TRANSITION TO PROGRAMME BUDGETING IN UGANDA: STATUS OF THE REFORM AND PRELIMINARY LESSONS FOR HEALTH

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World Health Organization

HEALTH FINANCING CASE STUDY No 20
BUDGETING IN HEALTH

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(Health financing case study; no. 20. Budgeting in health)

ISBN 978-92-4-002777-0 (electronic version)
ISBN 978-92-4-002778-7 (print version)

Suggested citation. Abewe C, Margini F, Mwami E, Mwoga J, Kwesiga B. Transition to programme budgeting in Uganda: status of the reform and preliminary lessons for health. Geneva: World Health Organization; 2021 (Health financing case study; no. 20. Budgeting in health). Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

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Production: Phoenix Design Aid A/S, Denmark

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FOREWORD

Public financing is critical for countries to make sustainable progress to Universal Health Coverage (UHC). Since the early 2000s, Uganda has undertaken major budgetary reforms to optimize budget planning, transparency and accountability. The two major reforms over this period include the shift from input-based budget approach to output-oriented budgeting (OOB) in FY 2008/09, followed by the introduction of Programme Based Budgeting (PBB) in FY 2017/2018.

This assessment sets out to review the status of PBB implementation in the health sector, with the purpose of informing and strengthening the transition to PBB and thus improving health service delivery outcomes. The report describes the transition from OOB to PBB and provides an analysis of the current budget structure. Some of the suggestions from this assessment have already been key in ensuring that the full potential of the PBB reform is realized. For example, the urgent need to improve interconnectivity of the Performance Budgeting System (PBS) tool with other PFMA tools such as the FMIS (Financial Management Information System), Integrated Personnel and Payroll System (IPPS) and the Debt Management System.

The Ministry of Health (MOH) recognizes the contributions of the relevant ministries, sampled Local Governments and Health Development Partners who richly contributed to this assessment. Special gratitude to the MOH Planning Department that worked closely with the World Health Organization (WHO) to ensure that this report was compiled as required.

For God and my Country.

Dr. Diana Atwine
Permanent Secretary, Ministry of Health

ACKNOWLEDGMENTS

This report was produced through the collective effort by the World Health Organization's (WHO) Department of Health Systems Financing and Governance and the Health Systems Department of the Uganda Country Office under the guidance and leadership of Hélène Barroy.

Important comments from Mr. Richard Kabagambe and Mr. John Kauta are gratefully acknowledged.

Financial support was provided by Foreign, Commonwealth & Development Office and the Global Alliance for Vaccines and Immunization as part of its Sustainability Strategic Focus Area.

ACRONYMS

BFP	Budget framework paper
CHWs	Community health workers
DHIS	District health information system
FMIS	Financial Management Information System
FY	Financial year
GDP	Gross domestic product
GH	General hospitals
GOU	Government of Uganda
HC	Health centre
HMIS	Health management information system
HSDP	Health Sector Development Plan
IPFs	Indicative planning figures
IPPS	Integrated Personnel Payroll System
MDAs	Ministries, Departments and Agencies
MoFPED	Ministry of Finance, Planning and Economic Development
MOPS	Ministry of Public Services
MTEF	Medium term expenditure framework
NDA	National Drug Authority
NDP	National Development Plan
NITAU	National Information Technology Authority
NPA	National Planning Authority
NRHs	National referral hospitals
NWR	Non wage recurrent
OAG	Office of the Accountant General
OBT	Output based tool
OOB	Output-oriented budgeting
OPM	Office of the Prime Minister
PBB	Programme based budgeting
PPA	Programme planning approach
PBO	Parliamentary Budget Office
PBS	Performance budgeting system
PFM	Public Financial Management
PHC	Primary healthcare
PPDA	Public Procurement and Disposal of Public Assets
PWGs	Programme Working Groups
RRHs	Regional referral hospitals
SWG	Sector Working Group
UAC	Uganda Aids Commission
UHC	Universal Health Coverage
UNMHCP	Uganda National Minimum Health Care Package
URMCHIP	Uganda Reproductive Maternal and Child Health Improvement Project
WHO	World Health Organization

EXECUTIVE SUMMARY

Public financing is critical for countries to make sustainable progress towards Universal Health Coverage (UHC). Given the centrality of public financing towards the attainment of UHC, WHO has initiated a collaborative agenda on Public Finance Management (PFM).

Since the early 2000s, Uganda has undertaken major budgetary reforms to optimize budget planning, transparency and accountability. In FY 2008/09, the government announced a shift from input-based budget approach to output-oriented budgeting (OOB). This was then followed by the Government of Uganda introducing Programme Based Budgeting in 2017/18, replacing output-oriented budgeting. While PBB borrowed heavily from the previous budget structure, its aim was to introduce reforms to strengthen the link between government strategic objectives, budget allocations and service delivery outcomes. The transition to PBB, however, has not been without challenges, some of which are intrinsic to the complex health financing landscape of Uganda, while others pertain to the roll out and operationalization of the reform.

Aside from the health financing terrain; a number of issues were encountered throughout the PBB reform process. Firstly, PBB is not well understood by all stakeholders and is conceived just as an extension of OOB. As a result, the programme structure and performance information of some health sector agencies are not fully aligned with PBB principles. Furthermore, there appears to be no direct link between the appropriations and prioritization of services to be provided.

Secondly, pre-existing administrative structures and mandates are yet to be aligned with the new budget structures. Additionally, there has been continued focus on the medium term expenditure framework (MTEF) ceilings during budget preparation and economic classification in expenditure management and control. As a result, the full potential of PBB is not realized.

Thirdly, the incongruence between the performance information used in the Annual Budget and Annual Performance reports persists.

Lastly, the health financing landscape in Uganda is characterized by multiple funding sources and heavy fragmentation of "resource pools". While some development partners channel their funds through the government system, the bulk of resources from development partners (76%) is intervention based and implemented by non-state actors outside the government system. As the PBB framework focuses on funds provided through government channels and appropriated by Parliament, a substantial amount of the resources to the health sector are not allocated using PBB.

1. INTRODUCTION

Many countries have initiated transitions to programme-based budget, as a means to better align with public policy priorities and enhance accountability and transparency. In addition to changes in the structure of budget documents, this reform triggers shifts in budgeting and expenditure management systems, which demand closer collaboration between finance and line ministries.

In 2018, the World Health Organization's (WHO) Department of Health Systems Governance and Financing began a work programme on issues related to health budget structure to generate evidence and to offer more support to countries as they undertake budget reforms. This work programme is divided into three principal areas: 1) A global review of health budget structures; 2) Case studies on the transition to programme budgets in the health sector; and 3) Training and support for health budget reform.

Since the early 2000s, Uganda has undertaken major budgetary reforms to optimise budget planning, transparency and accountability. To sharpen the focus on performance, in 2008 the government announced a shift from input-based budgeting to output-oriented budgeting (OOB). With the newly introduced performance focus, budgets were grouped by sector and allocations were linked to high-level sector policies and objectives set out in the budget framework paper (BFP).The budget structure was characterized by votes, departments and projects, with specific output objectives.

In FY 2017/18, the Government of Uganda embarked on implementation of Programme Based Budgeting (PBB). This reform, which borrows heavily from the previously existing budget structure, is aimed at strengthening the link between government strategic objectives, budget allocations and service delivery outcomes.

The purpose of this study is to assess the status of PBB implementation in the health sector in Uganda, with the aim of providing suggestions to strengthen its implementation. The report describes the transition from OOB to PBB and analyses the current budget structure with the purpose of understanding the links between various budgetary classification and funding mechanisms.

The report is structured into four sections. Section 1 outlines the transition process from OOB to PBB, and the expected objectives of the reform. Section 2 describes the structure of the health sector budget under the PBB reform as of FY 2019/20. Section 3 summarizes the key achievements of the reform in the health sector. Finally, Section 4 provides insights on the institutionalisation of PBB in Uganda.

2. CONTEXT OF THE REFORM

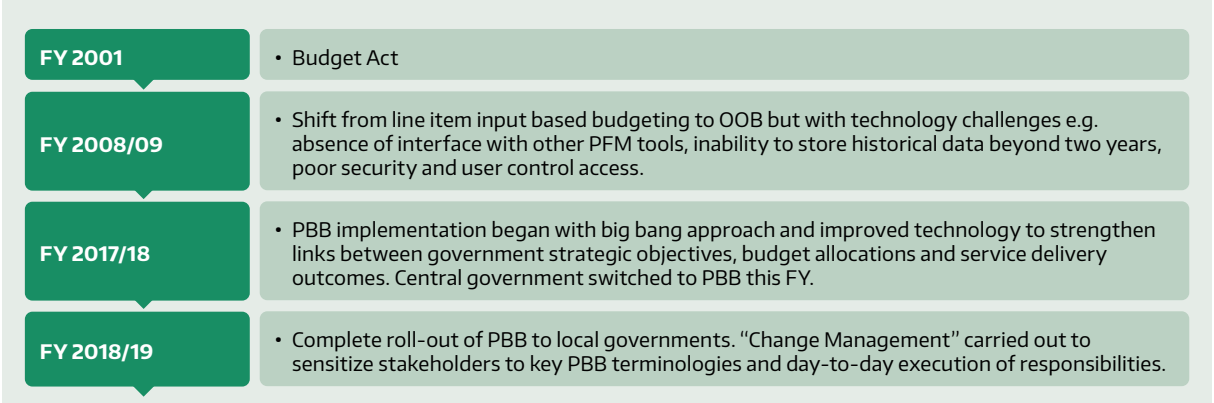
2.1 HISTORICAL BACKGROUND

The Government of Uganda has placed PBB at the centre of its PFM reform agenda. Prior to the PBB reform, the Ministry of Finance, Planning and Economic Development (MoFPED) introduced the MTEF as part of the budget planning process in 1992, and in 1994, line ministries formally began undertaking sectoral analyses. The pace of PFM reforms increased in the early 2000s. For example, under the 2001 Budget Act, the MTEF was formally changed to a public document requiring the approval of Parliament. Beforehand, Parliament acted as an "observer" and the Budget Framework Paper had the status of Cabinet Memorandum.

Since the early 2000s, a number of reforms were undertaken to strengthen budgeting, financial management, audit, and procurement systems at all levels to ensure more efficient and effective service delivery as well as to enhance value for money (Figure 1).

In 2008/09, the government announced a shift from input-based budget approach to output-oriented budgeting (OOB). With the newly introduced performance focus, budgets were grouped by sector and allocations were linked to high-level sector policies and objectives set out in the budget framework paper (BFP). The budget structure was characterized by votes, departments and projects, with specific output objectives. An IT application called "Output Based Tool" (OBT) was introduced for budget preparation and quarterly reporting. However, this reform grappled with some technological challenges. For instance, the absence of interface with other PFM tools like the the Financial Management Information System (FMIS), the

Figure 1. Key Public Finance Management Reforms in Uganda



inability to store historical data beyond two years, poor security, and user control access.

The transition from input-based budgeting to OOB in FY2008/09 led to a shift from focusing on inputs to outputs. This reform led to a shift in focus from eight MDAs (e.g. Ministry of Health, Health Services Commission, Uganda AIDS Commission) and inputs towards sectors and outputs. Moreover, quarterly financial and non-financial reports were introduced (Ministry of Health, 2004). Cabinet started to discuss budget performance reports, which fed into the Government Annual Performance Report prepared by the Office of the Prime Minister (Folscher, 2017).

While OOB was fully implemented, it grappled with a few challenges. The most important are outlined in the table below;

Table 1. Summary of the key issues related to OOB implementation

Conceptual issues	Implementation issues
1. Assumption of a mechanical link between outputs and inputs within Ministries, Departments and Agencies (MDAs) 2. Weak links between allocations and strategic objectives 3. Multiple, overlapping and unstructured detailed line information	1. Manual consolidation of votes 2. No storage of historical data for more than two years 3. Lack of flexibility during maintenance 4. No user control and delineation of roles and responsibilities for data security 5. Application management left to the end user 6. FMIS did not offer enough functionality

2.2 THE TRANSTION FROM OUTPUT ORIENTED BUDGETING TO PROGRAMME BASED BUDGETING

In FY 2017/18, the Government of Uganda embarked on implementation of PBB to strengthen the link between government strategic objectives, budget allocations and service delivery outcomes/results.

MoFPED was the lead ministry of the PBB reform process. In preparation for the roll out of PBB in MDAs, including the health sector, MoFPED established a high-level Steering Committee responsible for establishing the PBB implementation plan and providing guidance and oversight to the PBB Sector Working Group. A PBB Sector Working Group (SWG) constituted of representatives from the sector, the Ministry of Public Services (MoPS), the Office of the Prime Minister (OPM), the Public Procurement and Disposal of Public Assets (PPDA), the National Planning Authority (NPA), Parliamentary Budget Office (PBO), the National Information Technology Authority (NITAU) and MoFPED.

The transition to PBB heavily borrowed from the OOB mechanism. As such, the "vote function" (i.e. the money approved by Parliament to cater for the activities and programmes of government ministries and departments[1]) from the OOB became the "programme" in the PBB and the departments and projects within the vote became the sub-programmes. Outcome indicators and targets were identified for each programme and each sub-programme respectively. PBB was implemented using a web-based system –

1 Source: https://www.parliament.go.ug/faq/1177/what-vote-account

Performance Budgeting System (PBS) which replaced the OBT.

The process of implementation of the PBB reform in the health sector was carried out by the Sector Secretariat (MoH), as guided by MoFPED. Operationalization of the reform was largely driven by the health SWG which was chaired by the MOH Permanent Secretary and consisted of representative from MoH, and other key stakeholders including Civil Society Organizations, MoFPED, and development partners. Senior Management of MoH were responsible for providing overall guidance. The responsibilities of the SWG included;

a. Determining priorities and allocation of resources consistent with the National Development Plan (NDP), approve projects for submission to the development committee;
b. Proposing, for the approval of the Secretary to the Treasury, a Programme budget structure for the respective votes; and
c. Preparing budgets, reviewing performance and monitoring implementation of programmes and projects in the sector.

To support the PBB roll out, the government introduced the PBS. This new web- based electronic budget application was aimed at facilitating;

- The preparation of budget documents and execution reports
- Strengthening the link between financial budgets with results (outputs/outcomes)
- Facilitating consolidation of budget documents and reports by MoFPED

Figure 2. Implementation of the PBB in the health sector

The full transition to PBB is ongoing. As of FY 2020/21, the third National Development Plan (NDP III) established 18 programmes to support this transition. As a result, the budget will no longer be structured by sectors instead it will be structured by the newly established programmes, which are in alignment with the objectives of NDP III. The health sector will play a primary role in achieving the objectives under the new "Human Capital Development" programme, however it will also contribute to the priorities in 10 other programmes. The picture below shows the upcoming budget structure by programmes:

Figure 3. Link between NDP III Objectives, Strategies and programmes

NDPIII Objectives	NDPIII Strategies	NDPIII Programmes
1. Enhance value addition in Key Growth Opportunities	**1.** Promote agro-industrialization **2.** Increase local manufacturing activity **3.** Promote mineral-based industrialization **4.** Harness the tourism potential **5.** Promote export-oriented growth	**1.** Agro-Industrialization **2.** Mineral Development **3.** Sustainable Development of Petroleum Resources **4.** Tourism Development **5.** Natural Resources, Environment, Climate Change, Land and Water Management
2. Strengthen private sector capacity to drive growth and create jobs	**6.** Provide a suitable fiscal, monetary and regulatory environment for the private sector to invest **7.** Increase local content participation	**6.** Private Sector Development **7.** Manufacturing **8.** Digital Transformation
3. Consolidate & increase stock and quality of Productive Infrastructure	**8.** Institutionalise infrastructure maintenance **9.** Develop intermodal transport infrastructure **10.** Increase access to reliable & affordable energy **11.** Leverage urbanization for socio-economic transformation	**9.** Integrated Transport and Infrastructure Services **10.** Sustainable Energy Development **11.** Sustainable Urbanization and Housing
4. Increase productivity, inclusiveness and wellbeing of Population	**12.** Improve access and quality of social services **13.** Institutionalise human resources planning **14.** Enhance skills and vocational Development **15.** Increase access to social protection Promote Science, Technology, Engineering and Innovation **16.** Promote development-oriented mind-set	**12.** Human Capital Development **13.** Community Mobilization and Mindset Change **14.** Innovation, Technology Development & Transfer **15.** Regional Development
5. Strengthen the role of the State in development	**17.** Increase govt. participation in strategic sectors **18.** Enhance partnerships with non-state actors for effective service delivery **19.** Re-engineer Public service to promote invests. **20.** Increase Resource Mobilization	**16.** Governance and Security Strengthening **17.** Public Sector Transformation **18.** Development Plan Implementation

Source: (The Republic of Uganda, 2020)

2.2.1 EXPECTED GOALS AND OBJECTIVES OF THE PROGRAMME BASED BUDGETING REFORM

The introduction of PBB was expected to achieve the following goals and objectives;

Objective 1: Improved operational efficiency by addressing OBT weaknesses

The implementation of PBB and PBS was expected to deliver the following efficiency gains across government:

- Eliminate the manual consolidation of budget framework papers, estimates, and budget execution reports across MDAs and Local Governments (LGs).
- Automate the exchange of data with other systems such as FMIS and Integrated Personnel and Payroll System (IPPS).
- Provide access to historical budget data by users within MDAs and LGs.
- Enable central management and maintenance of the application thus eliminating time consuming practices under the OBT.
- Improve security management by restricting user access appropriately and delineating roles and responsibilities on the system among users.
- Eliminate the multiplicity of OBT versions saved on different personal computers, and
- Enhance the user friendliness of the system.

Objective 2: Improved transparency as a result of PBB implementation

Implementation of PBB involved setting of programmes objectives, outcomes and indicators. These indicators were expected to influence future funding levels. PBB was intended to improve transparency through providing a broader picture of the health sector desired outcomes, performance and budget execution. Additionally, PBB implementation was meant to directly link resources allocation and outcomes. Historical resource utilization trends would have also influenced future allocations, thus providing a more transparent justification for resource allocation within the government.

Objective 3: Improved expenditure prioritization

PBB was expected to create a linkage between the budgeting processes, the NDP and the Health Sector Development Plan (HSDP). Specifically, government spending decisions would be based on priorities set out in the NDP and HSDP. The newly introduced focus on prioritized outcomes would therefore optimize utilization of government resources and obtain value for money. By doing so, resource allocation would have been based on clearly identified, traceable and prioritized programme activities derived from the NDP.

Objective 4: Improved accountability, control and reporting

The PBB reform was aimed at improving accountability, expenditure control and reporting. In the short-term PBB was expected to provide a better understanding of the true costs of the services provided. In the long term, PBB was expected to provide leadership with a better understanding of the implications and costs associated with each Programme. PBB was expected to improve reporting by health sector agencies through performance reporting on core mandates of the sector agencies. This therefore requires proper definition of performance indicators during budget preparation as these would be considered as enablers for achieving resource accountability and control. A performance and expenditure report would be drafted based on PBB programmes.

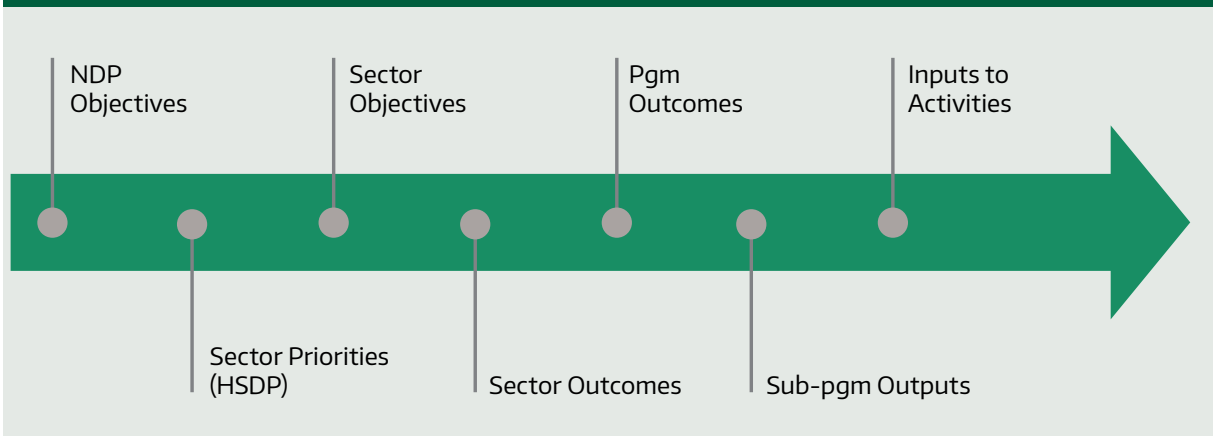
3. STRUCTURE AND CONTENT OF BUDGETARY PROGRAMMES IN UGANDA'S HEALTH SECTOR

3.1 STRUCTURE OF BUDGETARY PROGRAMMES IN UGANDA'S HEALTH SECTOR

The budget has a structural organization (i.e. by MDAs) and is developed using a five year MTEF. The budget is structured by MDA and is developed using a five-year MTEF. MoFPED sets annual sector ceilings based on macro-economic indicators and new government policies. Indicative allocations are provided for each vote. They are further divided between recurrent expenditures (wage and non-wage), capital expenditures and external financing.

The health sector is comprised of a number of votes including the Ministry of Health, the National Medical Stores, Regional Referral Hospitals among other votes (see Table 2). The budgetary structure for each vote is articulated into programmes, sub-programmes, projects and expenditure items. Vote priorities are derived from the sector priorities and also derived from the government priorities outlined in the NDP (Figure 4). As part of the budget development process, central level agencies are involved in the budget preparation process through the sector budget working consultative workshops, whereas LGs through the regional planning consultative workshops.

Figure 4. Structure for votes priority setting in the health sector



The health sector budget structure under the PBB reform was derived by simply converting vote functions under OOB reform into programmes. Departments and projects in each programme then formed the sub-programmes (Table 2). Under this structure, there is an officer responsible for delivering against each programme objective, and this has the potential to re-enforce the account-ability mechanism associated with PBB.

Table 2. Votes in OBT versus programmes in PBS for the Health Sector

Vote Code	MDAs	VOTE FUNCTIONS UNDER OOB	PROGRAMME FUNCTIONS UNDER PBB
014	Ministry of Health	Sector Monitoring and Quality Assurance	Health Monitoring and Quality Assurance
		Health systems development	Health infrastructure and equipment
		Health Research	Health Research
		Clinical and public health	Public health Services
			Clinical health services
			Pharmaceutical and other Supplies
		Policy, Planning and Support Services	Policy, Planning and Support Services
107	Uganda AIDS Commission	Coordination of multi-sector response to HIV/AIDS	HIV/AIDS Services Coordination
114	Uganda Cancer Institute	Cancer Services	Cancer Services
115	Uganda Heart Institute	Heart Services	Heart Services
116	National Medical Stores	Pharmaceutical and Medical Supplies	Pharmaceutical and Medical Supplies
134	Health Service Commission	Human Resource Management for Health	Human Resource Management for Health
151	Uganda Blood Transfusion Services	Safe Blood Provision	Safe Blood Provision
161	Mulago Hospital	National Referral Hospital Services	National Referral Hospital Services
162	Butabika Hospital	Provision of Specialised Mental Health Services	Specialised Mental Health Services
163-176	Referral Hospitals	Regional Referral Hospital Services	Regional Referral Hospital Services
304	Uganda Virus Research Institute	Health Research	Virus Research

The current programme structure in the health sector includes programmes and their descriptions; programme objectives; indicators and targets; as well as objectives, indicators and targets at sub-programme level. Programmes don't have a disease specific structure, but they rather follow the existing administrative/ accountability structures within the sector. HIV/AIDS is the only disease area structured as a Programme, and is placed under the Uganda Aids Commission (UAC). Instead, tuberculosis (TB) and malaria were treated as sub-programmes under the Pharmaceutical and other Supplies programme. Similarly, there is no specific programme for other policy priority areas like reproductive, maternal, neonatal and child health, or immunization.

The transition to PBB did not contribute to overcome the split between MoH and other central level agencies. The implementation of the reform was not fully leveraged to address previously existing inefficiencies and the pervasive fragmentation and rigidity at central level endures. As a result, resources are not allocated in a flexible way.

The conversion of Vote functions into programmes provided a linkage between the organization structure under OOB to programmes designed under PBB, and not necessarily an initiation of a new line culminating into a new structure. As such, there are intrinsic challenges that arose from the simplistic conversion of vote functions into programmes. By design, this has the potential to create duplications given that some sub-programmes, existing under different programmes could have been merged as they are all geared towards achieving a similar objective. Therefore, it is inferred that the creation of programmes did not follow a systematic approach of putting together independent, but closely-related items of expenditure or activities designed to achieve a common objective or objectives. Additionally, limited consideration was given to national and sector specific activities in totality. For example, although the mandate of the National Drug Authority (NDA) falls under the broad objectives of the health sector as stipulated in the NDP, this agency is not included in the budget structure of the health sector.

Additionally, as part of the efforts to reform objectives of PBB, activities planned for have to be linked to a clearly measurable goal and government objective. Each goal would then have performance indicators to measure achievement of the stated objective, and the budget allocation would constitute measurable objectives and performance measures for each programme. However, the performance indicators used under PBB implementation drew from the performance indicators provided under the NDP but they mostly capture processes and outputs, rather than outcomes. (Table 3).

Table 3. Extract from Ministerial Policy Statement 2018/19

Programme:	05 Pharmaceutical and other Supplies		
Programme Objectives:	To improve the quality and accessible medicines, equipment and other health supplies		
Responsible Officer:	Permanent Secretary, Ministry of Health		
Programme Outcome	Development of policy and guidelines for Medicines, equipment and other health supplies		
Sector Outcomes contributed to by the Programme Outcome			
1. Improved Quality of life at all levels			
Outcome Indicators	**Performance Targets**		
	2018/19	**2019/20**	**2020/21**
	Target	**Projection**	**Projection**
• Proportion of health facilities without drug stock out for 41 tracer medicines in previous 3 months	75%	80%	85%

Source: Ministry of Health, 2019b

The budgetary economics classification of the votes limits the full implementation of PBB. Each program is further divided into economic items (i.e. the wage, non wage and development grants). MoFPED poses expenditure control for the individual grants allocated to the votes and releases grant-specific funding for the relevant programmes on a quarterly basis. Throughout the budget cycle, it is not possible to undertake reallocations between the grants. The programme structure is not used to a large extent in expenditure management since budget control is still based on budget economic classification budget lines. The presence of this input based economic classification and associated rigidities contradict the spirit of PBB.

Table 4. Vote 116 (National Medical Store) Structure

Thousands UShs	2018/19 Approved Budget				2019/20 Draft Estimates		
Programme 59: Pharmaceutical and Medical Supplies							
Recurrent Budget Estimates	Wage	Non Wage	AIA	Total	Wage	Non Wage	Total
01 Pharmaceuticals and other health supplies	9,913,085	267,052,382	23,129,693	300,094,159	11,987,249	348,184,966	396,172,215
Total Recurrent Budget Estimates for Programme	**9,913,085**	**267,052,382**	**23,129,693**	**300,094,159**	**11,987,249**	**348,184,966**	**396,172,215**
	GOU	External Fin	AIA	Total	GOU	External Fin	Total
Total for Programme 59	276,964,467	0	23,129,693	300,094,159	396,172,125	0	396,172,125
Total Excluding Arrears	276,964,467	0	23,129,693	300,094,159	396,172,125	0	396,172,125
Total for Vote 116	276,964,467	0	23,129,693	300,094,159	396,172,125	0	396,172,125
Total Excluding Arrears	276,964,467	0	23,129,693	300,094,159	396,172,125	0	396,172,125

Source: (Ministry of Health, 2019b)

4. ACHIEVEMENTS AND CHALLENGES OF THE IMPLEMENTATION OF PROGRAMME BASED BUDGETING IN UGANDA'S HEALTH SECTOR

PBB reform is yet to deliver on the expected results that had been envisaged at roll out with regard to the way allocations are formulated, funds disbursed and executed. Insufficient change has been realized in resources allocation processes to the health sector and attainment of health sector outcomes. As part of the budget execution processes, control and reporting still remain centered on Vote Cost Centre structure and economic classification, rather than PBB programmes and outputs.

The structure of the health financing landscape in Uganda poses challenges to the successful implementation of budgetary reforms. In fact, whilst PBB implementation solely focuses on the on-budget funds that are appropriated by Parliament, development partners channel over 76% of their funds off budget. A mechanism has to be put in place to ensure that such funding also follows the PBB paradigm to progress towards the achievement of the desired results.

4.1 REFORM OUTCOMES ACROSS THE BUDGET CYCLE

Pre-existing administrative structures and mandates, duplication and overlap of activities

Previously existing administrative mandates within the health sector MDAs were not aligned with the PBB paradigm of combining activities which serve a common objective. This stems from the fact that at inception PBB programmes were determined on the basis of the previously existing sector administrative structures/mandates and the exercise did not aim to merge functions with similar or related objectives, as the PBB mechanism would ideally do. Instead, some of the programmes and sub programmes were further spread across more than one department or MDA. Some of the programmes and sub programmes were spread across more than one department or MDA. A case in point is HIV/AIDS that is included as a progamme (51 HIV/AIDS Services Coordination) under the UAC and is also included under the MoH programme structure under the a sub programme (0220 Global Fund for AIDS,TB and Malaria) and also under the Pharmaceutical and other Supplies programme (05). One further constraint observed during the study was the fact that there existed administrative mandates within the health sector that were not necessarily aligned with the PBB paradigm of amalgamating activities which serve a common objective.

An analysis of the Regional Referral Hospitals budget structure identified many unnecessary splits which has caused a number of overlapping sub-programmes. The extract below from the 2018/19 MPS for Jinja Regional Referral Hospital shows maintenance as a different sub-programme from rehabilitation.

Table 5. Extract from the MPS of Jinja Regional Referral Hospital

Billion UShs	FY 2017/18 Outturn	FY 2018/19		2019/20 Proposed Budget	Medium Term Projections			
		Approved Budget	Spent by End Dec		2020-21	2021-22	2022-23	2023-24
56 Regional Referral Hospital Services	7.967	11.704	4.525	12.100	12.002	12.002	12.002	12.002
01 Jinja Referral Hospital Services	**6.092**	**10.232**	**4.138**	**10.456**	**10.365**	**10.365**	**10.365**	**10.365**
02 Jinja Referral Hospital Internal Audit	0.505	0.017	0.000	0.021	0.014	0.014	0.014	0.014
03 Jinja Regional Maintenance	0.000	0.090	0.000	0.135	**0.135**	**0.135**	**0.135**	**0.135**
1004 Jinja Rehabilitation Referral Hospital	0.731	1.365	0.363	1.100	1.288	1.388	1.488	1.488
1481 Institutional Support to Jinja regional Hospital	0.640	0.000	0.025	0.388	0.200	0.100	0.000	0.000
Total for the Vote	**6.092**	**10.232**	**4.138**	**10.456**	**10.365**	**10.365**	**10.365**	**10.365**

Source: (Ministry of Health, 2019b)

Indicators definition, linkage between budget structure and resource allocation:

The current health budget structure, the identified programmes, and sub-programmes, outcomes and indicators were derived from sector strategic objectives as per NDP II, but their definition remains problematic. By converting Votes into programmes and Departments/Projects into sub-programmes, there was a missed opportunity of putting together independent but closely related expenditures/activities designed to achieve a common objective.

The current practice is that budget appropriation is done at vote level and not at programme level. Allocations from MoFPED to sectors are driven by an allocation formula which considers government priorities in line NDP, sector priorities, LG negotiations chaired by Local Government Finance Commission and the manifesto of the ruling government. Allocations within the vote can be varied by the accounting officer seeking approval from the MoFPED. However, the grants' economic classification, like salaries and conditional grants, cannot be varied. The linkage between budget structure and resource allocation remains weak, as no evident change in allocation of resources based on the performance of the different programmes and subprograms in the health sector has been reported. The weak link between outcomes and budget allocation has not encouraged stakeholders in the health sector to fully take on PBB reforms.

Intersectoral allocation of resources:

The Ministerial Policy Statement highlights sector priorities for the current financial year. However, it is difficult to link this narrative to the planned budgetary estimates since these priorities are not costed. As a result, it is difficult to ascertain if prioritization of allocations within the structure of the health sector budget is geared towards addressing the priorities highlighted. The extract below from the MOH Ministerial Policy Statement 2018/19 illustrates the issue:

Figure 5. Ministerial Policy Statement Sector Priorities

2. SECTOR PRIORITIES FOR FY 2018/19

a. Mobilising sufficient financial resources to fund the health sector programmes while ensuring equity, efficiency, transparency and mutual accountability.

b. Addressing human resource challenges in the sector (attraction, motivation, retention, training and development).

c. Improvement of Reproductive, Maternal, Neonatal, Child and Adolescent health services to reduce on mortality and morbidity and improve their health status.

d. Scaling up public health interventions to address the high burden of HIV/TB, malaria, Nutritional challenges, Environmental Sanitation and Hygiene, Immunization, Hepatitis B and Non Communicable Diseases by utilizing CHEWs.

Although performance reporting on expenditure and performance against targets at Programme level was expected to be a determinant of future funding levels, there does not seem to be a direct link between the budget appropriation and the performance. Despite being the most powerful relationship that can be leveraged in PBB to assess the adequacy of funding levels, the resource allocation process is largely determined by planning ceilings (MTEF ceilings) set by MoFPED. The predominant role of MTEF ceilings in the budgeting process has limited the full implementation of PBB, which has led to an overwhelming focus on ceilings instead of outcomes. In practice, performance is not the primary focus of the PBB reform, and thus remains secondary to the focus on MTEF ceilings. Stakeholders perceive that even with the best intentions of focusing their budgeting on outcomes, the fact that MTEF ceilings ultimately translate into department ceilings has been a limiting factor.

Alignment between budget structure and expenditure management/reporting:

As PBB is not yet adequately integrated in the budget preparation and planning framework for MDAs and LGs, challenges are carried forward into budget execution. Despite the introduction of PBB, management and control of budget expenditure across government still remains at line-item level. Although resource prioritization and expenditure management should follow the programme structure with focus on objectives/outcome, budget control in the FMIS is still hinged on administrative centers and budget line items and not PBB programmes. Specifically, budget is executed using pre-existing "Vote Cost Centres" which, in some cases, are not aligned with the newly created programmed. Moreover, while expenditure reports could be accessed based on programmes and sub-programmes, it is not currently the practice. Expenditure management and control is currently done through line item budget controls inbuilt into the FMIS and not at programme and sub-programme level. In reality, expenditure management and monitoring are still driven by inputs and not outcomes. This limits the full functionalization of PBB that focuses on management of resource utilization at programme level.

Flexibility of and within expenditure management:

The 2015 PFM Act allows for 10% reallocations between specified expenditure items; however health sector budget implementers perceive this flexibility as insufficient. Moreover, budget ceilings (MTEF ceilings and Indicative Planning Figures) issued by MoFPED remain Vote based and not programme based. Respondents revealed that even greater flexibility between expenditure items under a programme or sub-programme should be allowed for as long as the expenditure does not go beyond the Programme ceiling. This is when PBB will achieve full implementation. One of the key respondents at central level noted that;

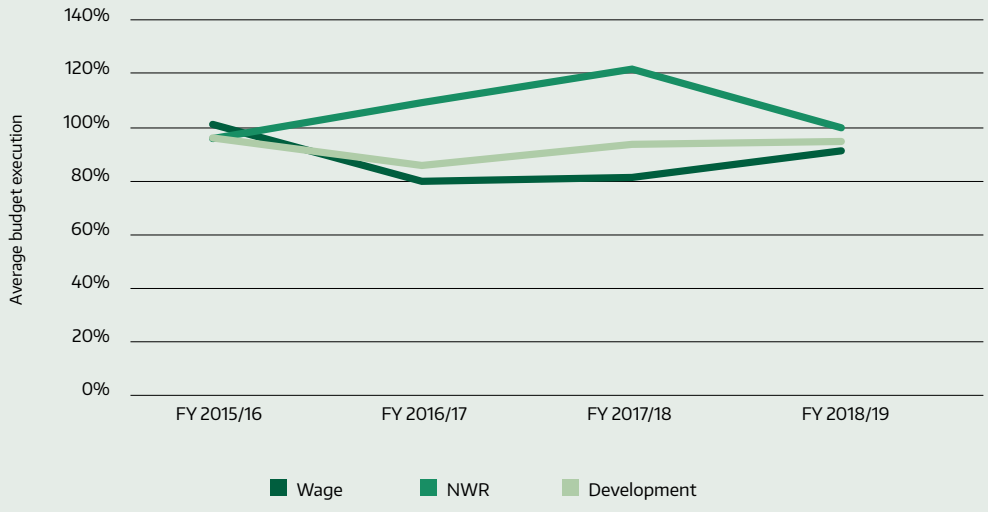
"… we are only allowed 10% reallocations between specified expenditure items, I think this percentage is very low and needs to be increased… as long we do not go beyond the programme ceiling, it should be okay… COVID-19 is a great example to illustrate my point… for us to better cope with the dynamic and complex health terrain, there is need for sufficient flexibility in the budgeting and planning frameworks…"

Despite the expected introduction of expenditure management and control at programme level, the continued use of line item expenditure control has lead to spending inflexibility. With the new FY 2021/22, it is envisaged that expenditure control will be done at programme level and this has the potential to realize the full benefit of control at programme level.

Budget execution:

The 2018/19 Annual Performance Report indicated a 94% overall budget absorption rate for the health sector. Between FY 2015/16 and 2018/19 the budget execution rate had an average of 88% for wages, 106.3% for non-wage recurrent (NWR) and 92.2% for the development grant (Figure 6).

Figure 6. Average budget execution rates



Source: Authors' calculations from (The Republic of Uganda, 2016, The Republic of Uganda, 2017, The Republic of Uganda, 2018, The Republic of Uganda, 2019)

The suboptimal performance was mainly caused by failure to absorb wage and gratuity allocations across all institutions in the sector. However, it is important to highlight that there is insufficient data to permit for an assessment of the impact of PBB on budget execution.

Disbursement rates remain lower for externally financed projects. In FY 2017/18, Gavi projects had a 9% disbursement rate due to protracted discussions on flow of funds modalities. Moreover, because of overlaps between GoU and Donors FYs, 61% and 60% disbursement rates were registered for Global Fund and Uganda Reproductive Maternal and Child Health Improvement Project initiative.

Reporting:

The health sector votes are expected to produce a quarterly and annual performance report using the PBS. The study found that indeed these reports are prepared. However, it was noted that there remains a challenge of limited automation of interfaces between FMIS, Health Management Information System (HMIS), Second District Health Information System (DHIS-II) and PBS making report preparation cumbersome and prone to error.

The annual health sector performance report also highlights progress, challenges, lessons learnt and proposes mechanisms for improvement. The reports further indicates the progress of the implementation of commitments in the Ministerial Policy Statement, overall sector performance against the targets set for the FY, and trends in performance for selected indicators over the previous FYs.

4.2 REFORM IMPLEMENTATION

Capacity of the health sector team to execute the reform:

Most of the health sector stakeholders appeared to perceive PBB as PBS i.e. an introduction of a new budgeting information system albeit not changing the existing budget framework of OOB. This was coupled with difficulty in appreciating new terminologies under PBB during the transition. The use of the term "programme" traditionally under the health sector had a different meaning, as a result an appreciation of its use under PBB remains a challenge.

To support the transition from OOB to PBB, in FY 2017/18 MoFPED organized trainings for MDAs including those in the health sector. PBS was also introduced to ease the transition and specific trainings were undertaken on the PBS roll out. However, the capacity building sessions were inadequate for all stakeholders in the health sector to fully appreciate PBB and its performance information requirements.

PBS was introduced to ease the budget preparation under PBB, including facilitating the consolidation of performance information. However, not all persons in the health sector involved in budget preparation and execution have access to PBS. Notwithstanding the trainings organized on the role out of PBS, it appears there remains a skill gap for some users on the full functionalities of PBS. Moreover, connectivity issues at district level pose challenges to the its utilizations. Secondly, the PBS platform has undergone several enhancements since inception and as such officers need to be trained on the operability of these enhancements.

A PBB manual was prepared to provide guidance on how to implement PBB. However, the manual is still in draft form and has not been circulated to all stakeholders. Without a guiding document, key actors have found it difficult to fully comprehend the new terminologies and the shift in focus from outputs to outcomes.

PBB Implementation at Sub National and health facility level:

At sub-national level, very small improvements in budget preparation, execution or reporting using a PBB structure since the introduction of the reform in FY 2018/19. Key informants, especially at local government level, noted that the PBB reform was largely understood to be an introduction of a new budgeting software (PBS), rather than a different approach to budget formulation and execution. Moreover, the IPFs shared by MoFPED during budget preparation process are still grant specific and do not present any correlation with the PBB outcomes as defined by the PBB structure for LGs. At LGs level, budget control and reporting remain focused on the grant's economic classification.

PBS is not sufficiently flexible and stable, thus creating challenges to its utilization. Users often face challenges to utilize the software, especially in peak hours, as a result of the unstable connectivity. As a result, the tool is not utilized to its full potential and the reform implementation has been stagnating.

PBB was aimed at linking resources allocation and service delivery by providing/setting performance targets (outputs and outcomes) upon which resources are allocated. Although service delivery related outcome indicators were introduced, performance reports did not directly mention the level of progress towards the set outcomes levels, but rather focused on inputs and outputs. For instance, the 2018/19 health sector annual performance report only has limited linkages with the health programme structure and its indicators. For example, the performance target of the Uganda National Expanded Programme on Immunization is to provide vaccination services against 10 target diseases for infants but progress against this indicator is not well articulated in the report. The interactions with districts and facility management teams did not reveal any conclusive linkages between PBB implementation and service delivery.

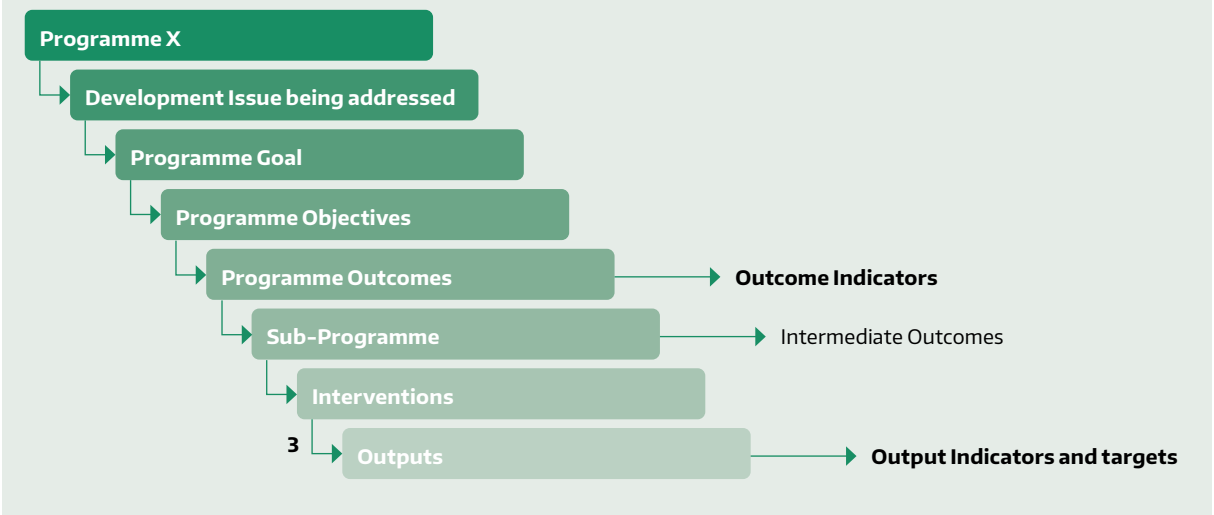
5. THE FUTURE OF PROGRAMME BASED BUDGETING IN UGANDA

This section provides an overview of the next stages of PBB implementation in Uganda.

5.1 INTRODUCTION OF THE PROGRAMME PLANNING APPROACH IN FY 2021/22 BUDGETING CYCLE

The Cabinet of Uganda approved the Third National Development Plan that will guide the nation in delivering Vision 2040. The Third National Development Plan (NDP III) has adopted a Programme Planning Approach (PPA) comprising of eighteen (18) programs that are to be aligned to PBB. The purpose of programme planning and budgeting is to improve the prioritization of resource allocation using performance indicators. The 18 programmes were established to address the persistent implementation challenges resulting from uncoordinated planning, weak harmonization, limited sequencing of programmes, and poor linkages between outcomes and outputs.

Figure 7. Summary of the NDP III Programme Planning Approach Logic



Source: The Republic of Uganda, 2020

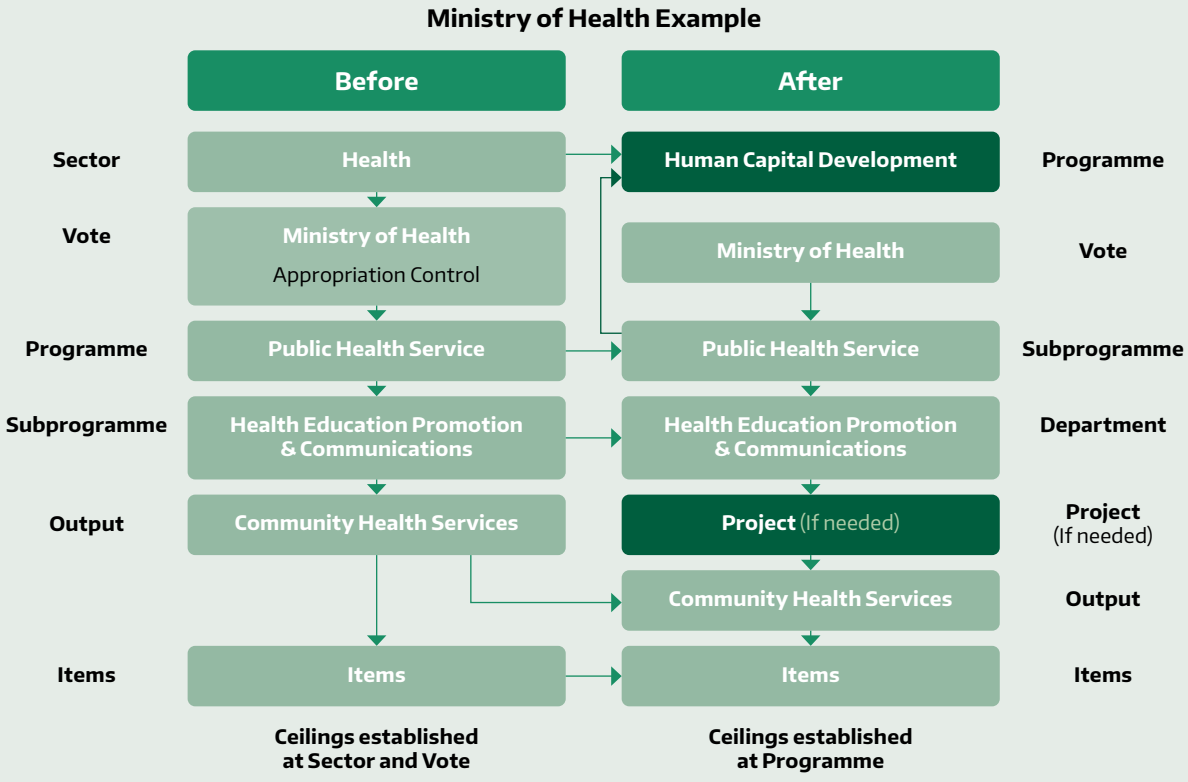
The Programme Planning Approach that is proposed by the NDPIII has the potential to strengthen the PBB which MoFPED started implementing in FY 2017/18. With the approval of the NDPIII, the National Budget must be linked to the Programmes indicated in the NDP III. The adoption of the programmatic approach in the NDPIII necessitates a shift from sectoral planning and coordination to programme planning and coordination. Program Implementation Action Plans (PIAPs) will be introduced and will constitute a link between ministries, departments and agencies and local government plans to the NDP III. The following critical steps have been undertaken:

a. Identification of lead Ministries for the 18 Programmes in the NDPIII;
b. Change of the MTEF from sectoral to the programme approach; and
c. Reconfiguration and alignment of the PBS to the new PPA.

5.2 IMPLICATIONS FOR THE HEALTH SECTOR

The new PPA structure has implications for all government entities and agencies including the health sector. Figure 9 is an illustration of the expected changes after the introduction of PPA.

Figure 8. Illustration of Programme Planning Approach in the Health Sector



Source: The Republic of Uganda, 2020

Specifically, the following changes will be made within the health sector as a result of the PPA:

- **A shift from sectoral planning and coordination to programme planning and coordination.** The SWGs will now be replaced by the 18 Programme Working Groups (PWGs).
- **Health activities are currently appearing in 11 out of the 18 NDP III programmes.** Although the bulk of MoH activities are in the Human Capital Development Programme, there are other health sector specific activities in 10 other programmes. This means that MoH is expected to participate in multiple PWGs at all levels of planning, budget execution and reporting.
- **Budget ceilings.** Budget ceilings will no longer be established at the sector and vote level but rather at the programme level. This has implications on flexibility of the budget at the sector level.
- **PIAPs will be introduced and will constitute a link between the MDA/LG Plans to the NDPIII**. PIAPs will be results and action based with annualized targets and costs for the five-year period.
- **Restructuring of the PBS**: Implementation of the NDPIII calls for the restructuring of the PBS to mirror the 18 programmes and to measure results based on these programmes.
- **Data Production and Management:** The data production frequencies will have to be synchronized with the NDPIII data needs. In particular, because Programme-Based Planning focuses on outcomes, there will be a need for integrating various surveys and/or conducting surveys that cover outcome indicators of the NDPIII. Therefore, designated data collection cycles will have to be observed.
- **Project approval process**: Under the existing arrangements, projects are approved by Project Preparation Committees of individual MDAs. This approval process will have to shift so that projects are approved by the Programme Working Group constituted by all agencies under a given Programme.
- **Reporting frameworks**: At the national level, an integrated web-based monitoring and evaluation system will be developed to track progress of NDP III implementation.

6. NEXT STEPS

Overall, progress has been made in transitioning to PBB within the health sector, however more needs to be done to fully realise the potential of this reform. The following offer a way forward to support the full implementation of PBB:

- Review and restructure the administrative structures to align to the PBB structure
- Review the PBB structure and amalgamate, Agencies, Departments, activities and sub programmes that are geared towards the same strategic objective into one Programme. For example, consolidate all AIDS related activities under one Programme.
- Change the budget control from being based on economic classification to programme classification.
- Clarify performance information and set baselines and targets for proper performance measurement. Furthermore, several indicators in the FY 2017/18 Ministerial Policy Statement indicated performance targets of 100% raising doubt on the realism of the targets.
- Finalize and disseminate the PBB manual and user guide as a basis for training, instruction, implementation and review.
- Provide continous trainings on PBB to ensure employees understand the concept and its implications for their work.
- Retrain the District Health Officers, accountants and biostatisticians at sub national level to enable them fully to comprehend the PBB.
- Institutionalize the off-budget resources tracking exercises and advocate for increased provision of donor resources on budget. Such information shall also be used to inform the donor transition plans and resources allocation decisions.
- Increase access and support to PBS especially for LGs. PBS is an online tool. The study found that many LGs have difficulties accessing internet both in terms of cost and the necessary infrastructure. One option of addressing this would be the development of an off-line solution which allows users to work off-line and synchronize with the Centre once access is availed.
- Improve interconnectivity of the PBS tool with other Public Financial Management and Administration tools such as the FMIS, IPPS and the Debt Management System.

7. APPENDICES

APPENDIX I: SOURCES OF INFORMATION

A CASE STUDY ON TRANSITIONING TO PROGRAMME BASED BUDGETING IN UGANDA'S HEALTH SECTOR

Guiding Study Questions		
#	**Question**	**Respondent/Response**
Study Area 1: The Context and process of transitioning to PBB in the health sector in Uganda		
i)	Could you briefly give me your understanding of the process of transitioning from OBB to PBB	
ii)	In your view, what was the objective of this transition? What was the Government trying to achieve by this process?	
iii)	What was your role in the process of transitioning from OBB to PBB?	
iv)	Under PBB, budgeting is done under programmes and sub-programmes. Could you be aware of the process of how these programmes and sub-programmes were determined/defined?	
v)	What is your understanding of performance indicators under PBB? How were your indicators determined? Are they relevant to you?	
vi)	Does the transition to PBB have any impact on expenditure management/ reporting?	
vii)	Could you describe how key programmes like HIV/AIDS, TB, Malaria, Immunization are treated under PBB budget structures? Do they have a special budget line and/or programmes?	
viii)	Did you observe any duplications and/or overlaps of activities in the process of transitioning to PBB? If so, how were these handled?	
ix)	Could you mention any challenges experienced in transitioning to PBB?	
Study Area 2: The Process of Implementation of PBB		
i)	What changes did you observe that came with the implementation of PBB?	
ii)	How did you notice the changes?	
iii)	What were the institutions driving these changes	
iv)	Mention any challenges that you are experiencing in the implementation of PBB	
Study Area 3: Structure and content of Health Sector PBB Budgetary Programmes		
i)	What are the budgetary rules that you follow in the implementation of PBB?	
ii)	Could you mention to use the distinct roles of the various stakeholders in Budget preparation, approval and execution?	

Guiding Study Questions		
#	Question	Respondent/Response
iii)	What is your role in the PBB implementation?	
iv)	Could you briefly highlight the main activities within the Uganda's budget calendar?	
v)	Are you aware of the PBB programmes under the Health Sector? Under what Programme does your institution/department fall?	
vi)	What periodic budgetary reports are you required to prepare under the PBB mechanism?	
vii)	Are you able to generate these reports on your own?	
viii)	Do you find the reports useful? Any improvements that you would like to see on the reports that would make them more useful?	
ix)	How useful do you find the PBB mechanism with regard to equitable allocation of resources within the Sector?	
x)	Is the PBB mechanic helpful in budget execution within the Sector?	
xi)	Is there alignment between budget structure and expenditure management/ reporting?	
Study Area 4: Outcomes of the PBB Reform		
i)	Do you find the reform effective?	
ii)	Do you find the PBB reform relevant?	
iii)	Are the PBB Programmes well aligned to the Sector priorities?	
iv)	Are the allocations based on Sector Priorities?	
v)	Has the implementation of PBB helped improve budget execution levels within the Sector?	
vi)	Is there flexibility within budget preparation and execution? Is the system flexible enough to allow virements and reallocations?	
vii)	How is PBB responsive to Strategic purchasing / Results Based Financing?	
viii)	How has the implementation of PBB affected service delivery at district and Health Facility Level?	

APPENDIX II: SOURCES OF INFORMATION

In undertaking this study:

1. WE INTERACTED AND HELD DISCUSSIONS WITH THE FOLLOWING STAKEHOLDERS

Name	Title/Responsibility in the company
Annet Musiime	Assistant Commissioner, Internal Audit, MoH
Stephen Kateregga,	Director, Value For Money Directorate, OAG.
John Kauta	Technical Advisor – Planning MoH
Swaleh Sebina	Economist – MoH
Richard Kabagambe	Assistant Commissioner – Planning MoH
Jimmy Ogwal	HMIS Officer – MoH
Stephen Ojambo	Commissioner – Treasury Inspectorate and Policy Department
Dr. Nabangi Charles	DHO – Mayuge DLG
Joshua Masini	Planner – Mayuge DLG
Paul Bamwesige	Senior Accountant – Mayuge DLG
Munyanya Faisal	Sector Accountant for Health Mayuge DLG
Louis Muhindo Ngobi	Hospital Administrator – Fort Portal RRH
Dr. Florence Tugumisirize	Hospital Director – Fort Portal RRH
Dr. Tusiime Charles	DHO – Kyenjojo DLG
Simon Peter Mugabi	Bio Stastician – Kyenjojo DLG
Mariam Kemigisa	Planner – Kyenjojo DLG
Bakura Peter	Sector Accountant for Health – Kyenjojo DLG
Nyesiga Reuben	District Health Inspector – Kyegegwa DLG
Edward Muhumuza	Bio Stastician – Kyegegwa DLG
Mugabi Ronald	Surveillance Officer – Kyegegwa DLG
Emmanuel Sande	Assistant Health Educator – Kyegegwa DLG
David Kwagonza	Sector Accountant for Health – Kyegegwa DLG
Dr. Solomon Asiimwe	DHO – Kabarole DLG
Byaruhanga Christopher	Bio Statistician Kabarole DLG
Daniel Musinguzi	District Planner - Kabarole DLG

2. WE REVIEWED THE FOLLOWING DOCUMENTS:

Document title
Health Sector Ministerial Policy Statement, Financial Year 2016/17
Health Sector Ministerial Policy Statement, Financial Year 2017/18
Health Sector Ministerial Policy Statement, Financial Year 2018/19
Health Sector Ministerial Policy Statement, Financial Year 2019/20
Public Financial Management Act 2015
Third National Development Plan (NDPIII) 2020/21 – 2024/25
Second National Development Plan (NDPII)
The first Budget Call Circular (BCC) on preparation of budget framework papers and preliminary estimates for the financial year 2020/2021
Annual Health Sector Performance Report FY 2018/19
MoH guidelines to the Local Government planning process, July 2019

APPENDIX III: BUDGET EXECUTION RATES

Vote	Name	FY 2015/16			FY 2016/17			FY 2017/18			FY 2018/19		
		Wage	NWR	Develop-ment	Wage	NWR	Develop-ment	Wage	NWR	Develop-ment	Wage	NWR	Develop-ment
014	Ministry of Health	105.3%	84.1%	79.9%	67.3%	80.1%	65.3%	79.4%	90.2%	110.2%	75.6%	94.4%	154.9%
017	Uganda Aids Commission	93.4%	91.6%	98.0%	85.4%	93.6%	41.1%	92.5%	99.4%	92.2%	97.9%	99.5%	99.8%
114	Uganda Cancer Institute	97.8%	96.3%	98.5%	97.7%	94.0%	97.1%	66.2%	97.1%	99.9%	100.0%	99.6%	100.0%
115	Uganda Heart Institute	99.0%	85.8%	96.7%	83.2%	101.8%	100.0%	68.8%	99.1%	100.0%	89.7%	96.5%	95.2%
116	National Medical Store	100.0%	100.0%	100.0%	0.0%	111.3%	0.0%	0.0%	229.3%	0.0%	100.0%	107.4%	0.0%
122	KCCA	108.7%	108.4%	99.7%	99.8%	100.7%	99.4%	100.0%	98.2%	98.8%	100.0%	94.5%	97.9%
134	Health Services Commission	109.0%	105.8%	97.1%	99.2%	99.5%	100.0%	92.0%	96.0%	100.0%	95.8%	98.8%	99.8%
151	UBTS	103.0%	97.5%	94.6%	78.8%	104.0%	70.9%	91.4%	155.6%	95.4%	99.8%	99.8%	100.0%
161	Mulago Hospital Complex	101.9%	100.7%	98.8%	84.7%	98.1%	91.2%	85.2%	102.3%	100.0%	83.7%	103.6%	100.0%
162	Butabika Hospital	94.6%	94.3%	99.8%	86.9%	105.1%	100.0%	89.0%	106.2%	100.0%	94.2%	99.3%	99.9%
163	Arua Referral Hospital	111.2%	105.3%	94.7%	92.9%	176.5%	99.3%	87.2%	103.2%	100.0%	89.0%	98.1%	99.9%
164	Fort Portal Referral Hospital	96.4%	90.1%	93.4%	88.5%	87.7%	97.1%	82.4%	94.6%	99.7%	87.1%	73.2%	100.0%
165	Gulu Referral Hospital	92.4%	86.6%	93.7%	81.3%	118.1%	100.0%	78.6%	137.1%	99.9%	89.2%	111.0%	99.9%
166	Hoima Referral Hospital	83.4%	79.0%	94.8%	59.3%	100.1%	100.0%	68.7%	93.3%	100.0%	81.3%	99.8%	100.0%
167	Jinja Referral Hospital	84.5%	84.4%	100.0%	67.6%	102.2%	96.4%	76.8%	135.2%	92.1%	77.8%	106.8%	99.9%
168	Kabale Referral Hospital	108.2%	125.1%	115.6%	79.9%	113.6%	120.5%	82.6%	99.7%	100.0%	88.5%	108.2%	100.0%
169	Masaka Referral Hospital	97.8%	91.8%	93.8%	85.6%	105.1%	102.6%	95.6%	98.0%	100.0%	94.0%	99.2%	100.0%
170	Mbale Referral Hospital	96.1%	85.0%	88.4%	94.4%	187.2%	108.0%	94.5%	108.9%	100.0%	92.3%	100.3%	34.6%

Vote	Name	FY 2015/16			FY 2016/17			FY 2017/18			FY 2018/19		
		Wage	NWR	Develop-ment	Wage	NWR	Develop-ment	Wage	NWR	Develop-ment	Wage	NWR	Develop-ment
171	Soroti Referral Hospital	90.7%	93.8%	103.4%	85.4%	97.7%	100.0%	96.7%	137.2%	42.1%	96.6%	108.3%	100.0%
172	Lira Referral Estimates	109.7%	107.2%	97.6%	83.7%	122.4%	95.1%	87.1%	108.4%	100.0%	86.7%	101.7%	97.8%
173	Mbarara Referral Hospital	127.3%	106.0%	83.3%	78.6%	105.8%	100.0%	87.7%	110.3%	94.6%	92.3%	101.2%	97.1%
174	Mubende Referral Hospital	93.4%	91.5%	98.0%	65.1%	120.5%	100.0%	72.2%	101.3%	99.8%	83.7%	97.2%	99.2%
175	Moroto Referral Hospital	114.4%	88.2%	77.1%	57.2%	113.6%	37.0%	68.8%	92.1%	100.0%	86.8%	100.5%	100.0%
176	Naguru Referral Hospital	91.8%	86.9%	94.7%	73.1%	95.0%	98.9%	76.0%	100.0%	100.0%	94.9%	98.7%	100.0%
304	UVRI	-	-	-	88.6%	95.2%	0.0%	86.9%	362.0%	100.0%	83.3%	89.8%	76.1%
501-850	Local Governments	108.2%	100.0%	100.0%	101.70%	97.8%	100%	98.3%	100.7%	100.0%	99.9%	100.0%	100.0%

Source: (The Republic of Uganda, 2016, The Republic of Uganda, 2017, The Republic of Uganda, 2018, The Republic of Uganda, 2019)

APPENDIX IV: EXTRACT FROM THE ANNUAL HEALTH SECTOR PERFORMANCE REPORT FY 2018/19

Milestone	Priority Actions/ Recommendations	Progress Achievements
Health financing		
Implement the Health Financing Strategy	Enact the NHIS law	Draft NHIS Bill 2019 approved by Cabinet on 24th June 2019, gazetted & submitted to Parliament for discussion in July 2019.
	Set up structures and mechanisms for NHIS management	Institutional capacity development framework for the NHIS implementation developed.
	Establish HIV/AIDS Trust Fund and Immunization Fund.	• HIV/AIDS Trust Fund was approved and regulations developed awaiting allocation of funds by MoFPED. • Immunization Board has been established and funded yet to be created.
	Continue progressive RBF roll-out	RBF approach has been rolled out in all districts in the country URMCHIP – 83 districts, URHVP – 26 districts, EHA – 4 districts, SPHU – 11 districts.

Source: (Ministry of Health, 2019)

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ISBN 978-92-4-002777-0