TRIBAL HELM

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SPECIALISTS IN DEVELOPING COMMUNITIES

Health Sector

Fiduciary Risk Assessment

Contents

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Abbreviations

AO	Accounting Officer
BCC	Budget Call Circular
BMAU	Budget Monitoring and Accountability Unit
Bn.	Billion
COFOG	Classification of the Functions of Government
CSO	Civil Society Organisations
DFID	Department for International Development
DPP	Director of Public Prosecutions
DPs	Development Partners
EMHS	Essential Medicines and Health Supplies
FINMAP	Financial Management and Accountability Programme
FRA	Fiduciary Risk Assessment
FY	Fiscal Year
HC	Health Centre
HPAC	Health Policy Advisory Committee
HRH	Human Resources Health
HRHIS	HRH Information Systems
HSSP II	Health Sector Strategic Plan II
HSSIP	Health Sector Strategic and Investment Plan
GAVI	Global Alliance for Vaccine and Immunisation
GoU	Government of Uganda
GFATM	Global Fund to Fight HIV/AIDS, Malaria and Tuberculosis

IFMS	Integrated Financial Management System
IGG	Inspectorate General of Government
JAF	Joint Assessment Framework
JBS	Joint Budget Support
LG	Local Government
LGMSDP	Local Government Services Delivery Programme
LTIA	Long Term Institutional Arrangements
MTEF	Medium Term Expenditure Framework
MDAs	Ministries Departments Agencies
MDALGs	Ministries Departments Agencies Local Governments
MDGs	Millennium Development Goals
MoFPED	Ministry of Finance Planning and Economic Development
MoH	Ministry of Health
NACS	National Anti-Corruption Strategy
NAADS	National Agricultural Advisory Services
NDP	National Development Plan
NGO	Non Government Organization
NHP	National Health Policy
NIS	National Integrity Survey
NSSF	National Social Security Fund
NMS	National Medical Stores
OAG	Office of the Auditor General
OPM	Office of the Prime Minister
PAC	Public Accounts Committee
PAF	Poverty Action Fund

PFP	Private For Profit
PHC	Primary Health Care
PNFP	Private Not For Profit
PFM	Public Financial Management
PEFA	Public Expenditure and Financial Accountability
PEAP	Poverty Eradication Action Plan
PEPFAR	United States President's Emergency Plan for AIDS Relief
RRH	Regional Referral Hospital
TM	Treasury Memorandum
UNMHCP	Uganda National Minimum Heath Care Package
UNAC	United Nations Convention on Corruption
USAID	United States Agency for International Development
Ushs.	Ugandan Shillings
VFM	Value For Money
WHO	World Health Organization

1 Introduction

1.1 The provision of access to health services is an important social policy of the Government of Uganda (GoU). It is also an area of development that has received, and continues to receive, large amounts of support from the international community. The size of national and international investments in health is significant enough to warrant close attention being paid to the way in which the relevant financial and other resources are managed.

1.2 This Fiduciary Risk Assessment (FRA) follows the guidance in the DFID *How to Note Managing Fiduciary Risk when providing Financial Aid* (HTN09). The approach and methodology was also agreed with DFID and the Embassy of Sweden in Uganda. It begins in Section 2 by reviewing the broad historical, governance and institutional context in which the health sector operates. Section 3 comprises an analysis of the performance of the Public Financial Management (PFM) system in the sector, employing selected Public Expenditure and Financial Accountability (PEFA) assessment approach and sector specific issues. Section 4 draws out from the PFM analysis the main fiduciary risks in the sector. This is followed by an assessment in Section 5 of the credibility of the reform process in the sector. Section 6 attempts to identify the financial impact of the sectoral fiduciary risks. Sections 7 and 8 contain respectively proposed safeguards to mitigate risks and a number of key performance indicators with which to monitor fiduciary risk. The FRA concludes with a bibliography of key documents consulted.

1.3 In accordance with the TOR, the FRA mainly comprised desk research of relevant documentary material, some of which was generic and other parts specific to the Health sector. This was supplemented by a very limited number of interviews with GoU officials and development partners. The consultants had the opportunity to meet and explain their work to the Sector Donor Working Group. Also, a field trip was organised to the Mpigi District to obtain valuable information at the district level.

1.4 The conclusions of the FRA are that the level of fiduciary risk in the Health sector is SUBSTANTIAL while the risk of corruption is HIGH. These conclusions are identical to those in the national FRA, reflecting the fact that, typically, the PFM weaknesses and deficiencies found at the national level are mirrored by sectoral performance. Similarly, the problems that Uganda faces generally in dealing with corruption of all kinds are also prevalent in the Health sector. Much remains to be done by the GoU to reduce both fiduciary risk and the risk of corruption. Development partners will need to consider how best they can assist GoU in achieving this. Civil society will also have a role to play in mitigating these risks, especially at sub-national level.

2 Historical Governance and Institutional Context

Historical overview

2.1 In the years immediately after attaining independence in 1962 Uganda had amongst the best health indicators and infrastructure in the region. The post colonial government inherited a health system that was largely designed around the provision of services at district hospitals. These were operated by both government and non government organisations (NGO) service providers, with a great many run by faith based groups including churches and other religious organisations.

2.2 However while overall levels of health infrastructure and service provision was relatively high in comparison with the rest of the region there were significant disparities in the level and quality of service provision. Colonial administrative centres were largely well served by infrastructure but in rural areas access to health care was extremely limited with the population often having to travel long distances to obtain services. Parts of the country, particularly the North, were particularly underserved in terms of both infrastructure and the availability of trained personnel.

2.3 A protracted period of civil war and widespread insecurity (from 1971-1986) severely disrupted the health sector in terms of both the availability of human resources and infrastructure. Upon attaining power in 1986 the current government inherited a health system which was in many parts of the country dysfunctional with infrastructure destroyed and personnel absent. Since the early 1990's the Government has given significant priority to health services. Improving health and health service delivery was identified as a key priority in the Poverty Eradication Action Plan and remains a significant priority in the new National Development Plan.

Health status

2.4 Health status in Uganda has improved since the early 1990's. Life expectancy increased from 45 years in the early 1990's to 52 years in 2009. HIV prevalence, 30% in the mid 1980's, fell to 6.2% in 2009. However significant challenges remain. Malaria, malnutrition, acute respiratory tract infections, HIV/AIDS and tuberculosis continue to be the leading causes of morbidity and mortality. Meanwhile increased prevalence of non-communicable diseases is an emerging problem in urban areas as lifestyles change. Uganda has one of the highest rates of road traffic related deaths per capita in the world. Trends in key health related outcomes and an assessment of progress towards targets set in the Poverty Eradication Action Plan (PEAP), National Development Plan 2010/11-2014/15 (NDP) and against the Millennium Development Goals (MDGs) are highlighted in the table below[1].

[1] Ministry of Health: Sector Performance Report 2008

Table 1: Key health related outcomes and an assessment of progress

Indicator	1995	2001	2006	PEAP Target (2007/08)	NDP target (2014/15)	MDGs target (2015/16)
Infant mortality rate (per 1000 live births)	81	88	76	68	41	41
Under 5 mortality rate (per 1000 live births)	156	152	137	n/a	60	60
Maternal mortality rate (per 100,000 live births)	527	505	435	354	131	131

2.5 The data presented above clearly illustrates that whilst progress has been made, health indicators in Uganda remain significantly off track in relation to both national targets and the MDG's. Concerted action to address this is required and a properly functioning and effective health sector has a critical role to play.

Health policy

2.6 Strategic direction and government priorities in health are determined and articulated in a number of key statements, policy documents and plans. These are outlined briefly below:

The Constitution of the Republic of Uganda: The 1995 Constitution (as amended) guarantees the right of access for all people of Uganda to basic health care services.

The National Development Plan (2010/11-2014/15): While the overall focus of the NDP is growth, prosperity and social transformation rather than poverty reduction, the importance of increasing access to quality social services is emphasized within the plan. It contains a detailed analysis of the current constraints in the health sector and establishes a number of key objectives that need to be met to address them. This includes strengthened organization and management of health services, improved policy, legal and regulatory frameworks and strengthened collaboration between Ministry of Health, (MoH), other parts of Government and public and private institutions.

National Health Policy II (2010/11-2019/20): The NHP II outlines Governments overall vision and strategic objectives for the health sector over the next decade. The Mission of the MoH is described as *"to facilitate the attainment of a good standard of health by all people of Uganda in order to promote a healthy and productive lifestyle"*. The policy identifies priority areas which, in terms of health services management, include: strengthened district health systems, reorganizing supervision and management systems and improving collection and the use of data to ensure evidence based decision making.

Draft Health Sector Strategic and Investment Plan (2010/11-2014/15): The Health Sector Strategic and Investment Plan (HSSIP) was developed to implement the NHP II. Recognizing resource constraints it

emphasizes the delivery of a national minimum health care package (UNMHCP). Component parts of the UNMHCP are arranged in clusters and are:

1. Health promotion, environmental health and community health initiatives;

2. Maternal and child health;

3. Communicable disease control;

4. Prevention and control of non-communicable diseases, disabilities, injuries and mental health problems.

The draft HSSIP includes a SWOT analysis and outlines the priority actions Government wishes to deliver over the next five year period to strengthen health systems. It also articulates the structure of the Sector Wide Approach and coordination between Government and health development partners. The document is yet to be finalized.

Management and organization of service delivery

2.7 Health service delivery, like other essential services is decentralized. The basic structure of the health delivery system and its intended functions are outlined below.

Table 2: Basic structure of the health delivery system and its intended functions

Level/Structure	Basic description of roles and functions
Ministry of Health	• Policy analysis, formulation and dialogue • Strategic planning and resource mobilization • Setting standards and quality assurance • Advising other Government departments and agencies on health issues • Capacity development and technical support and supervision • Provision of nationally coordinated services and coordination of research • Monitoring and evaluation of the overall health sector performance
Semi-autonomous institutions	These include agencies tasked with the provision of specialised clinical services e.g. Uganda National Blood Transfusion Service, Uganda Virus Research Institute, the National Medical Stores and National Drug Authority.
National and Regional Referral Hospitals & Public General Hospitals	**National Referral Hospitals:** Provide comprehensive specialist services and are involved in research and teaching. They are supposed to cater for the whole population and are fully autonomous. **Regional Referral Hospitals (RRH):** Provide specialist clinical services such as psychiatry, ophthalmology etc. and provide higher level surgical and medical care. RRH are also involved in teaching and research. Each is supposed to cater for a population of 500,000. The Regional Referral Hospitals have been granted self accounting status (and have their own vote in the budget) but are

Level/Structure	Basic description of roles and functions
	still formally managed by the MoH HQ. **Public General Hospitals:** Provide preventive, promotive, curative, maternity, and in-patient health services including surgery, blood transfusion, laboratory and medical imaging services. They also provide in-service training. Most serve a particular district. They are managed by District Local Governments.
District Health Systems	Responsible for the delivery of health services and management of human resources, the development and passing of health related by-laws and monitoring of sector performance. Local Governments manage public general hospitals and health centers and also provide supervision and monitoring of all health activities (including those in the private sector) in their respective areas.
Health Sub Districts	Is mandated with planning, organization, budgeting and management of the health services at health center level and Private Providers. At this level Health Centre IVs are tasked with providing a range of services including in-patient care and emergency surgery (including caesarian sections).
Health Centre III, II, I	**HC IIIs** provide basic preventive, promotive and curative care and provide support and supervision to lower level units. There are provisions for laboratory services for diagnosis, maternity care and first referral cover for the sub-county. **HC IIs** provide the first level of interaction between the formal health sector and the communities. HC IIs only provide out patient care and community outreach. **HC Is:** Village Health Teams staffed by volunteers who provide basic care and advice.

2.8 Private sector providers remain important in the delivery of health services. The private sector is composed of the Private not for Profit (PNFP), Private for Profit (PFPs) as well as traditional and complementary practitioners. Over 78% of the PNFP facility based service providers are faith based and are administratively controlled by their respective bureaus. PFP providers predominantly comprise of clinics, drug shops and drug vendors although there are a growing number of PFP hospitals in Kampala and other major urban centres.

Coverage

2.9 The GoU operates 2242 health centres and 59 hospitals with PNFP providers operating 613 health centres and 46 hospitals. Approximately 269 health centres and 8 hospitals are operated by PFP providers.

2.10 The national target for access to services is that everyone should have a health facility within 5 km of their residence. In 2008 access measured against this indicator was at 72%. However there are significant geographical inequalities in coverage and access to services of an acceptable quality is often further limited by a lack of medicines and personnel shortages.

Planning, budgeting and reporting

2.11 Planning starts at the Health Sub District Level. Health Sub Districts are expected to identify annual priorities with the participation of community representatives and the Village Health Teams. Annual work plans are developed and submitted to District for consolidation and forwarding to the MoH who examines individual district plans for compliance with policy, technical and financial guidelines. District plans along with those from the national and regional referral hospitals and semi-autonomous institutions are collated into a National Health Sector Annual Plan by the sector budget working group. This is then forwarded to the Ministry of Finance, Planning and Economic Development for consideration.

2.12 Financial releases, which are made in quarterly tranches against approved budgets, are triggered by receipt of work-plans and accountability for expenditure made in the previous quarter. Work-plans are submitted to the Ministry of Finance Planning and Economic Development (MoFPED). Funds are released in quarterly tranches in the form of conditional grants to district local governments who make disbursements accordingly.

2.13 Technical Reports are compiled at Health Sub District level, consolidated at Health District level, and are submitted to the MoH. Financial Reports are submitted to MoFPED.

Sector resourcing and issues arising

2.14 The MoH has estimated that Uganda Shillings (Ushs.) 1.5 trillion is required annually to deliver the UNMHCP. Whilst sector budgetary resourcing (excluding projects) increased from Ushs. 236 Billion in Financial year 2006/07 to Ushs. 434 Billion in Financial year 2009/10, there remains a significant shortfall. Core budget allocations accounted for approximately 60% of sector financing in FY 2008/09 with donor projects accounting for the other 40%.

2.15 Government allocations to health have averaged approximately 9.6% of the national budget over the last few years. NDP forecasts suggest that allocations to health will average 11.3% over the next 5 years. Whilst this represents an increase in terms of overall share, in actual terms it falls below the Ministry of Health target of 13.2%. With the new NDP having an emphasis on growth and prosperity some observers have expressed concern that this might have long term implications for ensuring adequate resource allocation to the sector.

2.16 Off budget development assistance is a significant component of the resources available for the health sector. According to MoFPED off budget funding constituted USD $440 million in FY 2008/2009 while the overall health budget stood at Ushs. 628 billion[2]. Much of this funding falls outside the overall health sector planning framework and there are therefore concerns that it could undermine the delivery of the proposed Health Sector Strategic and Investment Plan.

[2] MoFPED Budget Speech FY 2008/09-2010/11

2.17 There are a number of challenges to ensuring that there are sufficient resources available to deliver the minimum healthcare package. These include the escalating unit cost of healthcare due to inflation and the high population growth of 3.2 % which creates an ever increasing demand for health services. It is estimated that a per capita expenditure of USD 47.9 is required to fully implement the UNMHCP whereas only USD 12.5 is currently available[3].

Key constraints and challenges

2.18 Improvements in health indicators in the early-mid 1990's have been attributed to a number of reforms and developments at both the sector level and more broadly. These include:

- Prioritization and ring-fencing of the health sector budget under the Poverty Eradication Action Plan (PEAP) and the Poverty Action Fund(PAF);
- Substantial shifts in models of health service delivery – including the clustering of health units under the Health Swap, the development of a joint Health Sector Strategic Plan I and the development of the Uganda National Minimum Health Care Package which helped to prioritize resource allocations and interventions;
- Overall public financial management and public sector management reforms;
- Increases in resource flows by development partners which led to an expansion in health infrastructure.

2.19 However there are major concerns that progress in improving service delivery and health outcomes is not commensurate to the level of investment, and is static in some areas. A number of key constraints to improved sector performance and health outcomes are summarized below.

Human Resource Management

2.20 The sector has chronic staffing shortages. The overall health worker to population ratio is 1: 1,298 as opposed to the WHO standard of 1:439. The recruitment and retention of health staff remains a major problem despite significant steps being taken to develop a HR Policy under Health Sector Strategic Plan II (HSSP II) (2005-2010). Remuneration is low even by regional standards with a doctor in Uganda earning approximately four times less than his Kenyan counterpart. Health worker absenteeism has been estimated at 42.5% costing approximately Ushs. 63 billion per year, based on November 2010 data[4].

[3] Draft Health Strategic and Investment Plan 2010
[4] "Draft Final Appraisal Joint Assessment Framework 2" 18 November 2010 based on 12 November 2010 preliminary data

2.21 The emphasis within most curricula for health worker training is on curative care. Despite the PNFP subsector producing the majority of Primary Health Care (PHC) staff, recognition and inclusion of the PNFPs in national and district level decision-making for health training remains limited. There has been a lack of a functional integrated HRH Information System (HRHIS) that is able to generate up to date information for HRH planning and management although this is now being developed and rolled out at district level, with support from health development partners.

Management of drugs and supplies

2.22 A National Drug Policy is in place. Its stated objective is to ensure "the availability and accessibility at all times of adequate quantities of affordable, efficacious, safe and good quality essential medicines and health supplies to all who need them". The availability of essential drugs and supplies is a basic requirement for the delivery of the UNMHCP. Public sector national medicines procurement is mainly carried out through National Medical Stores (NMS).

2.23 Absolute funding for medicines has increased. Training of health care workers on drugs and supplies use and management was undertaken under HSSP II and support was provided to the National Medical Stores to improve their business processes, management information systems and enterprise resource plans.

2.24 However drug shortages and stock outs at health facility level have remained a significant problem. The Auditor General's Reports of 2006 and 2009 identified a number of reasons for this including the diversion of funds intended to be used for the procurement of medicines to other activities, and poor stock control. A recent study by the MoH, MoFPED and the World Bank [5]noted that whilst it was difficult to currently estimate losses incurred as a result of leakages at facility, this was likely to be a continuing problem and more work was required to both quantify the scale of the problem and address it. Losses of up to 2% of NMS stock are estimated to occur annually as a result of write offs of expired stock. Between July 2005 and July 2007 this is estimated to have caused losses totaling Ushs. 5.3 billion[6]. A new system for managing essential medicines and supplies has however recently been introduced and is discussed further in Section 3 of this report.

Inadequate health infrastructure and equipment

2.25 Poor infrastructure and equipment remain a significant constraint on the delivery of services. It is estimated that only one third of facilities that are intended to deliver maternity care have the basic supplies and equipment available to do so. Ensuring access to safe delivery services is an important component of efforts to reduce maternal mortality. Inadequate staff housing is also believed to be a significant factor in poor staff retention rates, especially in remote areas.

[5] World Bank, MoH, MoFPED, 2009, "Fiscal Space for Health in Uganda"
[6] Ibid

Inadequate supervision, management and monitoring

2.26 Efforts to improve health service delivery are seriously undermined by poor supervision and management at all levels. Management team or supervisory visits are irregular and clinical supervision is often of poor quality. Poor feedback mechanisms between levels in the health system (i.e. between health sub-district and district levels) have been cited as major constraints to ensuring proper planning and evidence based decision making and resource allocation.

A reputation for corruption

2.27 The Health Sector's image has been severely damaged in recent years by a number of high profile corruption scandals. These have included: the misappropriation and mismanagement of funds from the Global Fund to Fight HIV/AIDS, Malaria and Tuberculosis (GFATM) and the Global Alliance for Vaccines and Immunisation (GAVI), as well as an IGG investigation into the undeclared wealth of the MoH's Principal Accountant in 2008. Steps have since been taken to address some of the concerns raised, including the development of long term institutional arrangements for the management of project funds. Both the GFATM and GAVI have resumed disbursements. Nonetheless the sector's reputation was seriously tarnished both nationally and internationally by these incidents.

Conclusion

2.28 The Health Sector is faced with multiple challenges. With extremely high population growth there is an ever increasing demand for services with a rapid young population and an evolving disease burden. Resource allocations to the sector are unlikely to be able to match these demands and the delivery of the UNMHCP will remain a challenge. Even if additional resources were available, substantial improvements in the organization and management of the sector would be required to ensure that they could be used effectively to achieve better health outcomes.

3 Standard of Public Financial Management and Accountability

3.1 This section describes the standard of public financial management and accountability in the health sector. It is based on relevant aspects of the PEFA PFM assessment framework tool supplemented by analysis of sector specific risk areas. It was completed following a review of key reference documents supplemented by a number of focused interviews. The findings are presented according to the main categories of the PEFA assessment framework.

Category 1: Credibility of the Budget

3.2 Levels of expenditure and budget variance: Health sector expenditure has been close to budget over the last three years, with the overall variance in each year below 5%. Table 3 below provides an analysis of expenditure for FY 2009/10, FY 2008/09 and FY 2007/08 against the budget and the variance. Donor funded expenditure is excluded because actual expenditure figures were not available.

Table 3: Analysis of Health Sector expenditure against the budget for FY 2007/2008, 2008/09 and FY 2009/10

	FY2007/08			FY2008/09			FY 2009/10		
Spending Unit	**Approv. Budget Ushs. bn**	**Expenditure Ushs. bn**	**Variance %**	**Approv. Budget Ushs. bn**	**Expenditure Ushs. bn**	**Variance %**	**Approv. Budget Ushs. bn**	**Expenditure Ushs. bn**	**Variance %**
Ministry of Health	59.31	67.41	1.3	113.63	109.58	(3.56)	60.78	59.95	(1.36)
Uganda Aids Commission	2.93	2.93	0	2.83	2.79	(1.41)	3.83	3.79	(1.04)
Health Service Commission	1.77	1.70	(3.95)	2.04	2.00	(1.96)	2.56	2.47	(3.51)
Uganda Blood Transfusion Service	1.95	1.29	(3.38)	1.96	1.38	(2.95)	3.13	2.84	(9.26)
Mulago Hospital Complex	34.18	31.90	(6.6)	41.87	42.71	2.00	32.39	32.38	(0.01)
Butabika Hospital	11.34	10.61	(6.43)	11.85	11.92	0.59	12.70	12.69	(0.07)
Regional Referral Hospitals	27.37	27.36	(0.03)	43.61	44.65	2.38	46.51	46.44	(0.14)
District Local	142.64	130.59	(8.44)	157.59	166.40	5.59	192.89	197.55	2.4

	FY2007/08			FY2008/09			FY 2009/10		
Spending Unit	**Approv. Budget Ushs. bn**	**Expenditure Ushs. bn**	**Variance %**	**Approv. Budget Ushs. bn**	**Expenditure Ushs. bn**	**Variance %**	**Approv. Budget Ushs. bn**	**Expenditure Ushs. bn**	**Variance %**
Government									
National Medical Stores							75.71	54.67	(27.7)
Uganda Heart Institute							1.56	0.48	(69.2)
Uganda Cancer Institute							3.78	3.74	(1.3)
Total	**281.51**	**273.88**	**(2.7)**	**375.38**	**381.42**	**1.60**	**435.86**	**417.03**	**(4.32)**

Source: MoFPED Annual Budget Performance Reports 2007/08, 2008/09 and 2009/10

Note: Figures are before payment of taxes and arrears and exclude donor funding

3.3 An under spend of 4.32% was incurred in financial year 2009/10. This was largely due to the inability of National Medical Stores (NMS) to utilise released funds, with unspent balances of Ushs. 21 billion. The MoFPED 2009/10 Budget Performance Report offers no explanation for this variance. It maybe that this reflects some limitations on absorptive capacity as NMS adjusts to increased budget and new arrangements for the procurement and distribution of essential medical and health supplies introduced in July 2009, with all supplies now procured and distributed by the NMS.

3.4 An over spend of 1.6% was incurred in financial year 2008/09. This was covered by an in-year supplementary estimate of Ushs. 15.48 billion[7]. However, the supplementary appropriations would appear to have not been properly aligned with the overspending units as the Auditor General, in his 2008/09 report, reported excess expenditure, over budgetary approval, at Mulago National Referral Hospital of Ushs. 1.05 billion. Most of the health sector overspend (Ushs. 8.81 billion) was incurred at local government level where a significant proportion of it was spent on the PHC wage budget. There was only one significant variation, an under spend of 29.59% at the Uganda Blood Transfusion Service- however this represented only Ushs. 1.96 billion (0.52%) of the total sector budget.

3.5 Allocations and trends: Funding allocations and trends over the last three financial years by level of care are analysed in Table 4 below.

[7] MoFED Approved Estimates of Revenue and Expenditure, 2009/10

Table 4: Allocation of GoU funds by level of care 2007/08, 2008/09 and 2009/10

Spending Unit	2007/08 (Ushs. bn)		2008/09 (Ushs. bn)		2009/10 (Ushs. bn)	
MoH Headquarters	64.69	24%	99.87	27%	60.78	14%
National Referral Hospitals	40.98	15%	52.61	14%	45.09	10%
Other Agencies	5.87	2%	6.59	2%	90.57	21%
Regional Referral Hospitals	25.73	10%	44.56	12%	46.51	11%
District Health Services	131.6	49%	165.7	45%	192.89	44%

Source: MoFPED Annual Budget Performance Reports 2007/08, 2008/09, 2009/10

3.6 Budget analysis suggests that an increasing proportion of resources were being consumed by central administration - 27% in 2008/09, up from 16% in 2006/07. It would appear that this seems to be paid for by a lower proportion of expenditure going to district health services. Analysis of the flow of funds shows that expenditure at district level amounted to 45% of the overall sector budget in FY 2008/09, a fall of 13% over three years. However it is important to note that significant expenditure has been incurred centrally on medicines, vaccines and other medical supplies, including increasing expenditures on the purchase of anti-retrovirals. Furthermore, the 2009/10 figures suggest a positive shift away from central administration with the significant 19% increase in allocation to other agencies, most notably NMS.

3.7 Facility Based Private Not for Profit Providers: These remain important providers of services. They include the larger mission hospitals and health centres. They are financed by a combination of government subsidy (money and drugs), donor support, and the collection of user fees. The relative proportion of government subsidy and donor support is reducing year-on-year, resulting in a significant increase in the relative proportion, and absolute amount, of user fees. In 2005/06 user fees constituted 38% of the budget of these facilities. This rose to 55% in 2008/09. In absolute terms revenue from user fees increased from around Ushs. 30 billion in FY 2005/06 to approximately Ushs. 52 billion in 2008/09. This represents an increase of 73.3% over just four years. The equity implications of this on the poor in terms of their ability to access services and the proportion of their household income that they spend on health warrants further analysis. In some areas people rely heavily on these types of providers for hospital care.

3.8 Arrears: The level of domestic arrears in the health sector at 30th June 2009 stood at Ushs. 8.21 billion, up from Ushs. 5.13 billion at 30th June 2008. However the Auditor General reported that his office was unable to confirm the existence and accuracy of MoH arrears amounting to Ushs. 2.09 billion.[8] The largest source of health sector arrears is Mulago Hospital. The Auditor General's 2009 report noted that the Mulago Hospital stock of arrears of Ushs. 6.18 billion remained unpaid at the end

[8] Auditor General's Report for 2008/09, Volume II – "Central Government", p.92

of the financial year and that together with new arrears the amount of domestic arrears of Mulago Hospital amounted to Ushs. 7.89 billion in 2008/09. Mulago Referral Hospital accounted for 3.6% of the total stock of arrears in 2008/09, making[9] the level of arrears as a proportion of the health sector government recurrent non-wage expenditure of Ushs. 190.2 billion 4.3%.

Category 1: Credibility of the budget: overall risk rating	**Moderate**
The structure of the PFM system is sound and budget performance in recent years has been good. But there is a risk associated with the build-up of arrears particularly in regard to Mulago Referral Hospital which accounts for most of the arrears in the health sector and 3.9% of total government arrears. The lack of a clear national government policy to reduce arrears increases the risk that Mulago may continue to accumulate new arrears.	

Category 2: Comprehensiveness and Transparency

3.9 Adherence to regulations on budgeting and reporting: Spending units within the health sector use the main government classification system for budget preparation and reporting. This is compliant with MoFPED directives. The key regulations are the Public Finance and Accounting Regulations 2003 and the Local Government Finance and Accounting Regulations 2007. These regulations are sufficiently comprehensive to enable and ensure that there is transparency and accountability in the use of public resources. Within the health sector, there are specific guidelines relating to Primary Healthcare (PHC) wage and non-wage expenditure.

3.10 There are however, a number of issues that need to be addressed to ensure full compliance with the regulations, and to improve transparency. These are the following:

- Financial manuals and guidelines are not updated to reflect changes in policies (e.g. the new rules for procurement and distribution of medicines);
- Allocation process at district level needs to be clearer and more transparent, with published criteria for allocating funds to different units and in particular, clear guidance and limits on the proportion of funds that should be retained for district administration.

3.11 Planning and resource allocation processes: Planning and resource allocation processes are in theory highly decentralised and participatory. Health units are required to be closely involved in the development of annual sub-district plans which should reflect needs and priorities. Individual health sub-district plans are then reviewed at district level and included within the overall district plan and budget that is submitted up to the national level.[10]

[9] MoFPED "Arrears in the Audited Financial Statements for Financial Year 2008/09", July 2010
[10] FINMAP "Mid-term Review of Local Government Performance and Service Delivery", December 2009

3.12 In practice the budget and annual plans are often produced in a very top-down manner. The MoFPED sends out indicative planning figures to the districts in January of each year and the districts, in turn, set a figure for each health sub-district and health facility. The health facility then prepares the service plan according to the allocation. This approach, whilst pragmatic given the resource constraints and the limited planning capacity at district and sub-county level, creates a lack of ownership of the budget and service delivery plan at the facility level[11]. MoH input is limited to ensuring that work plans comply with technical and financial guidelines.

3.13 Overall sector budget and financial reports include all sector expenditures, broken down by type of spending unit. Donor budget support is incorporated within the 'GoU' expenditure classification. Donor-funded project expenditure (that which is communicated to MoFPED) is included in the budget. However in FY 2008/09 this could not be reported in the outturn analysis as donors had not provided the necessary data.

3.14 Impact of off budget expenditure: A significant proportion of donor funded health expenditure is off-budget. In FY 2008/09 off-budget donor project expenditure was estimated by the MoFPED to amount to approximately Ushs. 968 billion compared to on-budget project support (approximately Ushs. 235 billion). 92.7% of off-budget donor project expenditure was contributed by United States Agency for International Development (USAID) and United States President's Emergency Plan for AIDS Relief (PEPFAR). In FY 2009/10 an even greater proportion of donor support is believed to be off-budget[12]. These funds are channeled into the sector, largely at district level, by development partners and NGOs.

3.15 MoFPED is striving to get more donor funded expenditure on budget by rolling out Integrated Financial Management System (IFMS) to donor-funded projects, but it will be several years before this initiative is complete. The MoH finds it hard to track off budget donor support, and levels of support have often been unpredictable and volatile. There are also inconsistencies between the figures being reported by the MoH and those reported by MoFPED.

3.16 Most donors choose where to direct off-budget support and this may or may not be in accordance with the priorities established by the Ministry under either the Annual Plan or HSSIP. The majority of support goes to the three disease areas - HIV/AIDS, TB, and malaria. Whilst significant benefits have been realised through off-budget donor support, there is a risk that it could distort government processes for establishing priorities, systems strengthening and investment. It also results in duplication of administrative effort and expenditure due to the creation of project management units[13].

[11] Ibid
[12] MoFPED Budget Speech FY 2008/09-2010/11 (as reported in Draft Health Sector Strategic Plan)
[13] National Budget Framework Paper FY 2009/10 to FY 2013/14

3.17 The proportion of donor project support that is on budget is a key indicator for this section of the PFM assessment. The MoH target is for all donor project support to be on budget by 2015. In FY 2008/09 only 28.6% of the resources provided were on budget.

3.18 Resource allocation criteria: There are transparent and rules-based procedures for allocating funds to districts and other spending units. These include:

- Primary Health Care (PHC) non-wage expenditure allocations based on population size, mortality indicators, and number of live births – as a proxy for need
- PHC capital development grants based on specific needs assessments
- Allocations to hospitals based on the number of beds in the facility

3.19 Allocation criteria provide a consistent and easy to understand basis for resource allocation. They allow a degree of weighting to be attached to need based on population size and key health indicators. While the specific utility of allocation criteria can sometimes be complicated by health seeking behaviour, for example, people living near district borders may choose to obtain services from a facility outside their district, the criteria in use do reflect approaches that are in common use internationally and are credible. The MoH is currently further reviewing allocation criteria with assistance from World Health Organisation (WHO).

3.20 There are currently no clear rules for resource allocation to 'hard to reach' areas and for emergency response. This remains a gap in resource planning and management. There are also major deficits in the effective use of criteria to determine the allocation of medicines from the National Medical Stores.

3.21 Information provision: At the national level information on resource allocation and transfers is published on the MoH website and policy statements and reports are freely available. The publication of information at district, and lower levels, is more problematical. Information is supposed to be displayed on notice boards at health centers, but the range and standard of information displayed is variable. Relevant information about issues affecting the sector is also made available in the print media.

3.22 Oversight of semi-autonomous bodies: The MoH has a legal mandate to exercise oversight over the different semi-autonomous bodies that operate within the sector. Each institution enters into a Memorandum of Understanding with MoH, and a representative from the Ministry sits on the Board of each of these institutions. The institutions are represented on the Health Policy Advisory Committee and on technical working groups. Despite this framework there are concerns about the actual standard and effectiveness of oversight mechanisms. Memorandum of Understandings typically lack detailed appraisal mechanisms, performance targets, and reward and sanction mechanisms.

Category 2: Comprehensiveness & transparency: overall risk rating	**Substantial**
The level of off-budget donor project support is substantial and it is clear that some donors do not	

provide sufficient and timely financial information on sector funding and assistance. This makes it very difficult for GoU to plan effectively and to match resources to health sector priorities. It also risks distorting the focused pursuit of priorities determined under the HSSIP. The basis for allocating funds to hospitals and districts is based on clear and standardized allocation criteria that are kept under review. However there is a lack of appropriate criteria to determine the supply of medicines from National Medical Stores. Given that this represents the biggest vote in the health budget this is of concern and needs to be addressed.

Category 3: Policy-based Budgeting

3.23 Budget preparation processes: Budgeting within the sector is carried out in accordance with MoFPED guidelines and agreed procedures. During the process of developing the Budget Framework Paper, there is regular communication with officials in MoFPED and a specific MoFPED budget officer is allocated to the sector to provide technical advice.

3.24 Preparation of the Health Sector Budget Framework Paper is coordinated by the Planning Department within MoH and involves consultation within the sector that draws together the key players, including development partners and civil society. However, the budget development process is hampered by frequent, and often delayed, changes to budget ceilings communicated by MoFPED.

3.25 To ensure that there is a consistent and policy-driven build-up of the budget, the MoH provides a planning framework to guide district officers in preparing their submissions. While there is a good understanding of the process at a senior level, there are doubts about the standard and content of plans emerging from the lower levels, where the need for planning and budgeting is not as readily appreciated[14].

3.26 There is also a lack of alignment of priorities between the MoH, district health teams and health facilities. There is frequently a significant disconnect between what individual facilities consider to be priorities and what is approved by higher levels in the ministry. As a result, there is a distinct lack of ownership of the budget and service plans at ground level[15].

3.27 Negotiation of overall sector allocations: With the adoption of the NDP, there is likely to be less scope for negotiation over sector (and sub-sector) allocations. The sector allocation is based on nationally agreed priorities. The NDP incorporates a comprehensive section on “Health and Nutrition”. There are eight separate objectives, with related strategies and interventions. The latest draft HSSIP is equally comprehensive, with five overall objectives, related strategies and interventions, indicators and targets, and implementing arrangements.

[14] FINMAP “Mid-term Review of Local Government Performance and Service Delivery”, December 2009
[15] Ibid

3.28 Work is ongoing to align the structure and content of the two plans. Two of the overall NDP sector objectives appear as sub-objectives in the draft HSSIP. MoFPED is currently working with all sectors, including health, to improve the alignment of sector plans with the NDP.

3.29 Alignment of plans to expenditure frameworks: Both the health objectives of the NDP and the HSSIP appear very ambitious in scope. There is an on-going exercise to cost the sector plan, using three different baseline financing assumptions. It is likely that the outcome of this will suggest that the proposed strategies and interventions need to be scaled back, and that efforts should be focused on a more limited number of achievable outcomes. The draft HSSIP is intended to inform the sector Budget Framework Paper and annual work plans. However there is a big hurdle to overcome in reconciling the cost of implementing the plan with the resources available to the sector as detailed in the most recent Medium Term Expenditure Framework (MTEF). Efforts are currently underway to develop a series of policy options that reflect a number of potential resourcing scenarios. However this is likely to be a considerable challenge and will be further complicated by the amount of resources currently provided off budget.

3.30 Under the Sector Wide Approach arrangements, there is a technical working group that analyses budget allocations to the sector and advises on the distribution of allocations among sector priorities. Within Parliament the Social Services Committee examines sector budget appropriations. However it does not review expenditure decisions, which is the role of the Public Accounts Committee.

Category 3: Policy Based Budgeting: Overall risk rating	**Substantial**
The NDP and sector strategies are ambitious given the tightening fiscal position within the sector and do not appear to adequately reflect well known capacity constraints in delivering services. The draft HSSIP has not yet been converted into detailed prioritized action plans and budgets that are clearly linked to stated policy. While there are currently attempts to do this, and to develop policy options based on different resourcing scenarios, this is likely to prove to be a considerable challenge. The high level of resources currently provided off budget is likely to make this task more complicated.	

Category 4: Predictability and Control in Budget Execution

3.31 Processes for release of funds: Funds are released to spending units once the required documents have been completed and approved by the Budget Monitoring and Accountability Unit (BMAU) within MoFPED. These include work plans, procurement plans, and performance reports. Within the BMAU there are staff with health sector experience. Enquiries by the assessment team confirmed that they make field visits.

3.32 Timeliness: Releases to district health services in FY 2008/09 were 5.6% higher than the approved budget (covered by supplementary appropriation). However funds were often released late with significant implications for service provision and proper utilization and control. During a field visit to Mpigi district, the assessment team was told that the fourth quarter budget release was received by

the district in the first week of June. There is anecdotal evidence of significant delays at district level in transferring the funds from district accounts to lower level Primary Healthcare non-wage accounts. However, documentary evidence to confirm this was not available.

3.33 The 2009 Public Expenditure Review also identified delays in the transfer of funds from district general fund accounts to health sector accounts as a significant problem. It found that at the district level, approximately 14% of funds did not reach their intended recipients. PNFP facilities tended to receive the least proportion of their budgets.

3.34 Financial and management controls: The draft HSSIP states that a comprehensive system of financial and management controls has been established. Significant effort has gone into developing objectives, and outlining 'interventions' that might achieve these standards, and in specifying performance indicators. However the 'core' of the internal control system, i.e. the identification and management of financial and operational risks, is still lacking.

3.35 Arrangements exist for controlling expenditure at service delivery level. However a number of surveys and tracking studies have identified poor compliance with expenditure controls, evidenced by unaccounted expenditures and counterfeit receipts[16]. Budget execution guidelines are also frequently not followed. A tracking study in 2009[17] found that public regional and national referral hospitals typically did not spend the specified percentage (50% and 40% respectively) of PHC grant on Essential Medical Health Supplies (EMSH)[18]; and that less than 10% (or none at all) was allocated to the repair and maintenance of medical equipment. Whilst the procurement and delivery of essential medical supplies has since been recentralized (partly in response to this problem) this example serves to highlight the issue of with non compliance with guidelines and rules.

3.36 Audit: An independent internal audit function exists within the MoH, headed by an Assistant Commissioner who reports to the Permanent Secretary. The function has a separate budget line; the relationship with the Permanent Secretary is governed by an audit charter; and international auditing standards are applied[19]. However, the effectiveness of the internal auditing function seems to be constrained by a number of factors. These include:

- Difficulty in accessing the required information to develop audit plans
- Lack of appreciation by MoH staff of the role of internal audit
- Limited action taken by ministry officials on audit recommendations.

[16] Assessment of Governance Challenges to Health System Performance
[17] MoH "Essential Medicines and Health Supplies Tracking Study", October 2009
[18] Ibid
[19] Draft Health Sector Strategic Investment Plan, 2009/10 to 20124/15

A separate internal audit function also exists at district level, but the district audit teams cover all sectors and don't necessarily have sector-specific experience. Audit visits to local health facilities are irregular and usually focus on compliance issues.

3.37 Control of essential medicines and supplies: A significant proportion of the health sector budget is consumed by Essential Medicines and Health Supplies (EMHS). The 2009 Budget Framework Paper included a 2009/10 budget projection for Pharmaceuticals and other Supplies of Ushs. 301 billion (including on-budget donor funds). Long standing concerns exist regarding some weaknesses in the management and supply chain. An Essential Medicines and Health Supplies (EMHS) Tracking Study, finalized in October 2009, identified numerous, often systemic, failings. The 2009/10 Budget Framework Paper acknowledged:

> *'large scale deficiencies in the management of pharmaceutical supplies, leading to reports of 72% of facilities with inadequate or no stocks of the essential six tracer drugs at any one time in 2007/08. There are deficiencies in procurement planning by user entities at district and hospital level, further constraining the timeliness of supply'.*

3.38. New arrangements for the procurement and distribution of EMHS were introduced in July 2009. All supplies are now procured and distributed by the National Medical Stores which were recapitalized and provided with support to improve the supply chain. It remains to be seen whether or not this will result in improvements in the availability of supplies and the incidence of stock outs at health facility level.

3.39. There is considerable waste in procuring and maintaining capital items. Ambulances are grounded due to lack of funds for maintenance and fuel. Poor management and oversight of works services has allowed contractors to get away with shoddy work resulting in unused buildings whose specifications do not meet the needs of the health facility[20].

3.40 Human resource management and supervision: One of the main difficulties experienced in delivering healthcare services is the recruitment and retention of suitably qualified personnel. In 2008/09 only 56% of establishment posts were filled by qualified staff. There are large regional inequalities and discrepancies between referral hospitals, where the proportion of qualified staff is relatively high, and local health centers. Rates of absenteeism are also significant, and have been estimated to be to be as high as 37%[21]. In one particular district, visits to health facilities failed to find the 'person in charge' for four out of five health centers visited[22].

3.41 The failings in service delivery identified in this section can be partly attributed to a lack of leadership, management and supervision. Managers do not effectively exercise their leadership roles

[20] FINMAP "Mid-term Review of Local Government Performance and Service Delivery", December 2009
[21] "Public Expenditure Review (Focus on Affordability of Pay Reform) and Health Sector", May 2009
[22] FINMAP "Mid-term Review of Local Government Performance and Service Delivery", December 2009

and the administrative sanctions available are often not applied. The quality and extent of monitoring and supervision throughout the sector remains a major issue. This has been blamed on limited financial resources and logistics, as well as inadequate systematic and effective support from the relevant ministries[23].

3.42 Lack of supervision is particularly evident at community level. The Health Unit Management Committees that are expected to play a part in oversight of the facilities lack the resources and the capacity to perform their role. There are no structured supervisory visits by the district or sub-district administrations – only 10 out of 67 facilities in one particular district had any written reports from supervision[24].

Category 4: Predictability and control in budget execution	**High**
Delays in the transfer of funds appear to remain a significant issue resulting in interruption to the delivery of services. The supply and control of drugs and other medical supplies has been a problem although attempts have recently been made to address this with reorganization of NMS. The impact of this remains too early to judge. The effective delivery of health services is constrained by human resources capacity issues including recruitment and retention, high rates of absenteeism and poor supervision and management. A recent study conduced by the World Bank, MoH and MoFPED[25] estimated that the health sector loses Ushs. 36.7 billion annually due to waste through worker absenteeism, expired drugs and poor payroll management.	

Category 5: Accounting, Recording, and Reporting

3.43 Roll out of IFMIS: The central government Integrated Financial Management System (IFMS) is currently operational at MoH headquarters and other central institutions, regional hospitals and some local governments. According to the draft HSSIP the introduction of IFMS has delivered a number of benefits[26].

3.44 However there are major challenges in rolling out the system across the health sector. Where users are geographically dispersed, as is the case with healthcare facilities, the cost of establishing and maintaining the necessary IT infrastructure is substantial. For the foreseeable future, therefore, data will continue to be transmitted manually from most districts and all lower level facilities. This leaves open the possibility of incomplete and unreliable capture of financial information.

3.45 Compliance with accounting regulations: The draft HSSIP states that the sector follows the Public Finance and Accounting regulations 2003 and Local Government Finance and Accounting

[23] Ibid
[24] FINMAP "Mid-term Review of Local Government Performance and Service Delivery", December 2009
[25] World Bank, MoH, MoFPED, 2009, "Fiscal Space for Health in Uganda"
[26] "Draft Health Sector Strategic and Investment Plan", 2009/10 to 2014/15

Regulations 2007. These regulations are comprehensive and are designed to ensure that there is transparency and accountability in the utilisation of public resources. However there is significant non-compliance with laid-down procedures. The Auditor General's Report for 2008/09 identified several weaknesses in the standard of recording and accounting at the MoH. These included:

- A change in the reported overdraft on the expenditure account, compared with the year-end position for 2007/08, was not properly reconciled
- Funds advanced totalling Ushs. 858.7 million, for which there was no budgetary approval, had not been accounted for
- Documents relating to in-year accumulated arrears, said to be Ushs. 427.2 million, were not available for audit
- Payments amounting to Ushs. 95.7 million to one particular company lacked supporting documents. Management's position was that 'they were still verifying the records to establish the linkage with the original documents'.

3.46 Reporting: In-year release of funds to districts is dependent upon receipt by MoFPED of quarterly financial (Form A) and performance (Form B) reports. Releases are often delayed because of delays in completion of these reports. Specifically, the extent of information required in Form B on outputs (output description, output indicator, timing of outputs, activities to deliver outputs, inputs) for each programme and project appears excessive for quarterly reporting purposes. Districts have stated that they require, on average, two weeks to complete the forms and that 'it is difficult to incorporate the required information for activities that run across quarters or outputs which may not be realized within any relevant quarter of reporting'[27]. Late submission and approval of the forms is reportedly one of the underlying reasons for the late release of funds. This has negative impacts on service delivery.

3.47 Donor projects: The extensive number of donor-funded projects (60) that require separate accounting and banking arrangement place a significant burden on MoH finance staff. Even projects that purport to use existing government PFM systems frequently require additional project-specific safeguards (e.g. recruitment of discrete 'project' staff to handle the project finances; enhanced oversight arrangements etc). This additional accounting and reporting burden is often complicated by the fact that the projects have their own specific requirements and reporting formats.

3.48 HMIS: Information on aspects of service delivery is collected by the Health Management Information System (HMIS). However the HMIS faces a number of challenges. Timeliness of reporting is currently estimated at 68%. Data analysis and its utilization for planning purposes remain low[28]. The existence of parallel data collection systems for vertical programs, including some donor projects, puts a

[27] FINMAP "Mid-term Review of Local Government Performance and Service Delivery", December 2009
[28] "Draft HSSIP Strategic and Investment Plan", 2009/10 to 2014/15

strain on the capacity HMIS personnel. Lower level facilities complain that 'they have inadequate knowledge to fill out the reports and that it takes a lot of time'. Standards of record keeping are often extremely poor[29].

3.49 Annual Health Sector Performance Report: The MoH publishes an Annual Health Sector Performance Report. This provides a comprehensive description of activity throughout the sector and sets out results against a wide range of indicators and targets, for the delivery of clinical services. The Annual Report provides a frank and useful assessment of the successes and challenges faced in the sector over the previous year and it is discussed extensively within the Health Policy Advisory Committee (HPAC) and more widely.

3.50 Key indicator: The key indicator for 'Accounting, Recording and Reporting' is the number and proportion of budget entities receiving an unqualified audit opinion. Table 5 below summarises trends in the number of clean audits achieved by health sector spending units. While the coverage of units increased, the percentage of clean audits fell from 69% in 2006/07 to 50% in 2008/09[30] . It is significant to note that for the last three years MoH and Mulago Hospital have never achieved an unqualified opinion (clean audit). In addition, six referral hospitals that received unqualified opinions in 2007/08 obtained qualified opinion in 2008/09, indicating a worsening trend in the number of clean audits in the health sector.

Table 5: Health Sector Audit Opinions: 2006/07, 2007/08 and 2008/09

Financial year 2006/07			
Spending unit/unqualified opinion	**Spending unit/qualified opinion**		
Soroti Referral Hospital	Ministry of Health		
Arua Referral Hospital	Mulago Hospital		
Kabale Referral Hospital	Butakiba Referral Hospital		
Hoima Referral Hospital	Mbale Referral Hospital		
Mbarara Referral Hospital			
Health Service Commission			
Masaka Hospital			
Lira Hospital			
Uganda Blood Transfusion Services			
	No. of audits	**No. clean audits**	**% of clean Audits**

[29] Ibid
[30] The last year for which audited accounts are available.

Totals 2006/07	**13**	**9**	**69%**
Financial year 2007/08			
Spending unit/unqualified opinion	**Spending unit/qualified opinion**		
Butukiba Referral Hospital	Ministry of Health		
Uganda Blood Transfusion Services	Mulago Hospital		
Soroti Referral Hospital	Uganda Aids Commission		
Mbarara Referral Hospital			
Kabale Referral Hospital			
Masaka Referral Hospital			
Jinja Referral Hospital			
Hoima Referral Hospital			
Fort Portal Referral Hospital			
Mbale Referral Hospital			
	No. of Audits	**No. clean Audits**	**% of clean Audits**
Totals 2007/08	**13**	**10**	**76%**
Financial year 2008/09			
Spending unit/unqualified opinion	**Spending unit/qualified opinion**		
Health Service Commission	Ministry of Health		
Uganda Blood Transfusion Services	Lira Referral Hospital		
Gulu Referral Hospital	Mbale Referral Hospital		
Soroti Referral Hospital	Jinja Referral Hospital		
Mbarara Referral Hospital	Arua Referral Hospital		
Kabale Referral Hospital	Fort Portal Referral Hospital		
Masaka Referral Hospital	Hoima Referral Hospital		
Butabika Referral Hospital	Mulago Hospital		
	No. of Audits	**No. clean Audits**	**% of clean Audits**
Totals 2008/09	**16**	**8**	**50%**

Source: Annual Reports of the Auditor General 2006/07 - 2008/09

Category 5: Accounting, Recording and Reporting: Overall risk rating	High
Half of health sector spending units did not receive a clear audit opinion in 2008/09 and six referral hospitals that obtained clean audits in 2007/08 did not maintain that standard in 2008/09 – they were given qualified opinions by the Auditor General. There are numerous examples cited in the Auditor General's Reports of poor financial management and the standard of record keeping and accounting within the sector.	

Category 6: External Scrutiny and Audit

3.51 The Office of the Auditor General (OAG) has been strengthened over the last two years and now benefits from new legislation that provides for his independence.[31]The office carried out an extensive range of audits within the health sector as part of its audit of the 2008/09 financial statements.

3.52 A review of the Auditor General's 2008/09 Report for Central Government identified numerous instances of poor financial management within the MoH. The 2009/10 Health Sector Budget Framework Paper reported that the Auditor General had identified numerous instances of misappropriations of funds meant for drugs, as well as drug theft from health units.

3.53 The Office of the Auditor General carried out a 'value for money' (VFM) study in 2008/09 titled 'Procurement and Storage of Drugs by National Medical Stores'. The report identified numerous failings and weaknesses. However, there was no indication as to whether management accepted the report's findings, conclusions, and recommendations although new arrangements for the procurement and distribution of EMHS through the NMS were introduced in July 2009.

3.54 Ministries and agencies generally have a poor track record with regard to acting on audit recommendations. This attitude is partly driven by the weak and ineffective arrangements for government (through the MoFPED) to officially respond to audit findings and recommendations through the issuance of a Treasury Memorandum (TM) following approval of Public Accounts Committee (PAC) reports by Parliament. In 2008/09, the Auditor General identified nine separate issues that had been raised in his previous year's report for which MoH management had not provided adequate information on the action being taken. This notwithstanding, the MoH is the only sector ministry that has developed an action plan to address these issues. Also, the Auditor General is invited to make a presentation during the annual Joint Review Mission.

3.55 Financial management of the World Bank Health Systems Strengthening Project is being mainstreamed within the MoH. It will draw on existing GoU internal and external audit arrangements which were assessed by the World Bank and considered to be adequate for managing the project.

[N]eeds to be deleted

Category 6: External Scrutiny and Audit: Risk rating	**Substantial**
The capacity of the Auditor General's office has been strengthened, and its standard of reporting has improved. The MoH is the only sector ministry to have developed an action plan to address audit report issues. However ensuring that prompt and effective action is taken in response to audit recommendations remains a key challenge and one that primarily has to be addressed at the national level through the Treasury Memorandum mechanism provided for follow up of audit findings.	

4 Assessment of Key Fiduciary and Corruption Risk

Fiduciary Risk

4.1. The key fiduciary risks identified in this assessment are set out and explained below. They have been identified from an analysis of the standard of public financial management (detailed in Section Three) and from reviewing the extensive range of sector specific plans, performance reports, and research and diagnostic studies.

The overall level of fiduciary risk is rated as Substantial. There have been several instances of financial mismanagement at senior levels in the Ministry of Health. This has impacted on the standard of leadership, governance and integrity at the centre. A significant proportion of funding for the sector comes from donors and most project expenditure remains off-budget. Translating the new five year Health Sector Strategic and Investment Plan, which is very ambitious, into achievable focused prioritized plans and operational budgets will present significant challenges. There are major inefficiencies in the delivery of healthcare services and wastage and evidence of 'leakage' at all points in the supply chain.

1	**Poor governance and integrity within the Ministry of Health**
	Several high profile cases of financial mismanagement and corruption have resulted in a legacy of poor governance, integrity and leadership at senior levels. Whilst these led to considerable increased scrutiny of the sector both within Government and by development partners as well as the institution of new arrangements for the management of project resources, the embedding of systematic arrangements within the ministry for ensuring good governance and reducing the scope for corruption remains work in progress. There is a 'Health Governance Strategy and Action Plan' that has come in conjunction with the World Bank 'Uganda Health Systems Strengthening' project. It remains to be seen whether this will be sufficiently 'owned' by senior health sector officials.

2	**Expenditure arrears continue to be accumulated**
	The stock of expenditure arrears increased by 60% in 2008/09, from Ushs. 1.7 billion in 2007/08 to Ushs. 6.18 billion in 2008/09. The policy in place for their reduction is one of arrears having first call on new resources. However, this carries over the problem rather than addressing the cause, and may not be sufficient. Given that the health sector is suffering from a fiscal squeeze as a result of static real-spending terms, increasing population, and high healthcare inflation, it will be difficult to eliminate arrears without

	affecting the level and quality of care.

3	**Most donor project support is off budget**
	Over 70% of donor project support is off-budget. This presents serious planning and accounting challenges within the sector, especially at the Ministry of Health, where the accounts team manage 60 separate project accounts (with up to 120 associated bank accounts). To compound this problem, donors are deficient in providing timely and reliable data - the 2008/09 sector accounts were incomplete because some donors had not provided the required data. The high level of donor funding of the sector, both on and off budget, exposes the provision of services to considerable risks such that if donor funding was suddenly cutback (for example, in response to evidence of financial mismanagement and corruption) a crisis in service delivery would be precipitated.

4	**Strategic plans (the National Development Plan and the [draft] Health Sector Strategic and Investment Plan) bear little relationship to what can realistically be delivered**
	Health sector strategic plans are extremely ambitious and are unrealistic given the current projected forward resource envelope. Although attempts are being made to cost the latest HSSIP covering the five year period 2009/10 to 2014/15, it will remain a challenge to convert this into agreed practical task-based and prioritized action plans. There is a risk that there will be no effective policy link to budget development and hard decisions on priorities could arguably be evaded at the national level.

5	**There are serious inefficiencies and wastage of resources at service delivery level**
	Overall failings in public service management are contributing to fiduciary risk within the sector. Weak human resource management, limited financial management skills, and ineffective supervision, coupled with low capacity and motivation of health workers, has resulted in poor levels of service delivery in many areas. This problem is exacerbated by poor standards of infrastructure (e.g. poorly maintained clinics and a lack of housing for key

	sector workers) and shortages of functioning equipment. Health worker absenteeism has been estimated at 42.5% costing approximately Ushs. 63 billion per year, based on November 2010 data.[32].

6	**There have been significant weaknesses at all levels of the Essential and Medical Health Supplies (EMHS) management and supply chain**
	Despite existing training programmes, many healthcare workers still lack the skills to manage stocks of medicines and supplies. The National Medical Stores continue to experience difficulty in managing and distributing supplies. This has resulted in regular stock outs of basic supplies at most health facilities. There are high levels of wastage, with expired drugs being destroyed; and anecdotal evidence points to the fact that the leakage of supplies from all points of the chain remains a considerable problem. New arrangements for the procurement and distribution of EMHS were introduced in July 2009 – all supplies are now procured and distributed by the National Medical Stores. NMS was recapitalized and support provided to improve the supply chain. It remains too early to judge whether or not this has resulted in improvements in the availability of supplies and the incidence of stock outs at health facility level. This will require close monitoring.

Risk of corruption

The overall risk of corruption in the health sector remains high. There have been several instances of grand corruption over the last few years. The international and national attention which these cases received has probably reduced the short term risk of grand corruption and led to the introduction of new institutional arrangements and controls. However there are still major issues related to the effective control of assets and the effective management of staff which require ongoing and systematic attention.

4.2 The key corruption risks in the health sector are set out below. The major forms of corruption that have occurred in the sector are described and progress in addressing them is assessed. Drivers of corruption are identified.

1	**Forms of corruption**

[32] "Draft Final Appraisal Joint Assessment Framework 2" 18 November 2010 based on 12 November 2010 preliminary data

	Grand corruption. There have been several instances of grand corruption within the sector over the last five years involving senior health officials. The Global Fund to Fight Aids Tuberculosis and Malaria (GFATM) suspended its grant in August 2005 after its local fund agent identified serious mismanagement of GFATM funds estimated to amount to USD $1.6 million. An IGG report on the use of funds provided by the Global Alliance for Vaccines Initiative found "gross mismanagement and abuse of funds by officials in the Ministry of Health and others who were not officials of the Ministry" with up to USD 2 million reported to have been misappropriated. In 2009 the IGG directed that the Principal Accountant of the Ministry of Health should be dismissed after he was accused of submitting a false declaration of his income, assets and liabilities, as required by the 2002 Leadership Code. Lack of adherence to procedures for the procurement or contracting of goods and services: The Auditor General's report for FY 2008/09 identified a number of cases where procurement and contracting rules and procedures were flouted. Procurements amounting to Ushs. 356 million for the supply of goods and services were made without following proper PPDA procedures. In the management of public works the report identified two instances where Ushs. 907 million was paid to two construction companies for construction work in public hospitals without any evidence that the work was properly supervised and that interim certificates were certified by the Ministry of Works and Transport. Misuse and ineffective control of Essential Medicines and Supplies: A large proportion of the health sector budget is used to procure essential medicines and health supplies (EMHS). It is anticipated that in 2010 over Ushs. 301 billion will be spent on the procurement of pharmaceuticals and other supplies. There is a long history of concerns about weaknesses in the management and supply chain. An Essential Medicines and Health Supplies (EMHS) Tracking Study in October 2009 identified numerous, often systemic failings and suggested that there was significant leakage at almost all points in the supply chain. Levying of informal user fees and charges The 3rd National Integrity Survey (NIS III) suggested that the levying of informal user fees or demands for bribes for the provision of services remained widespread and was a significant problem.

2	**Progress**
	Government responded to the GFATM and GAVI scandals in a number of ways. The three Ministers of Health charged with overseeing the programme were removed in May 2006 and Government established a Commission of Inquiry chaired by then Principal Judge of the High Court. The report of the Commission recommended further investigation into the three Ministers and other managers of the Grants. Government also committed itself to recovering

	the misappropriated funds and to initiating further legal action if necessary. A review of project funding arrangements within the MoH was initiated. There have so far been four convictions of persons implicated in the misuse of the Global Funds after a protracted process of investigation, prosecution and creation of a special division to try corruption cases in July 2008. The Auditor General's report of FY 08/09 noted that approximately USD $514,285 of the misappropriated funds had been recovered, although this fell below the target set. At an institutional level new modalities (known as Long Term Institutional Arrangements) for the management of projects were introduced. These modalities seek to more closely align the management of these funds with government processes and systems, and to strengthen the capacity of the Ministry of Health to perform program management functions. New arrangements for the procurement and distribution of EMHS were introduced in July 2009. All supplies are now procured and distributed by the National Medical Stores. At the same time the NMS was recapitalized and support provided to improve the supply chain. The GFATM and GAVI cases revealed the extent to which some senior officials were prepared to abuse their authority, as well as the lack of adherence to financial controls and regulations within the Ministry. To some extent the high levels of publicity that the GFATM and GAVI cases received may have reduced somewhat the risk of occurrence of grand corruption in the MoH. The roll out of the LTIA arrangements should also improve the management of project funds and ensure better controls. However these high profile cases severely dented the reputation of the Ministry and highlighted the extent of the risk of corruption both within the MoH and across Government more widely. The control of essential medicines and supplies, adherence to procurement and contracting rules, and the levying of informal charges for access to services are some of the systemic and inter-related issues affecting the organization and management of health services that will require concerted efforts in order to be addressed effectively.

3	**Drivers of corruption**
	There are a number of key drivers of corruption within the health sector. <u>Poor strategic direction, management and leadership:</u> Policy and decision making processes within the sector remain weak and priorities poorly defined. Policy documents are extremely, and arguably, overly ambitious, and are often not translated into clear, focused and prioritised work plans that systematically tackle key issues. Sector leadership has been fluid in the past years with more than 40% of top leadership positions vacant. Despite some improvements, a number of challenges remain. These include the need for systematic and

	concerted action to respond to the findings of audit reports, ensuring compliance with accounting and procurement procedures, enforcement of proper recording keeping and reporting, and the application of sanctions when required. Inefficient disbursement and release of resources While resource tracking surveys suggest that there have been improvements in the proportion of resources reaching their final destination there are continued reports of significant delays in the release of funds, especially releases for the fourth quarter which are sometimes received less than a month before the end of the financial year. Late release often results in the circumvention of procurement rules and procedures. Delayed public sector reforms: Reforms intended to systematically address human resource management and restructuring, including pay and performance related issues have not been taken forward at the pace or extent that is required to achieve meaningful results. Sector resourcing The fact that over 70% of donor project support remains off budget presents considerable constraints and risks. The management of these projects and programmes arguably diverts attention and resources from ensuring that internal controls and processes are strengthened and complied with. While the introduction of the LTIA processes is an attempt to address this implementation, enforcement remains an ongoing challenge.

5 Assessment of whether reform activities are judged to be credible

5.1 The extent to which the country level reform programme (essentially FINMAP) will affect the health sector is considered in the country level fiduciary risk assessment. This assessment focuses solely on activities that are specific to the health sector.

5.2 The assessment considers whether health sector reform programmes are 'credible' enough to address recognized needs, as identified by the following key fiduciary risks:

- actions to improve governance and leadership within MoH and also at local level;
- actions to address human resource delivery constraints (at local level);
- actions to improve efficiency of resource usage and effectiveness of service delivery;
- actions to improve management and performance of drugs supply chain;
- actions to reduce leakage and petty corruption (e.g. charges for 'not for sale' drugs).

Overall sector reform plans and processes

5.3 Key government plans for the sector are set out in both the National Development Plan and the draft HSSIP. Both these documents recognise that there is need to address a range of issues related to the management of health services, including the control of supplies and medicines, the better supervision of health staff and financial and technical reporting.

5.4 The NDP identifies a number a number of constraints within the sector which affect the ability of Government to deliver the UNMHCP. These include weak policy, legal and regulatory frameworks, inappropriate structures for inter-sectoral collaboration, and ineffective human resource management, supervision and monitoring at all levels. The document lays out a number of objectives and strategies to address these issues.

5.5 The HSSIP is intended to cover the period 2010-2015. It identifies constraints to health sector performance and outlines government plans to address these. Specific issues related to overall governance and leadership, human resources, and resource usage (including drugs and medical supplies) are highlighted in the document.

Related projects

5.6 There are a number of on-going projects within the health sector that should underpin efforts to address the needs identified. Four projects are worthy of specific mention given their focus on supporting and underpinning critical reform processes and addressing identified weaknesses in the sector. They are:

1) World Bank Strengthening Health Systems Project 2010 – 2015

2) BTC and SIDA: Institutional Capacity Building in Planning, Leadership and Management in the Ugandan Health Sector: 2010 – 2014

3) USAID – Securing Ugandans' right to Essential Medicines (SURE) Project

4) Transparency International – Transparency and Integrity in Service Delivery in Africa (TISDA)

These projects have an important role to play in informing and establishing the basis for reform but will need strong political support from both within and outside the sector to be taken forward and appropriately mainstreamed if they are to be sustainable.

Credibility of reforms

5.7 Issues identified as key to the credibility of reform processes are identified and discussed below.

Government leadership

5.8 Key policy documents identify, largely accurately, key capacity constraints in the sector and the need for reform in a number of areas. The corruption scandals involving GFSATM and GAVI funds in particular arguably served to highlight the seriousness of the issues faced within the sector and brought a degree of political commitment and impetus for reform both from within the sector and from political leadership. However the depth and extent to which reform processes are fully owned within the MoH and are given appropriate priority remains questionable. Approaches to tackling specific issues are often ad hoc and appear to be based on "fire fighting" and the deflection of public or donor demands for action rather than the incremental and systematic addressing of the structural and institutional issues within the sector. An example of this is the establishment within the President's Office of a unit to monitor the use of medical supplies (the National Unit for the Monitoring of Medical Supplies) rather than unequivocal political support for efforts to ensure that the sector has the leadership and resources required to deal with these issues.

5.9 In theory donors are harmonised around sector priorities outlined in the HSSIP and engagement is managed through the development partners group and the SWAP process. Health development partners are also represented on the Health Policy Advisory Committee. There have been notable attempts to ensure more effective sector donor coordination and harmonisation in line with the Paris Declaration.

5.10 However in practice harmonisation still presents major challenges. A significant proportion of donor sector project support (over 70% in FY 2010/2011) to health remains off budget and this significantly risks undermining efforts to promote and build ownership and systems within the MoH. While the introduction of the LTIA in the wake of the GFATM and GAVI scandals was an important step towards promoting greater harmonisation the number and volume of projects remains a significant challenge. Even when projects are "on budget" it has to be noted that a significant proportion of MoH personnel time is inevitably taken up in managing and servicing project requirements rather than

carrying out activities aimed at strengthening the core functions of the MoH and service delivery systems in line with sector priorities.

Are proposed reforms realistic and achievable?

5.11 The National Health Policy (NHP II) and draft HSSIP are intended to articulate GoU plans and priorities for improvements in health status and the delivery of services. The NDP also highlights actions that are required to address key constraints affecting performance and delivery in the sector.

5.12 Overarching plans of this nature should, by definition, be wide in scope and ambitious. However the HSSIP is arguably over ambitious and will be seriously under resourced based on current projections of sectoral allocations over the next five years. Translating the HSSIP into clear and prioritised work plans will be a significant challenge and there is a risk that the key reforms required will not be prioritised and taken forward in a systematic and incremental manner.

Demands for change

5.13 The GFATM and GAVI scandals did serve to create a spotlight on the situation in the sector and brought calls for change at the national and international levels. The non-availability of essential drugs and high rates of health worker absenteeism are concerns that have been increasingly voiced by Ugandans' including those living in rural areas. A number of civil society interventions supported by donors have sought to increase voice and accountability on health issues.

5.14 This creates long term opportunities for better accountability and increased responsiveness within the sector. However turning these concerns into practical and deliverable solutions that are institutionalised within service delivery structures will require concerted and ongoing efforts both by those within and outside the sector. Many ordinary Ugandans, especially those living in remote and particularly underserved areas, still have relatively little knowledge of their rights or the capacity to effectively hold service providers to account.

6 Assessment of the Financial Impact of PFM Weaknesses

6.1 The potential financial impact of weaknesses in the PFM system, as highlighted by the key fiduciary risks set out in Section 4, has been calculated by reference to DFID guidance[33]. This analysis covers those key fiduciary risk areas for which there is a specific related flow of funds. As such, the analysis focuses on two specific risks – the build-up of expenditure arrears and the supply and distribution of medicines and health supplies.

6.2 The results are set out in Table 6.1 below[34]. The estimated flow of funds and estimated financial impact relate to a fiscal year. The identification of additional safeguards is considered in Section 7.

Table 6.1: Summary of estimated financial impact of PFM weaknesses

PFM System	Nature of risk	Estimated flow of funds	Estimated financial impact	Basis of calculation
Supplies	Loss and theft of medicines and drugs from all points of the supply chain.	Ushs. 54.67 billion	Ushs. 1.3billion	Flow of funds based on 2009/10 outturn for NMS in budget entities' vote analysis, as set out in MoFPED Annual Budget performance Report October 2010. Estimates from MoFPED, World Bank, and MoH study Fiscal Space for Health in Uganda March 2010.
Payroll	Absentee staff paid for services they are not providing.	Ushs. 152.21 billion	Range Ushs. 63.9 billion	Health worker absenteeism is currently estimated at 42.5% (Draft

[33] Paragraphs 51-54 and Annex 117 of the How to Note
[34] Based on the format presented in Annex 17 of the How To Note

PFM System	Nature of risk	Estimated flow of funds	Estimated financial impact	Basis of calculation
				Joint Assessment Framework (JAF) Final Appraisal 18 November 2010, based on 12 November 2010 preliminary data)
Expenditure Arrears	Significant arrears will attract interest payments and have previously resulted in successful legal action against GoU. Also, the prospect of delayed payment can result in contractors and suppliers charging premium prices.	Ushs. 8.21 billion	Ushs. 358.8 million	Expenditure arrears stood at Ushs. 8.21 billion at 30 June 2009. The approved 2009/10 budget included provision for payment of arrears of Ushs. 2.23 billion. Interest (at 6%) on aged (over 12 months) arrears (Ushs. 5.98 billion) amounts to Ushs. 358.8 million.

7 Safeguards and Residual Risks

7.1 Having identified fiduciary risk, the usual approach is to incorporate short-term safeguards into the design of aid instruments and programmes. These safeguards should be focused on control over the use of resources by Ministries Departments Agencies (MDAs) and local governments. In designing short-term safeguards, care should be taken to avoid those that may have negative impact on national systems. The aim should be to continue to encourage the development of PFM best practice systems. In Uganda this means further developing technical capacity and consolidating and broadening the ongoing FINMAP implementation process.

7.2 This is already occurring with the ongoing harmonised Developing Partners (DPs) support behind a strengthened approach to PFM that through a process of broad consultation is supporting the current FINMAP and developing an improved sequencing and prioritisation of PFM reform measures to be implemented under the next phase of PFM reform. Ongoing support to the FINMAP meets the three DFID key criteria of: (a) country led PFM reform strategy and action plan; b) co-ordinated multi-year programme of work that supports and is aligned with the Government's PFM reform strategy and c) shared information pool.

7.3 Well designed safeguards should contribute to managing fiduciary risk in both the short term, by reducing the risk of leakage and inefficiency in the use of funds, and in the long term, by strengthening PFM systems. Each safeguard should have a clear rationale, linked to a clearly defined risk. The safeguards proposed have been designed with these factors in mind and also the wider governance situation.

7.4 The residual risk is an assessment of that risk which is likely to remain, after the application of the safeguard and any reform programme. In most programmes and activities, there will normally be an element of residual risk that cannot be eliminated.

7.5 The fiduciary risks in Section 4 have been mapped to the planned reforms in order to identify residual risks i.e. those not covered by existing reform programmes or only addressed in the long-term. The fiduciary risks are addressed by FINMAP and other initiatives and therefore are not appropriate for short-term safeguards, as they would risk undermining the coherence of longer term reforms. However, it should be noted that timescales for these reforms to take place are medium or long term in many cases, so that fiduciary risks will remain for some time.

7.6 A number of risks are caused, in part, by weak procurement capacity and insufficient procurement audits and enforcement. Neither of these causes will be substantially reduced in the short-term, although both are included in FINMAP reforms. While areas for short-term safeguards are limited, a separate DFID consultancy has recommended short term safeguards for procurement focusing

on developing civil society organisations (CSO) capacity in getting organised to undertake a monitoring role.[35]

Risk description	Short term Safeguards	Residual Risk	Monitoring
1. Non-compliance with procurement rules; weak procurement capacity; insufficient procurement audits and enforcement	Assistance to CSOs in getting organised to undertake this role, in terms of management, identifying suitable resources and addressing internal issues of ensuring confidentiality, no conflicts of interest etc. Training to all CSOs on procurement issues and what to monitor. Assistance in sensitising local communities on procurement monitoring issues and their constitutional rights – this would include such things as providing simplified guides to the procurement rules and related laws to district CSOs to enable them to educate local communities . Such sensitisation could also be conducted by CSOs for the private sector. Assistance to district CSOs in understanding how to prepare integrity pacts. Ongoing mentoring by external experts (particularly with sector specific skills) to undertake monitoring alongside civil society in the short term. This will be necessary both for capacity building	M	Joint Assessment Framework Annual Sector Performance Report FINMAP Progress Reports PPDA procurement audits PPDA Compliance Checks CSOs reports

[35] Department for International Development, *Additional Safeguards for Procurement*, email from Crown Agents consultants November 2010

Risk description	Short term Safeguards	Residual Risk	Monitoring
	purposes and to give credibility to CSOs in the short term.		

8 Monitoring Fiduciary Risk

8.1 Health sector fiduciary risk and service can be monitored by using a small number of key performance indicators, which are already in place. The JAF already monitors key fiduciary risks identified in this assessment.

8.2 This includes for JAF at the national level:

- expenditure arrears (Auditor General annual reports)

At the health sector level JAF includes:

- proportion of approved posts filled by qualified health workers (HR-MIS)
- health worker absenteeism rate (UBOS annual survey)
- proportion of health facilities without drug stock outs for 6 tracer drugs (MoH Annual Survey).

8.3 In addition the HSSIP has developed a comprehensive monitoring and evaluation framework that is based on HMIS and the Annual Health Sector Performance Report. During the life of the HSSIP a priority for the health sector is to strengthen HMIS through filling of vacancies, in service training, provision of requisite hard and software.

Against this background, no new indicators are recommended. Instead, it is recommended that the key fiduciary risk indicators that are already operational be used to monitor performance.

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