Ministry's workshops as planned, causing under-utilisation of resources at the workshops. The difficulties in implementing the PPM are attributable to location of workshops from health facilities, low quality of work done at the workshops, lack of spare parts and insufficient maintenance budget.

144. The workshops have insufficient equipment, train personnel do not adequately lack technical expertise and necessary spare parts are unavailable. These issues were identified in a specialist report in 1998, but the Ministry has not fully taken action on the recommendations in the report. If the implementation of PPM at the Ministry's workshops should be enforced, these problems must be addressed. On the other hand, if the current practice where most health institutions at the lower level use private garages should be allowed, there is the need to review the policy of the Ministry having its own workshops.

145. We noted that some spare parts allocated to health facilities have not been paid for. This situation, if not addressed, can lead to the collapse of the Spare Part Revolving Fund and could be detrimental to the implementation of the PPM Scheme.

Transport management

146. The Ministry has an elaborate transport management system set out in its Transport Management Handbook. However, staff who are supposed to use the Handbook, do not have a thorough knowledge of the administrative procedures and requirements for documentation of data. We observed that files at the facility level did not contain maintenance records and other information on the individual vehicles. Furthermore, logbooks were not properly completed and the procedures for control of fuel were not implemented. This is the result of poor operational management and a lack of training of relevant staff. Ultimately, the quality of decision-making is affected when information about the vehicles is not properly recorded.

147. Auction sales have not been properly managed by the Ministry. There are outstanding debts to be paid by auctioneers, and health institutions have not paid monies from auction sales into the Consolidated Fund as required. The Ministry receives vehicles from donors that are supposed to be disposed of after five years. Monies received are
supposed to be paid into the Consolidated Fund, while the Ministry does not provide any budget for transport acquisition. The present system makes it difficult to manage acquisition and disposal efficiently. After getting rid of "old" vehicles that have become uneconomical to use, monies realised cannot be used to procure or rehabilitate vehicles.

148. Other problems we observed in the management of the fleet were that:

- the pooling policy was not followed;
- there were irregular monitoring and non-submission of returns on performance of vehicles;
- MOH was unable to adequately train key staff involved in transport;
- accident cases were not well managed in the Ministry; and
- the Ministry has not been able to prevent extensive thefts of motorcycles.
CHAPTER FIVE
RECOMMENDATIONS

Acquisition of transport

149. In order to improve the acquisition of transport we recommend to the Ministry to:

- Provide a budget line for transport acquisition and also establish a Depreciation Reserve Account into which shall be paid amounts equivalent to the annual depreciation provisions on the vehicles/motorcycles. This is necessary for the Ministry to be able to set its own priorities right, in respect of transport acquisition, independent of donors. The amounts so realised from the depreciation charges should be invested and used to acquire new vehicles to replace others at the end of their life span. For example, COCOBOD is operating such a scheme which MOH and GHS can study and operate.

- Consider changing the Replacement Policy and taking the real condition of vehicles into account in assessing transport needs, as well as in initiating replacement of vehicles. Together with a budget line, this could pave the way for a more realistic and effective process of planning for procurement of vehicles and motorbikes.

- Assess whether it is economical to keep vehicles aged between 10 and 20 years in the fleet, even if they are in a good or fair condition.

- Seek authorisation from the Ministry of Finance to use proceeds from auction sales for acquisition of newer and more efficient vehicles and rehabilitation of broken down vehicles to enhance the Ministry’s transport operations.

Transport allocation

150. To improve transport allocation, we recommend that the Ministry and GHS should:

- Analyse and assess the type and distribution of vehicles among regions and other institutions, in order to ensure the relevance of the Standard Transport Model.
Review the procedures for allocation of vehicles. Analysis of existing vehicles and their condition ought to form the basis for assessment of needs and allocation of new vehicles based on the established criteria. The Ministry and GHS should also consider the concerns of the Regional Directors and Directors of other institutions in the allocation process.

Fleet maintenance

151. To improve fleet maintenance and the efficient use of resources, we recommend to the Ministry and GHS to:

- Review the PPM Scheme, with the intention to either reinforce or abandon it. If the PPM Scheme is to be implemented, the Ministry should develop the workshops by properly equipping, staffing and managing them. This review should include determining whether the PPM Scheme is more cost effective than other sources of supply. The recommendations in the specialist report of 1998 need to be fully addressed. If health institutions are to be allowed to use private garages, the Ministry should review the need to operate its own workshops.

- Plan and budget for PPM services aside of the maintenance budget of the Ministry. This would ensure that health facilities have adequate financial means to implement the Scheme.

- Recover outstanding debts in respect of the Spare Parts Revolving Fund to sustain its operation.

Transport management

152. To improve transport management, we urge the Ministry to:

- Improve the system of reporting on the fleet of vehicles. Reporting Forms 6 and 7 need to be re-designed, in order to capture all information on operating costs of vehicles to include lubricants, tyres and batteries. The reporting system should also reflect the kind of fuel used (diesel and gasoline) and age blocks of vehicles to improve monitoring of the running cost of the vehicles.

- Take advantage of the pooling system for efficient and effective health care delivery, especially at Headquarters.
Train staff and test drivers regularly. There is a need for training to acquaint managers, transport officers, drivers and other staff with developments in transport and the Ministry’s procedures and regulations. Drivers must also be frequently tested for sight, knowledge of road signs and defensive driving. Only licensed drivers should be allowed to drive the Ministry’s vehicles to minimise accidents.

Take preventive action aimed at reducing theft of motorcycles. Security locks and alarm systems can be fitted on motorcycles. The Ministry could also design and imprint an identification logo on the bikes. Further, it may be considered if the Yamaha AG-100 model can be replaced with equally high performance models that are less attractive to the thieves.

Improve the management of auction and disposal of vehicles. The Ministry should take action to recover all outstanding monies from auctioneers. There is also a need for the Regional Health Administrations and other institutions to account for auction proceeds. Further, vehicles earmarked for disposal should in the future be disposed of as soon as possible to save them from further deterioration and to generate some funds.
Appendix A: Places visited during the audit

The following places were visited

1. Korle-Bu Teaching Hospital
   Accra

2. Greater Accra Regional Health Administration

3. Tema Central Mechanical Workshop
   Tema

4. Limb Fitting Centre Workshop
   Accra

5. Ashanti Regional Health Administration
   Kumasi

6. Okomfo Anokye Teaching Hospital

7. Metropolitan Health Administration

8. Manhyia Hospital

9. Amansie East District Health Administration & Hospital
   Bekwai
   Ejisu-Juaben

10. District Health Administration
    Ho

11. Volta Regional Health Administration
    "

12. Volta Regional Hospital
    "

13. District Hospital
    "

14. District Health Administration
    "

15. Volta Regional Mechanical Workshop
    "

16. Northern Regional Health Administration
    Tamale
    "

17. Regional Hospital
    "

18. West End Hospital
    "

19. Municipal Health Administration
    "

20. Northern Regional Mechanical Workshop
    "

21. Upper West Regional Health Administration
    Wa
    "

22. Regional Hospital
    "

23. District Health Administration
    "

24. Mechanical Technology Centre
    "

Transport Services in the Ministry of Health & Ghana Health Service
Appendix B: Key players and their functions

Ministry of Health

The Ministry of Health provides strategic and policy direction. The Ministry enters into dialogue with its development partners for the provision of vehicles etc. to the health sector.

Co-operating Partners

The Co-operating Partners or donors who provide assistance to the MOH and GHS include DfID, DANIDA, UNFPA, WHO and UNICEF. Donor conferences are organised annually between the MOH and its partners to deliberate on health issues and the way forward.

At these meetings, the transport needs of the MOH/GHS are tabled before the donors who subsequently make pledges in the form of loans and grants for the procurement of vehicles. The Co-operating Partners procure the vehicles and deliver them to the MOH. Between 1997 and 2001, DfID was the main supplier of vehicles to the Ministry. Crown Agents Ghana Ltd. procure the vehicles for and on behalf of DfID and the MOH.

The Ghana Health Service

The duties and responsibilities\(^1\) of *GHS Headquarters* are as follows:

- Facilitate the development and review of transport policy
- Allocation of new vehicles
- Prepare procurement plans for transport acquisition
- Prepare vehicle replacement plans
- Provide a centre of expertise to monitor performance of in-house and external workshops
- Ensure the safe and legal operation of vehicles
- Establish spare parts control system
- Produce periodic Transport Management Reports

\(^1\) See GHS Transport Policy March 2003.
• Advise on vehicle needs
• Set performance standards for vehicles
• Provide technical reports to the regions
• Ensure compliance with the Transport Policy at all levels
• Monitor and evaluate transport operations and performance
• Liaise with relevant transport stakeholders
• Facilitate the establishment of Accident/Incident Committees
• Manage the vehicle disposal system
• Ensure that maintenance systems are in place and strictly adhered to
• Conduct periodic transport audit
• Any other transport duties that may arise

The Headquarters Transport Office is responsible for the operational management of Headquarters fleet.

All Regional Health Directorates (RHDs) shall establish a Transport office and be responsible for the performance of the following duties.

• Keep the regional transport inventory
• Prepare vehicle replacement plans for submission to Headquarters
• Ensure the safe and legal operation of vehicles
• Advise on the allocation of vehicles
• Manage vehicle maintenance arrangements (in-house and third party)
• Co-ordinate the regional distribution of stores
• Arrange training in line with national policies
• Provide assistance to RHDs/Institutions on transport related matters
• Collate district vehicle performance statistics and consolidate into a regional report
- Manage the vehicle disposal system
- Ensure that maintenance systems are in place and strictly adhered to
- Ensure compliance with the Transport Policy at all levels
- Conduct periodic vehicle parade
- Oversee the general management and operations of the Regional Workshop
- Liaise with other transport organisations
- Conduct periodic transport audit
- Any other transport duties assigned by Headquarters

**District Health Directorates**

- Keep an up-to-date inventory and vehicle records
- Schedule vehicle use
- Make adjustment to that plan as circumstances change
- Issue and control fuel
- Ensure the safe and legal operation of vehicles
- Produce budgets and plans for vehicles
- Plan and ensure strict adherence to maintenance schedules
- Identify training needs and facilitate training
- Monitor vehicle performance and provide summary records to the Regional Health Administration
- Supervise and control drivers
- Conduct vehicle parade

**Transport Officers for the Hospitals and Institutions in the Districts**

Perform the above duties for the respective Institutions.
General Staff

All personnel of MOH and GHS are to ensure that the use and operation of vehicles shall enhance the longevity of the resources and contribute to the achievement of organisational objectives.
Appendix C: Organisational structure of the Ghana Health Service

Ministry of Health

Ghana Health Service Council

Teaching Hospital Management Board

Director General

Teaching Hospitals

Policy, Planning Monitoring & Evaluation

Institutional Care Division

Planning, Budget & External Aid Unit

Information Monitoring & Evaluation Unit

Centre for Health Information Management

Research Unit

Public Health Division

Regional Health Administration

Human Resources Development Division

Health Administration & Support Services Division

Stores & Supplies Division

Finance Division

Regional Hospital

District Health Management Team

Sub-district Health Management Team

Health Centre

Planning

Personnel Management

Training

Equipment

Estate Management Unit

Transport Management Unit

Headquarters General Administration

Procurement Unit

Storage, Warehousing & Distribution Unit

Information & Inventory Control Unit

Supportive & Monitoring Unit

General Accounting Unit

Reporting & Analysis Unit

Headquarters Accounts

1 Transport Services in the Ministry of Health & Ghana Health Service
Appendix D: Non-payment to Spare Parts Revolving Fund

1. Central Mechanical Workshop - Tema, Debtors as at 18 February 2003, Cedis

<table>
<thead>
<tr>
<th>Institution</th>
<th>Debt (Cedis)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tema Polyclinic</td>
<td>6,175,100</td>
</tr>
<tr>
<td>District Health Management, Sekondi</td>
<td>137,600</td>
</tr>
<tr>
<td>District Health Administration, Aflao</td>
<td>7,073,880</td>
</tr>
<tr>
<td>Tema General Hospital</td>
<td>195,250</td>
</tr>
<tr>
<td>Central Medical Stores, Tema</td>
<td>2,720,750</td>
</tr>
<tr>
<td>District Health Management, Jasikan</td>
<td>16,384,441</td>
</tr>
<tr>
<td>Mamprobi Polyclinic</td>
<td>2,356,500</td>
</tr>
<tr>
<td>Regional Director Health Service, Greater Accra</td>
<td>4,420,380</td>
</tr>
<tr>
<td>Worawora Government Hospital</td>
<td>5,003,902</td>
</tr>
<tr>
<td>Regional Director Health Service, Tamale</td>
<td>110,000</td>
</tr>
<tr>
<td>Accra Metropolitan Health</td>
<td>1,427,800</td>
</tr>
<tr>
<td>Ridge Hospital, Accra</td>
<td>9,756,150</td>
</tr>
<tr>
<td>District Health Management, Kadjebi</td>
<td>25,311,950</td>
</tr>
<tr>
<td>Regional Hospital, Koforidua</td>
<td>14,249,400</td>
</tr>
<tr>
<td>District Health Management, Akim Oda</td>
<td>150,700</td>
</tr>
<tr>
<td>Regional Health Administration, Ho</td>
<td>8,381,450</td>
</tr>
<tr>
<td>District Health Management, Saltpond</td>
<td>1,019,700</td>
</tr>
<tr>
<td>Maamobi Polyclinic</td>
<td>8,118,000</td>
</tr>
<tr>
<td>District Health Management, Suhum</td>
<td>162,800</td>
</tr>
<tr>
<td>GHS Headquarters</td>
<td>107,498,083</td>
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<tr>
<td>Regional Hospital, Cape Coast</td>
<td>132,000</td>
</tr>
<tr>
<td>Pantang Psychiatric Hospital</td>
<td>1,581,800</td>
</tr>
<tr>
<td>MOH Headquarters</td>
<td>34,458,317</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>256,825,953</strong></td>
</tr>
</tbody>
</table>

Source: Compiled during audit

2. Technology Workshop, Wa, Debtors as at August 2002, Cedis

<table>
<thead>
<tr>
<th>Description</th>
<th>Debt (Cedis)</th>
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<tbody>
<tr>
<td>Regional Health Administration, Wa (2000/2001)</td>
<td>59,052,911</td>
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<tr>
<td>Other MOH &amp; non MOH debtors</td>
<td>40,300,000</td>
</tr>
<tr>
<td>Nodowli (Loan to acquire engine)</td>
<td>13,000,000</td>
</tr>
<tr>
<td>Nandom (Loan to acquire cylinder Head and Parts)</td>
<td>3,944,000</td>
</tr>
<tr>
<td>Spare Parts Revolving Fund</td>
<td>33,934,000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>150,230,911</strong></td>
</tr>
</tbody>
</table>

Source: Compiled during audit
### 3. Northern Region Health Administration Spare Parts Revolving Fund, Cedis

<table>
<thead>
<tr>
<th>District</th>
<th>Bill</th>
<th>Paid</th>
<th>Outstanding</th>
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<tbody>
<tr>
<td>Saboba/Chereponi</td>
<td>11,654,000</td>
<td>11,654,000</td>
<td>-</td>
</tr>
<tr>
<td>Gusu/Karega</td>
<td>11,832,000</td>
<td>11,832,000</td>
<td>-</td>
</tr>
<tr>
<td>West Mamprusi</td>
<td>10,710,000</td>
<td>10,710,000</td>
<td>-</td>
</tr>
<tr>
<td>Tolon/Kumbungu</td>
<td>16,647,000</td>
<td>11,619,000</td>
<td>5,028,000</td>
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<tr>
<td>Zabzugu/Tatale</td>
<td>9,685,000</td>
<td>9,685,000</td>
<td>-</td>
</tr>
<tr>
<td>Yendi</td>
<td>14,133,000</td>
<td>7,000,000</td>
<td>7,133,000</td>
</tr>
<tr>
<td>Savelugu/Nanton</td>
<td>9,709,000</td>
<td>9,709,000</td>
<td>-</td>
</tr>
<tr>
<td>East Mamprusi</td>
<td>11,872,000</td>
<td>8,000,000</td>
<td>3,872,000</td>
</tr>
<tr>
<td>Tamale</td>
<td>16,647,000</td>
<td>8,323,000</td>
<td>8,324,000</td>
</tr>
<tr>
<td>West Gonja</td>
<td>11,949,000</td>
<td>6,000,000</td>
<td>5,949,000</td>
</tr>
<tr>
<td>East Gonja</td>
<td>15,485,000</td>
<td>5,000,000</td>
<td>10,485,000</td>
</tr>
<tr>
<td>Bole</td>
<td>11,878,000</td>
<td>-</td>
<td>11,878,000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>163,572,000</td>
<td>110,912,000</td>
<td>52,669,000</td>
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</table>

Source: Compiled during audit

### 4. SPRF - Ashanti Regional Health Administration, Cedis

<table>
<thead>
<tr>
<th>Region</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional Medical Stores, Kumasi</td>
<td>234,570</td>
</tr>
<tr>
<td>District Hospital, Obuasi</td>
<td>3,030,300</td>
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<tr>
<td>Regional Health Administration, Kumasi</td>
<td>300,000</td>
</tr>
<tr>
<td>District Hospital, Mampong</td>
<td>5,185,800</td>
</tr>
<tr>
<td>District Health Administration, Juaso</td>
<td>2,693,300</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>11,443,970</td>
</tr>
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</table>

Source: Compiled during audit
Appendix E: Auction of vehicles/motorbikes without any treasury receipts for payments into the Consolidated Fund

<table>
<thead>
<tr>
<th>Date</th>
<th>Authority</th>
<th>Place</th>
<th>Auctioneer</th>
<th>Net amount Cedis</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/03/1997</td>
<td>MOH/CAD/D007/C</td>
<td>Wa UWR</td>
<td>J.B. Adade, Kumasi</td>
<td>12,356,300</td>
</tr>
<tr>
<td></td>
<td>COS/1002CAV</td>
<td>Greater Accra Region</td>
<td>Adusa-Kobi Mart</td>
<td></td>
</tr>
<tr>
<td>13/10/1997</td>
<td>COS/1002CAV</td>
<td>Accra/Tema</td>
<td>- do -</td>
<td>6,149,000</td>
</tr>
<tr>
<td>19/02/1998</td>
<td>COS/1002CAV</td>
<td>Western Region</td>
<td>Sharh Mart, Accra-North</td>
<td>20,150,905</td>
</tr>
<tr>
<td>08/04/1998</td>
<td></td>
<td></td>
<td>Mathew Mart, Tdi</td>
<td>3,036,450</td>
</tr>
<tr>
<td>30/11/1998</td>
<td>COS/1002CAV</td>
<td>Greater Accra Region</td>
<td>King David Mart, Tdi</td>
<td>10,848,110</td>
</tr>
<tr>
<td>20/04/1999</td>
<td>COS/1002CAV</td>
<td>Accra</td>
<td>S.O. Quaye, Jordan Mart</td>
<td>4,849,950</td>
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<tr>
<td>05/2001</td>
<td>SS/7.SF.7</td>
<td>Central Mechanical Workshop, Tema</td>
<td>Sharm Mart, Accra-North</td>
<td>10,607,050</td>
</tr>
<tr>
<td>28/02/2002</td>
<td>OP/1002/COS</td>
<td>Greater Accra</td>
<td>Shargaw Ventures</td>
<td>2,697,000</td>
</tr>
<tr>
<td>02/08/2002</td>
<td>OP/050/COS</td>
<td>Accra (Eye Care Staff)</td>
<td>Joyful Mart, Suame</td>
<td>14,020,700</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>17,600,000</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td></td>
<td>102,315,465</td>
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</table>

Source: Compiled during audit

Auctions without treasury receipts and where information on the net amount was not available

<table>
<thead>
<tr>
<th>Date</th>
<th>Authority</th>
<th>Place</th>
<th>Auctioneer</th>
<th>Net amount Cedis</th>
</tr>
</thead>
<tbody>
<tr>
<td>13/01/1995</td>
<td>COS/1002CAV</td>
<td>Bolgatanga</td>
<td>Mystic Mart, Koforidua</td>
<td>N/A</td>
</tr>
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<td>04/02/1998</td>
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Source: Compiled during audit