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Financial Management Arrangements for Externally Funded Projects in The Health Sector: A Cost-Benefit Analysis

UGANDA CASE STUDY

WORLD BANK GROUP

uhc2030
International Health Partnership

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LIST OF ACRONYMS

DP	development partner
GAC	Governance and Anti-Corruption
HFSA	Health Financing System Assessment
HNP	Health, Nutrition, and Population (sector of the World Bank)
HSDP	Health Sector Development Plan
HSSIP	Health Sector Strategic Investment Plan
IFMIS	integrated financial management information system
IHP+	International Health Partnership Initiative
LPO	local purchase order
LTIA	long term institutional arrangements
MDA	ministries, departments and agencies
NDP II	Second National Development Plan
OAG	Office of the Auditor General
PAC	Public Accounts Committee
PEFA	public expenditure and financial accountability
PFM	public finance management
PIU	project implementation unit
PMU	program management unit
PPDA	Public Procurement and Disposal Authority
SAI	Supreme Audit Institution
SWAp	sector-wide approach
TA	technical assistance
TSA	Treasury single account system
UHC	universal health coverage

EXECUTIVE SUMMARY

This study reviews the use of siloed, stand-alone arrangements for donor-financed projects in the Uganda health sector. Reviewing the contributions of four major development partners—the World Bank, the Global Fund to Fight AIDS, Tuberculosis, and Malaria, the Global Alliance for Vaccines and Immunization (GAVI), and KfW Development Bank—it compares the financial management (FM) related cost incurred through their parallel implementation arrangements to the cost of an alternative implementation scenario. This alternative scenario assumes (i) a partial use of country systems, primarily the Supreme Audit Institution, which has the capacity to conduct audits, and (ii) partial use of common or joint financial management that does not rely on country systems[1] wherever the country system arrangements are deemed weak and therefore perceived to have high fiduciary risks. The overall goal of the study is to provide an evidence-based approach for determining the costs and benefits of parallel FM arrangements for donor-financed projects, by comparing the cost of the parallel arrangements with the cost that would have ensued from either a scenario where the arrangements were aligned with country systems or harmonized among a set of development partners.

The study is a task under the broader Public Financial Management (PFM) in Health global flagship study. The global flagship focuses on analyzing key challenges and opportunities associated with PFM arrangements in the health sector in client countries and proposing possible ways to strengthen such arrangements for better program/project design, implementation, and service delivery.

In countries where a large portion of health sector funding comes from external development assistance, strengthening and using country PFM arrangements decisions are embodied in the design and implementation approach for such assistance. Where external assistance is channeled through the recipient country's budget, and country systems are used for implementation, there is an opportunity to strengthen and reinforce and such systems. On the contrary, where development assistance is off-budget and implemented through parallel or donor-specific implementation arrangements, strengthening of country systems is often undermined.

[1] Budgeting, funds flow, internal controls, internal audit, accounting and financial reporting.

The analysis focuses on the Uganda health sector context, reviewing the current practices in the sector, the strengths and weaknesses of the sector's financial management arrangements, and the comparative costs to the development partners of using the current parallel arrangements versus joint arrangements, evaluating any potential efficiency gains and reductions in transaction costs that the latter might provide. The data for the cost of parallel arrangements was provided by the participating development partners over the period 2011–15. The data for analyzing the assumed scenarios was collected directly from the Ministry of Health and in-country health development partners, as well as through market analysis of current market prices of inputs for the scenario.

The study finds that Uganda's Ministry of Health has in the past pursued development partner harmonization and alignment, and this was achieved up until late 2012, when a scandal broke out in the Office of the Prime Minister. The scandal led to the withdrawal of development partners from budget support to Uganda,[2] a scale-down of overall support, and a consequent surge in the use of parallel arrangements in all sectors, including health. The knock-on effect of the corruption scandal still hangs over the public sector, albeit efforts are being made to remobilize the development partners in the health sector in order to support a results-based financing operation, as a precursor to bringing back harmonization and alignment. Fiduciary risks are still perceived to be high, and these attempts have yet to gain traction and convince development partners to move away from continued reliance on ring-fenced parallel implementation arrangements.

Based on the analysis of data collected from the four participating donors in the study, the total cost of parallel arrangements between 2011 and 2015 was US$16.9 million. This contrasts with an estimated cost of US$4.75 million over the same period assuming development partners had made harmonized implementation arrangements.

The total disbursed amount for project/program implementation for the participating development partners for the study period was US$359.90 million; the total cost of parallel arrangements was therefore 5 percent of the total amount disbursed over the study period.

The study concludes that development partners in the Uganda health sector could still pursue harmonization and alignment in financial management by using agreed-upon arrangements that would not increase the fiduciary risks associated with the sector and could in fact reduce them. The use of a program management unit (PMU) arrangement, which promotes joint financial arrangements, could help minimize fiduciary risks, reduce the cost of implementation, and enhance transparency and accountability for the use of funds, all by reducing the fragmentation that undermines the strengthening of the country systems in the long run. There are also opportunities to consider using government systems that could be monitored and that are widely accepted, such as the supreme audit institution (SAI), which is considered to be independent. The estimated cost of partial use of country systems and harmonization is approximately one percent of the total disbursed by the four donors over the study period.

A joint assessment of the sector's financial management systems by both the development partners and the ministries of Health and Finance could be good starting point for identifying weaknesses, and developing a joint capacity building plan to help address the weaknesses. A joint capacity building plan could form the basis for building trust in the country system and forging a harmonized or aligned arrangement for implementing development partners' projects.

[2] Lorenzo Piccio, "In Uganda, donors divided on response to aid embezzlement scandal," *Inside Development*, Funding Trends, Devex.com, at https://www.devex.com/news/in-uganda-donors-divided-on-response-to-aid-embezzlement-scandal-79925.

1 INTRODUCTION

This study seeks to understand the costs and benefits of using un-harmonized and unaligned implementation arrangements for donor-financed projects in the health sector in comparison with the costs and benefits of using harmonized and aligned arrangements. Analyzing the cost of un-harmonized and unaligned implementation arrangements is a task under the global study: PFM in health: Service delivery challenges and opportunities. The study—"PFM in Health: Service Delivery Challenges and Opportunities"—aims to analyze key challenges and opportunities associated with PFM arrangements in the health sector in client countries and programs and to propose possible ways to strengthen PFM arrangements for better design, implementation, and service delivery.

In countries where a large portion of health sector funding comes from external development assistance, strengthening and using country PFM arrangements decisions are embodied in the design and implementation approach for such assistance. Where external assistance is channeled through the recipient country's budget, and country systems are used for implementation (in accordance with the International Health Partnership (IHP+) principles), there is an opportunity to strengthen and reinforce and such systems. On the contrary, where development assistance is off-budget and implemented through parallel or donor-specific implementation arrangements, strengthening of country systems is often undermined.

The 2014 IHP+ performance monitoring report[3] noted that, despite improvements in partner countries' PFM systems, health support on-budget and the use of country systems for implementation decreased. This reflects continued lack of donor trust in country systems; a situation that has perpetuated fragmentation and its attendant high transaction cost and inefficiency, notwithstanding evidence from several high profile financial scandals in several countries in recent years that, such arrangements do not necessarily reduce fiduciary risks. As a part of the larger PFM in health study, a review was conducted to analyze data on specific FM cost items[4] from a variety of countries to help determine the costs and benefits of fragmented donor FM arrangements in the health sector.

[3] IHP+ report monitors compliance with IHP+ principles in partner countries.

[4] Cost elements include fees paid for FM consultants, internal audits, costs of accounting software, external audit other than SAI, FM-related special or in-depth reviews, and fees paid to UN agencies, fiduciary agents, project implementation units.

This task aims to collect evidence through country case studies to compare the divergence of actual practice from the stated or envisioned procedures along the health delivery value chain of the selected outputs under Pillar 1, *Health sector service delivery PFM framework.* Under this country case-study activity, actual cost figures were collected relating to financial management (FM) staffing, operating costs, accounting software, internal audit, and external audit from four major health donor agencies supporting the health sector (see Appendix B for the data collection template). The costs were compared with the estimated cost of an alternative implementation scenario that assumes (i) a partial use of country systems, primarily the supreme audit institution, which has the capacity to conduct audits, and (ii) partial use of common or joint FM that does not rely on country systems,[5] wherever the country system arrangements are deemed weak and therefore perceived to have high fiduciary risks.

The analysis is based on the International Health Partnership Initiative (IHP+) principles of FM harmonization and alignment. To enhance development effectiveness in the health sector, IHP+ recommends harmonization of implementation approaches among partners wherever the country's FM systems are found to be weak. The joint arrangement is expected to help promote joint support by development partners to strengthen the country system in the medium to long term while program implementation continues. In countries where FM arrangements are considered adequate, IHP+ recommends alignment of the implementation approach with the country system.

[5] Budgeting, funds flow, internal controls, internal audit, accounting, and financial reporting.

BACKGROUND: THE UGANDAN HEALTH SECTOR PROGRAM

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Uganda's national health program is outlined in its Health Sector Development Plan (HSDP) 2015/16–2019/20. This HSDP is the second in a series of six five-year plans aimed at achieving Uganda's Vision 2040, whose goal is to build a healthy and productive population that contributes to socioeconomic growth and national development. The goal of the HSDP plan is to accelerate movement toward universal health coverage (UHC) with all the essential health and related services needed for the promotion of a healthy and productive life. The key objectives for this five-year plan are

1. To contribute to the production of healthy human capital for wealth creation by providing equitable, safe, and sustainable health services;
2. To increase households' financial-risk protection against impoverishment due to health expenditures;
3. To address the key determinants of health by strengthening inter-sectoral collaboration and partnerships; and
4. To enhance health-sector competitiveness both in the region and globally.

Implementing the Uganda National Minimum Health Care Package continues to be the core strategy for achieving maximum outcomes in HSDP. A stronger focus is being placed on health promotion and disease prevention using a multi-sectoral approach. Furthermore, deliberate efforts will be directed at harnessing the contributions of health-related sectors and those of communities toward achieving positive health outcomes that are sustainable.

Among the seven priorities identified in the HSDP for investment is health financing. The plan states that the sector will work toward mobilizing and allocating resources to implement planned services in an efficient, effective, and equitable manner by introducing a number of reforms. These include reforms in systems for revenue generation, in risk pooling and strategic purchasing of services, in the public financial management and procurement systems, and in the governance and regulatory systems for the National Health Insurance Scheme.

The plan recognizes that the pursuit of public finance and accountability and of fiscal decentralization and a sector-wide approach (SWAp), as well as the introduction of output-based

budgeting and reporting tools, among other things, has facilitated improvements in health service delivery over the last 15 years. This recognition highlights the link between the strength (or otherwise) of public financial management arrangements and the achievement of results in the health sector.

PROGRAM IMPLEMENTATION

3

Summary of Sector Health Sector Challenges

Uganda is still far from reaching its ultimate goal of achieving universal health coverage, as the still high rates of preventable illness and mortality make clear. The under-five mortality rate improved substantially between 2006 and 2013, from 137 deaths (per 1000 live births) to 69 deaths, yet this latter rate is still a high one. The infant mortality rate has been improving more slowly, declining between 1995 and 2014 from 85 deaths (per 1000 live births) to 54 deaths (WHS estimates) in 2014. Most worrisome, the neonatal mortality rate has remained relatively constant (at 27 deaths per 1000 live births),[6] and so has the maternal mortality rate (at about 438 deaths per 100,000 live births). Other challenges within the sector include the following.

Communicable disease: HIV, malaria, lower respiratory infections, meningitis, and tuberculosis still are estimated to cause the highest numbers of years of life lost in Uganda. In addition to these major causes, the sector has faced challenges with new and re-emerging conditions that affect far fewer people but remain significant public health risks, such as polio, Hepatitis E and B, Ebola, Marburg, and Nodding disease.

Noncommunicable illness: As a result of changes in lifestyle, noncommunicable diseases are increasingly becoming a major burden. Although rates of protein deficiency have been reduced, this form of malnutrition still remains the underlying cause of nearly 60 percent of infant deaths.[7] The latest measurement of risk factors shows that alcohol use, tobacco use, household air pollution, childhood underweight, iron deficiency, and high blood pressure are the most significant risk factors, responsible for more than 16 percent of all disease conditions.

Research challenges: The sector still faces challenges in meeting its health research needs, including inadequate numbers of skilled staff in all research institutions, inadequate government financial allocation to research, and weak collaboration mechanisms among planners, research institutions, industry, academia, and development partners.

[6] Uganda Ministry of Health, *Health Sector Development Plan 2015/16–2019/20* (September 2015).

[7] Uganda Nutrition Action Plan (UNAP) 2011–2016.

Access to treatment: For most Ugandans, reaching health facilities is still a challenge. The proportion of the population leaving within five kilometers of a health facility is currently at 72 percent. There are still severe inequities in the availability of facilities, ranging from a low of 0.4 facilities per 10,000 population (Yumbe District) to a high of 8.4 facilities per 10,000 population (Kampala). Over the years, many health facilities have been renovated and equipped, but in general most facilities still depend on inadequate and poorly maintained medical equipment.

Funding for medicines: Funding for medicines has improved in recent years, although the greater proportion (81 percent) of this funding is from development partners and it is largely skewed toward addressing HIV/AIDS, malaria, and tuberculosis. The per-capita government expenditure on essential medicines and health supplies (EMHS) in fiscal 2013–14 was about US$2.40, which is below the estimated requirement in the health sector strategic investment plan (HSSIP) of US$12 per person.

Workforce challenges: The inadequacy of the health workforce creates a bottleneck for the appropriate provision of health services, with challenges in adequacy of numbers and skills as well as widespread problems in retention, motivation, and performance. Recent efforts by both the government and development partners have made inroads in these problems, facilitating the recruitment of much-needed staff: the proportion of approved posts has risen from 56 percent in 2010 to 69 percent in fiscal 2013–14.[8]

Public health governance: Sector governance and stewardship has been changing at the highest level, leading to frequent changes in stewardship direction.

[8] Uganda National Planning Authority, *Second National Development Plan 2015/16 – 2019/20* (June 2015).

GOVERNMENT AND PARTNER PLANS AND GOALS

4

The Second National Development Plan (NDP II) 2015/16–2019/20, emphasizes the following goals in the health sector: mass management of malaria prevention; the National Health Insurance scheme; universal access to family planning services; development of health infrastructure; reduction in maternal, neonatal, and child morbidity and mortality; scaling up of HIV prevention and treatment; and the development of a center of excellence in cancer treatment and related services.

The HSDP II (2015/16–2019/20) has goals that are more specific, especially regarding disease and mortality prevention. Its overarching goal is to accelerate movement toward Universal Health Coverage (UHC) with essential health and related services needed for the promotion of a healthy and productive life. The sector is focusing on attaining the following results: reducing the infant mortality rate (per 1,000 live births) from 54 to 44 and the maternal mortality rate (per 100,000 live births) from 438 to 320; reducing fertility to 5.1 children per woman; reducing stunting among children under age five from 33 to 29 percent; increasing measles vaccination coverage for children under one year of age from 87 to 95 percent; increasing the tuberculosis case detection rate from 80 to 95 percent; increasing antiretroviral therapy coverage from 42 to 80 percent; increasing deliveries in health facilities from 44 to 64 percent; and increasing level IV health centers offering emergency obstetric care services from 37 percent to 50 percent.

The HSDP II foresees its implementation through a sector-wide approach (SWAp) arrangement, with the Ministry of Health taking the lead roles in policy making, providing guidelines, training and capacity-building, monitoring the health sector, and coordinating partners. The plan recognizes that to achieve the SWAp arrangement the sector needs effective governance structures at all levels, enforcement of rules, especially at the decentralized levels, joint planning and budgeting, regular performance reviews, and commitment to achieving the sector goals and objectives.

The HSDP II will be financed through a public-private arrangement in which the Government of Uganda contributes 27 percent, existing and bilateral partners contribute 36 percent, and multilateral partners contribute 7 percent, while the remaining 30 percent is funded from private contributions. Private sources will include households, NGOs, and private employers. The overall cost of the HSDP II, based on its service coverage targets, is estimated at approximately US$25.32 billion.[9] The plan is being implemented both at the national and subnational levels of government.

[9] Uganda Ministry of Health, *Health Sector Development Plan 2015/16–2019/20* (September 2015).

DEVELOPMENT PARTNERS WITHIN THE HEALTH SECTOR

5

The existing partnership instrument—the Compact Memorandum of Understanding (MoU)—serves as the formal instrument to guide the functioning of the partnership in health. It is guided by the principles of development effectiveness established by the International Health Partnership (IHP+). However, although the Health Policy Advisory Committee (HPAC) and Health Development Partners remain active forums for health policy dialogue, aid coordination in the sector has not been very effective in recent years, since many partners have reverted to using parallel arrangements for implementing their support in the sector.

The sector initially had a SWAp arrangement to which most donors contributed through budget support under the guidance of the Compact MoU, with the exception of USAID. However, with accumulating burden of the 2013 scandal involving the Office of the Prime Minister, the early-2016 scandal involving misuse of Global Fund aid,[10] and prevailing governance issues, the partnership within the sector disintegrated. Some bilateral donors opted to abandon on-budget support with clear stand-off positions, and as a result parallel arrangements were introduced.

Nevertheless, the Ministry of Health and some development partners continue to pursue harmonization and alignment, and for this purpose they are considering various mechanisms. A basket-fund arrangement was recently proposed, although that proposal is still at a nascent stage. Other proposals—especially for the new HSDP II—include the use of results-based financing to bring back alignment on the basis of agreed-upon indicators and results. A 2014 sector assessment reveals that only 49 percent of the development partners in the sector were on budget as of that year. Of those on-budget, only 43 percent were using country systems for public financial management, and of this last group, only 34 percent were able to provide three-year expenditure plans. The trend, instead, is for partners to provide annual expenditure plans.[11]

[10] Richard Kavuma, "Uganda's failure to spend Global Fund grants denies thousands HIV treatment," *The Guardian*, March 2, 2016. https://www.theguardian.com/global-development/2016/mar/02/uganda-failure-to-spend-global-fund-grants-denies-thousands-hiv-treatment.
[11] IHP+, *Country Score 2014 Assessment*.

SUMMARY OF THE FM ARRANGEMENTS IN THE HEALTH SECTOR

6

Planning, Budgeting and Monitoring

The Ministry of Health implements both clinical and public health programs and activities through a decentralized health system that caters to integrated health care at the primary, secondary, and tertiary care level, while the administration and management of medicines and supplies are centralized. Planning and budget preparation is managed within a five-year horizon, but it is only weakly linked to the National Development Plan. Constant changes to the budget ceilings and frequent supplementary budgets undermine allocative decisions.

The major source of revenue in the health sector comes from the Health Development partners. Approximately 51 percent of these partners' sector support remains off-budget, leaving just 49 percent estimated within the government's budget. To this extent, the use of country planning and budgeting systems in the sector is largely ad hoc and incomplete. Off-budget expenditure is unknown, and development partners are not keen to provide this information to the Ministry of Health.

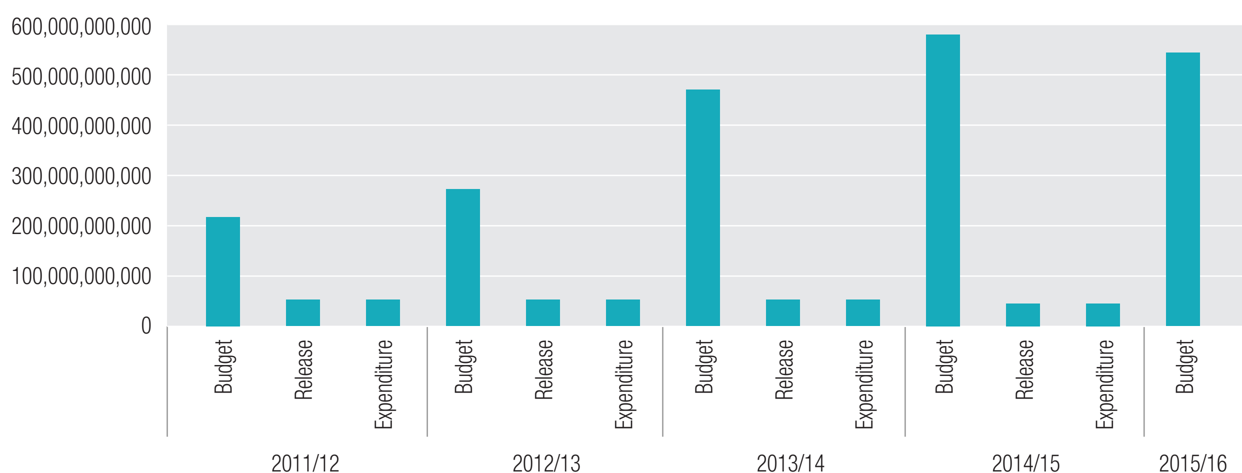
In absolute terms, government allocation to the health sector has increased over the last five years. However, as a percentage of total government expenditure funding for the health sector has actually decreased. The total government expenditure on health as a percentage of GDP has also been decreasing over the years, dropping from 9.6 percent in fiscal 2009–10 to 7.9 percent in fiscal 2012–13.

TABLE 1 ■ Government and Development Partner Allocations to the Health Sector, 2010–15 (in Billions of Ugandan Shillings)

Fiscal Year	Government of Uganda funding	Donor projects	Total
FY2010/11	570	90	660
FY2011/12	593	206	799
FY2012/13	631	221	852
FY2013/14	711	417	1,127
FY2014/15	749	533	1,281

Source: Annual Health Sector Performance Report.

FIGURE 1 ■ **Health Sector Budget, Releases, and Expenditures, FY2011/12 to FY2015/16 (in Ugandan Shillings)**



Source: Uganda Boost Data (December 2015).

Analysis of the health sector budget over the last five years reveals that government releases annually show significant variances between their estimated budget amounts and releases for expenditure (see Figure 2). This variance ranges between 80 and 95 percent, which puts into question the accuracy and realism of the budgeting process. There are irregular releases of funds, which delays implementation. In addition, since off-budget funds cannot be adequately planned for, there is a need for a comprehensive planning system to bring accounting of all available resources into agreement.

Funds Flow

Uganda is implementing a treasury single account system (TSA) with quarterly releases to the ministries, departments and agencies (MDAs). However, the TSA system still needs to be aligned with the budget preparation, procurement planning, and accounting systems. Most development partners' funds in the sector have been off-budget following the scandals in 2013 and the previous corruption scandals involving the Global Fund and GAVI. Ever since, development partners have preferred project support and ring fencing of their funds by implementing them through parallel arrangements.

The bulk of health service delivery responsibilities were devolved to local governments several year ago. The existing legal framework provides for intergovernmental fiscal transfers (unconditional, conditional, and equalization) and several types of local own-source revenues. Conditional transfers for health services are made to the districts, and those relating to health facilities are sent directly to the facilities. Other grants, such as those from GAVI and the Global Fund, are disbursed according to the approved district plan.

Previously, funds for health facilities were channeled through the districts, but now all facilities have opened their own accounts at whatever bank they prefer. Consequently, transfers are made on a quarterly basis directly to the facilities. The challenge here is that maintaining these accounts comes with a high administrative cost.

Accounting

Funds allocated to the health sector are accounted for using both automated and manual processes at the district level and, especially, at the facilities

level. Up to the end of fiscal 2014–15, the Ministry of Health's projects were using the Navision accounting system for accounting and reporting. The Ministry of Finance, on the other hand, has been piloting a projects module using an integrated financial management information system (IFMIS), and is in the process of scaling up its implementation to cover more projects. However, some major challenges remain, such as improving discipline in capturing commitments, full compliance with accounting standards, and improving consolidation procedures. Districts and facilities also continue to use manual record keeping.

Internal Control and Governance and Anti-Corruption (GAC) Arrangements

Internal controls are documented in the government's Financial and Accounting Manual and regulations. The regulations outline all controls and procedures for revenues and expenditures as well as the functions and responsibilities of officers. According to the 2012 PEFA, the internal controls and internal audit are weak, and payroll and procurement are insufficiently controlled. Reports from the Internal Audit and Inspectorate Department and the Auditor General cite numerous irregularities by ministries, districts, and agencies. Such irregularities include advances not accounted for, goods accepted that do not meet specifications ordered, commitments made without prior local purchase order (LPOs), infrastructure projects that do not meet standards, and weak capacity, especially at the district and facility levels.

The Ministry of Health is grappling with the effects of governance problems both at the ministry and at the Office of the Prime Minister. These problems have had significant effects on the way development partners work with the ministry. Governance issues, corruption scandals, and a failure to meet key indicators have led to very unpredictable budget and sector support. As mentioned earlier, most development partners have opted to use ring-fencing methods, such as direct disbursements and project support.

In recent years there has been a significant staff turnover at the Ministry of Health, especially at senior and top management levels. This high turnover has led to frequent changes in stewardship direction and thus affected governance.

Financial Reporting

The Ministry of Health has set up coordination and administrative units for the development partners implementing projects directly with the ministry. Quarterly reports are prepared for each development partner concerning both financial and technical progress. As mentioned earlier, up until now the ministry has been using the Navision accounting system to prepare reports, and at the subnational and facility levels various systems are used to prepare such reports. The ministry has noted instances of duplication in reporting, especially at the district level, which has sometimes caused information to be misrepresented or incoherent. Due to the lack of uniform reporting arrangements, the parallel donor arrangements are causing fatigue to the ministry as the donors make their separate, frequent, and various information requests.

While IFMIS has been rolled out at the national and subnational levels, projects are not yet reported on using IFMIS but, instead, multiple reporting systems are used. The Ministry of Finance has, however, developed a projects module on IFMIS for projects to use going forward, and to date IFMIS has been rolled out at four national referral hospitals.

External Oversight

All entities of the central government, including non-commercial parastatals, are audited every year by the Office of the Auditor General (OAG) using international standards of auditing, and reports are submitted

to Parliament by March according to the statutory deadline. The quality of the audit is high and meets international standards. Moreover, the 2008 Audit Act strengthened the OAG's independence, and the office's audit scope and coverage have been expanded.

Parliament, on the other hand, undertakes annual reviews of fiscal policies, the medium-term fiscal framework, and the proposed annual budget. The Parliament Public Accounts Committee (PAC) holds in-depth hearings with accounting officers of all MDAs on the findings of the OAG report.

The challenge for external oversight is inadequate and delayed follow-up on audit recommendations, as made by the Auditor General, Public Procurement and Disposal Authority (PPDA) and Internal audit, which in turn undermines accountability.

7 SUMMARY OF FIDUCIARY RISKS IN THE HEALTH SECTOR

Altogether, we identify eight areas of fiduciary risk in the health sector, which can be summarized as follows.

1. Loss of trust. Loss of trust has led donors to withdraw support or bypass government systems. Uganda suffered a serious setback in donor support in fiscal 2013–14, especially in loss of general budget support and sector support, due to governance issues and corruption scandals that led many donors to either suspend budget support temporarily or completely. The health sector was then affected by very unpredictable budget support, which in turn led donors to deal directly with the government agencies or, in many cases, to bypass t.he government systems by making parallel arrangements. Overall use of government procedures in aid management is now below 50 percent.

2. Failure to disburse funds. There is also a risk of donors failing to disburse funds on time and according to the commitments made. Usually, annual disbursements are much lower than the commitments made. The Ministry of Health, in its annual performance report, has highlighted the challenge of inadequate and irregular releasing of donor funds, which delays implementation.

3. Poor flow of donor information. Reporting and accountability data are rendered inaccurate by the poor flow of information from donors. Forecast data on project support are often unreliable, and generally the inflow of information from donor agencies in the health sector is inadequate. In many cases this makes reporting and accountability information inaccurate.

4. Unharmonized reporting formats. Current arrangements require project personnel to report back to development partners using different, unharmonized formats. Current reporting arrangements require the project personnel to prepare reports on the basis of each partner's own formats and templates. Partner-specific reports require the use of spreadsheets to adapt reports to the required formats, mainly due to the need to attribute expenditure and revenue for particular outputs and outcomes. Due to these requirements, the use of IFMIS as a single accounting system may not turn out to be attractive the development partners. Likewise, the use of a single financial statement may not be attractive, due to the need to attribute funds and expenditures.

5. Overburdened staff. The above-described multiple reporting requirements overburden already inadequate staff. The multiplicity of separate reporting and other implementing arrangements required by the development partners makes excessive demands of project staff, whose numbers are already inadequate, and this also lowers the quality of services delivered.

6. Invisibility of off-budget fund transfers. Because the central ministry is often bypassed by development partners, it is unable to determine and quantify off-budget expenditures, and at the local level project funding is often duplicated. This is due to the direct engagement of development partners with government agencies, especially with local governments, and the limited flow of information from the partners to the Ministry of Health. This has also resulted into multiple funding of activities, especially at the local government level. Most resources remain off-budget, mainly as a result of direct implementation and tripartite agreements with partners or NGOs, so resource harmonization and alignment remain little more than good intentions. For the same reasons, because the central planning machinery is by-passed by partners, there is no clear resource mapping.

7. Still-weak coordination among development partners. Instruments for partnership and coordination within the Ministry of Health require further strengthening. Currently, although the Health Policy Advisory Committee (HPAC), the Health Development Partner Meeting, and the Sector Working Groups are all active, a number of initiatives and interventions have been introduced that have led the development partners to abandon the government's initiatives. For example, partners have stepped away from the Long Term Institutional Arrangements (LTIA) in favor of the Global Financing Facility, which weakened the efforts towards harmonization. New instruments have also been proposed, such as the partnership-fund and the basket-fund arrangements.

8. Excessive administrative costs at the Ministry of Health. Siloed, project-based administration at the Ministry of Health is wasting resources. Each donor-funded project has its own administrative unit within the Ministry of Health, with an entire team of project staff to manage it. As a result, more funds are absorbed by administrative costs and less are available for actual service delivery.

All of the above have contributed to the perceived high level of fiduciary risk in the health sector and resulted in (or perpetuated) the widespread use of parallel implementation arrangements for donor-financed projects. While a number of country compacts have been designed on the principle of harmonization, thus far only a handful of donors have participated in them, despite the fact that those outside these initiatives are party to the IHP+ agreement signed in February 2009. A Basket Fund mechanism is being considered by the Belgian Technical Cooperation (BTC), Sweden, and the World Bank. This is expected to help promote harmonization, although there are no immediate plans to implement this arrangement.

COST-BENEFIT ANALYSIS FOR HARMONIZING DEVELOPMENT PARTNERS' FINANCIAL MANAGEMENT IMPLEMENTATION ARRANGEMENTS

8

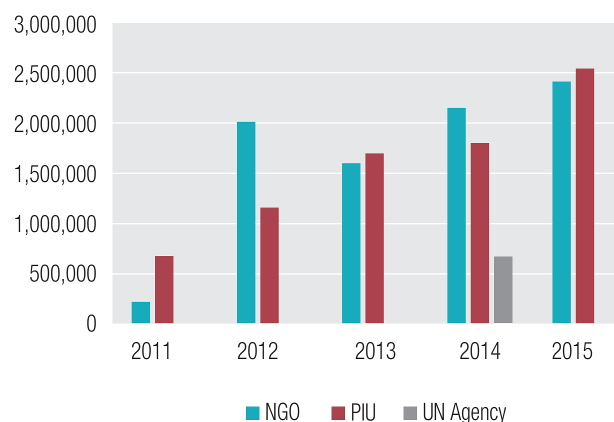
Needs and requirement analysis

Given the above risks and limitations, an arrangement for fiduciary collaboration that would still provide a good foundation for the envisaged pooled funding arrangement, if it crystallizes, would be to consider setting up a *Health PFM Project/Program Management Unit (PMU*). Such an arrangement would need to be made on the basis of implementation arrangements agreed to by both the government and the development partners. The intention would be first to harmonize as development partners and subsequently to harmonize and align with the government. The use of country systems may not be as appropriate given the existing circumstances and/or political economy.

The main objective of such a PMU arrangement would be to obtain a common agreement with the development partners, strengthen coordination, and aim to employ IFMIS and a common reporting framework. Doing so should subsequently lead to one consolidated financial statement within the health sector, one audit report, and joint financial supervision. The PMU would take on only project fiduciary responsibility, while the responsibility for program implementation would rest with the current line directorates in the Ministry of Health. Specific country systems such as external audits and use of the accounting system could be used on the basis of specific agreements or terms of reference.

As demonstrated in Figure 3, the current trend in the health sector is the use of project implementation units (PIUs) and UN agencies to implement donor funded projects. These ring-fenced mechanisms are parallel to the country system and fully staffed with project staff, which translates into additional costs for maintaining each unit, thus taking funds away from service delivery. Similarly, each PIU has a bank account, which attracts its own fees

FIGURE 2 ■ Trend of Development Partners' Implementation Arrangements, 2011–15 (US$)



Source: Based on data collected from the four development partners: World Bank, Global Fund, GAVI, and KFW.

to maintain, and a separate external audit is usually conducted for each project managed.

Further, disbursement information was obtained from the OECD Creditor Reporting System to help compare the cost of parallel arrangements with the total amount disbursed over the study period (see Tables 3a and 3b). The over cost of parallel arrangement is 5 percent of the total disbursed over the study period, with KfW contributing the largest share of the cost.

TABLE 2 ■ Total Cost of Implementation Arrangements Per Year, 2011–15 (in US$ Millions)

Year	NGO	PIU	UN agency	Fiduciary agent	Total
2011	0.21	0.67	0.00	0.00	0.88
2012	2.01	1.18	0.00	0.00	3.19
2013	1.60	1.76	0.00	0.00	3.36
2014	2.20	1.86	0.66	0.00	4.72
2015 & beyond	2.40	2.58	0.00	0.00	4.98
Total	8.42	8.05	0.66	0.00	17.13

Source: Based on data collected from the four development partners: World Bank, Global Fund, GAVI, and KFW.

TABLE 3A ■ Total Disbursed Amount (in US$ Millions)

	World Bank	GAVI	Global Fund	KfW	All agencies
2011	9.05	12.54	9.47	1.00	32.05
2012	9.62	12.22	93.44	0.95	116.22
2013	26.22	30.92	23.13	1.01	81.28
2014	17.92	35.58	19.37	1.11	73.98
2015	22.07	33.25	0.00	1.06	56.38
Total	**84.87**	**124.50**	**145.40**	**5.13**	**359.90**

Source: OECD Creditor Reporting System.

TABLE 3B ■ Cost of Parallel Arrangements as a Percentage of Actual Disbursement (in US$ Millions)

	World Bank	GAVI	Global Fund	KfW	All agencies
Implementation costs	0.0	11.0	6.0	0.0	17.0
Disbursements	84.87	124.50	145.40	5.13	359.90
Implementation as percentage of disbursements	0%	9%	4%	0%	5%

Source: Authors calculations based on information provided by Donors (WB,GF,GAVI&KFW) and OECD creditor reporting system.

TABLE 4 ■ A Framework to Analyze the Requirements and Key Outcome Indicators of Selected Implementation Arrangements

Harmonized implementation arrangements	Needs analysis narrative	Requirement analysis	Actions required	Cost of proposed arrangements over a 5-year period (in US$ millions)
Planning and Budgeting	There are approximately 16 major development partners (DPs), excluding NGOs, CSOs and PNFPS (Church based) operating within the Ugandan health sector. These partners use a mixture of financial management arrangements, with the majority using parallel systems. Due to these parallel arrangements, the institutional planning machinery is bypassed, rendering it impossible for the government to focus its sector priorities and planning arrangements. Off-budget funds cannot be adequately planned, and thus a need arises for a system for comprehensive planning to bring resources and activities into agreement and to have a mechanism for monitoring the end result. To this extent, the Ministry of Health (MoH) has set up a one-country platform for M&E. This will further be strengthened by the harmonized approach, especially to collect data from the participating DPs and consolidate off-budget funding in actual terms.	Harmonized *one* financial statement Technical support	Establish a comprehensive planning system. Develop a planning database for resource mapping. Mobilize information on multiyear estimates.	US$0.80
Accounting information system	Uganda has a success story in its implementation of IFMIS; however, projects are still using their own accounting systems due to the different reporting requirements for the projects. Since 2014 the Ministry of Finance has developed a project module on IFMIS; 6 pilot projects have been using the system and a decision has been taken to roll IFMIS out to all projects for fiscal 2015/16. Nevertheless, IFMIS is only applicable to DPs on budget, and therefore there is a need to invite the off-budget DPs to first agree on a comprehensive reporting format that addresses the DP concerns, such as attribution of expenditures or else a focus on results and out-puts rather than expenditures. Therefore, there is a need to facilitate the harmonization of reporting formats and the roll-out of IFMIS.		Develop a forum to negotiate the reporting formats and templates. Implement DP funds module. Publish the financial statements for transparency and accountability.	Counterpart funding
Reporting templates	Due to multiple reporting and data manipulation out of the accounting systems, information is often incoherent and misrepresented. Therefore, there is a need to harmonize and standardize the reporting formats and templates, on the basis of international public sector accounting standards and agreed-upon reporting arrangements. Ultimately, producing a single report will both meet the DP requirements and lead to the production of one financial statement.		Develop reporting templates and assign this mandate to the PMU. MoH & donors together with the MoF, develop the required standard reporting format.	Counterpart funding
Ministry of Finance	The Ministry of Finance in Uganda has the leading role for preparation for financial statements, are the custodian of IFMIS and the implementation of the PFM act. It is therefore important for the ministry to take a pivotal role in providing guidance to the MoH in the process of harmonization. There will therefore need to set aside a coordination budget for the Ministry of Finance and coordination of the flow of funds, including developing a corruption and fraud frame to reinstitute the DP trust in government systems		Develop a fraud and corruption frame work acceptable to the DPs, support IFMIS roll out to the project, map out funds flow mechanism for the PMU agreed upon by the DPs. Facilitate the development standard reporting templates.	

(continued on next page)

TABLE 4 A Framework to Analyze the Requirements and Key Outcome Indicators of Selected Implementation Arrangements *(continued)*

Harmonized implementation arrangements	Needs analysis narrative	Requirement analysis	Actions required	Cost of proposed arrangements over a 5-year period (in US$ millions)
External audit / Supreme Audit Institution	Institutionally external audits for government ministries, districts, and agencies are carried out by the Office of the Auditor General (OAG). The MoH is annually audited by the OAG, as are all projects on budget. However, for funding off-budget, parallel arrangements are used. The OAG is independent, with adequate capacity and audit coverage. Therefore, once agreed to by both DPs and the government, sector oversight for all sector projects may be provided by the OAG. Under the PMU, the Supreme Audit Institution (SAI) may be supported on overheads/variable costs.	One audit report	Agree to terms of reference between the DPs and the government. (PFM strategy is already targeting the strengthening of the capacity of the OAG).	US$0.50
Coordination	There is a need to strengthen the existing coordination arrangements within the sector. It is expected that the PMU will provide a coordination function for all financial management arrangements for the projects.	Joint FM supervision	Recruit PMU coordinator, agree to TOR for the PMU coordinator, agree to supervision frequency and supervision plan.	US$0.75
Staffing	The estimated level of staffing is shown in Appendix Table A.2 below. While it would be less costly to use existing public service staff, the existing circumstances may not warrant this. For the DPs to address the trust issues, the PMU should be built with project staff independent of the existing public service staff. They will perform core functions as well as build capacity at the local government level, especially at the facility level where the MoH may have direct influence.	Strengthened staffing capacity to both perform core functions and train national counterpart staff	Recruit the required staff.	US$2.52
Administrative costs	PMU administrative costs	Operating costs	Mobilize the PMU set up.	US$0.68
TOTAL				**US$5.25**

APPENDIXES

Appendix A. Cost-Benefit Analysis

Additional data is still being collected from more development partners. However, the preliminary results based on the available information received from the four development partners within the Uganda Health Sector show the total fiduciary costs for the parallel arrangements as US$17.10 million. (*See Table 2 above*.) This amount is significantly higher than the estimated cost of US$5.25 million (*see tables A.1, A.2, and A.3, below*) involved in setting up a single Program Management Unit (PMU) to house all donor funded projects. These costs mainly include labor costs, PMU operating costs, technical assistance and joint supervision. Other recommended actions such as audit will be absorbed into the existing arrangements and/or counterpart funding.

MoH has made attempts toward harmonization and alignment of project implementations arrangements and procedures through the use of the Long Term Institutional Arrangements (LTIA) for those projects that are on budget. LTIA is aligning or embedding projects within existing government systems. A number of donors have used this arrangement to implement projects within MoH, such as Saudi Arabia, Italian Cooperation, World Bank, African Development Bank, Spanish Debt Swap, Belgian Technical Cooperation, etc. but not a complete buy-in by all DPs in the sector. And even then, these are not pooled partners, they implement individual projects. The LTIA system has not gained prominence among the DPs and it has also other challenges, such as delays in disbursements, substantial bureaucracy, and capacity issues. Therefore, the PMU proposal will build on the positives of this arrangement but also seek to develop a joint or pooled arrangement as a way to reduce transactional costs for project implementation.

In order to achieve one consolidated financial statement, **one audit report, and joint supervision**, the monetary costs involved in setting up and operating a single project implementation unit, housing all donor projects within the health sector, is based mainly on having one accounting information system in place, having adequate numbers of accountants in place, and providing capacity building at both national and county governments levels. The PMU will support both levels of government**.**

One consolidated financial statement: To the extent possible, the projects funded by DPs within the sector will use the existing system for the government. The government has rolled out IFMIS to all MDAs, and they are in the process of being rolled out to projects. A project module has been developed and was initially piloted in six projects; however, during fiscal 2015/16 a decision was taken to roll out to all projects. The assumption for the study is that the projects within the PMU will continue to use IFMIS under close scrutiny, and both the government and DPs will agree on the monitoring mechanism, the adequacy of the system, accessibility by facilities, reporting frequency, and reporting templates. It is also assumed that IFMIS will be able to produce trial balances for each project to be used for preparing quarterly reports to the DPs. It is however noted that reports will be prepared and produced outside IFMIS, but in Excel. The benefit is that there will be a common database for all DP support, a single report will be prepared saving the Ministry a lot of time in preparing multiple reports for the different donor requirements. Also, the PMU and DPs will not incur any additional costs.

The challenge currently faced by the MoH is the DPs' requirements for specific reports and attribution of expenditure. Secondly, IFMIS has so far not been able to produce reports by component or category, due to the chart of accounts that is designed on the basis of the government's specific reporting requirements; however, these reports can be prepared outside the system.

Staffing costs: The model assumes that the PMU will be headed by a program manager not only to provide strategic direction but also to create awareness within the PMU staff of the aid effectiveness agenda. A finance manager is to provide technical guidance, who will administratively report to the program manager;

however, functionally he/she will report to the head of accounts for MoH, to ensure that the PMU is not a completely separate entity. These will be supported by 10 accountants within the PMU. The costing for their remuneration has been largely based on what they currently pay project personnel.

Comprehensive planning and budgeting: Comprehensive planning and budgeting is undermined by the on- and off-budgeting and by the on- and off-planning issues. The underlying implication is that not all funding to the sector is captured, especially the off-budget support, predictability of funding is constrained, and information on multi-year estimates is difficult to obtain. In order to achieve the goal of preparing one financial statement, there is a need to map out the resources within the sector to ensure equitable resource allocations both at the national and the local government level, and also to be in a position to map the support provided by DPs and monitor aid flow in the sector. There will be a need to map all resources and have a comprehensive database. Currently, the MoH has a number of information systems to support the resource allocations, but the available information is inaccurate. This is an area where the DPs will have to play a major role by providing the required information and ICT to plan, monitor, coordinate and track inflows and out flows. To strengthen the partnership between the government and the DPs, it is proposed that the government contribute to the PMU in the form of counterpart funding. A technical assistance has been proposed, cutting across the PMU, and will provide support and advise on the process of planning and budgeting within the sector. The PMU coordinator will be allocated the role of coordinating between the donors and the government to collect the required information, liaising with the existing coordination desks in the sector.

Single audit for the health sector: The required result here is to achieve a consolidated and audited financial statement for the sector. Given that SAI has adequate capacity and independence, it is proposed that the SAI will carry out the audits for all the projects as it is the current practice now for all the on-budget projects. However, since the PMU will be using agreed-upon procedures, the terms of reference and the report template will be agreed upon by all the DPs to ensure that the audit covers all areas they would like to see covered. The current PFM strategy also foresees the strengthening of capacity at the Office of the Auditor General (OAG). A provision of US$0.50 million has been made to support the variable costs of the OAG for a period of five years.

Joint supervision and coordination: An investment of US$0.75 million over a period of 5 years will be committed to support supervision and coordination of the investments by the DPs within the sector towards achieving joint FM supervision. It is also expected that over time there would be a division of labor between the DPs to monitor and report on specific areas to be supervised, which would reduce this cost in the medium to long term. The health sector is already pursuing a one-monitoring-and-evaluation framework across the sector. The investment is an estimate using market trends in the sector, and it takes into account travel costs to the local governments,

TABLE A.1 ■ One-Time Costs (in US$ Millions)

Implementation arrangement	Item	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Project supervision cost	Travel/Per Diem	0.15	0.15	0.15	0.15	0.15	0.75
Planning & budgeting		0.20	0.15	0.15	0.15	0.15	0.80
Total one-time cost		**0**	**0.30**	**0.30**	**0.30**	**0.30**	**1.55**

Source: Authors calculations based on information gathered from ministry of health, DPs and market place.

accommodation, international travel (visiting teams), per-diems, communication costs, and facilitation. The assumption is that at least districts and facilities implementing the health projects will be supervised at least once or twice annually, with the second visit triggered by the findings of either the first visit, audit reports, and/or any specifics arising after the first visit. It is assumed that each DP will be represent by at least 2 people, and a joint report will be prepared and disseminated to all partners.

TABLE A.2 ■ Labor Costs (in US$ Millions)

Post	Item	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Unit FM manager	Staff time	0.07	0.07	0.07	0.07	0.07	0.35
Project accountants (10)	Staff time	0.30	0.30	0.30	0.30	0.30	1.50
Internal auditors (2)	Staff time	0.06	0.06	0.06	0.06	0.06	0.30
Support staff (4)	Staff time	0.07	0.07	0.07	0.07	0.07	0.36
Total labor cost		**0.50**	**0.50**	**0.50**	**0.50**	**0.50**	**2.51**

Source: Authors calculations based on information gathered from ministry of health, DPs and market place.

TABLE A.3 ■ Implementation Costs (in US$ Millions)

Implementation arrangement	Item	Year 1	Year 2	Year 3	Year 4	Year 5	Total
External audits	Overhead	0.10	0.10	0.10	0.10	0.10	0.50
Operating cost	Admin costs	0.20	0.12	0.12	0.12	0.12	0.68
Total implementation cost		**0.30**	**0.22**	**0.22**	**0.22**	**0.22**	**1.18**

Source: Authors calculations based on information gathered from ministry of health, DPs and market place.

Appendix B. DP Data Collection Template

PFM IN HEALTH SECTOR STUDY COSTS OF UNHARMONIZED AND UNALIGNED IMPLEMENTATION ARRANGEMENTS SURVEY: OUTSTANDING COMMITMENTS								
AGENCY NAME:		COUNTRY NAME:						
1	Implementation arrangement (please select by highlighting in yellow)	Project Implementation Unit(PIU)	Fiduciary Agent (FA) (firm)	UN Agency	NGO(s)	Individual Consultants/ TA/ Firm other than FA	Firm other than FA	Other (Please specify)
2	Current Number of entities/persons							
3	Average Contract Term							
4	**Cost Elements: Outstanding Commitment Beyond 2014**	**Amount in USD**	**Amount in USD**	**Amount in USD**	**Amount in USD**	**Amount in USD**	**Amount in USD**	**Amount in USD**
(i)	Total Fees to be paid (for FM-related staffing)							
(ii)	Accounting software cost to be financed by the project/program proceeds							
(iii)	Financial or procurement external audit other than country SAI to be paid							
(vi)	Special reviews – post procurement, internal audit, fiduciary review internal audit (if applicable) to be paid							
(v)	Other cost to be paid (please specify)							
	Total							

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