

# Equity of local government health financing in Uganda

**Fiona Davies, Matt Geddes and Martin Wabwire**

**August 2021**

Public finance and service delivery



## Abstract

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The majority of public health spending in many low- and middle-income countries is executed by subnational governments. Efforts to increase health spending to achieve universal health coverage therefore need to take into account the efficiency, effectiveness and equity of health spending at the subnational level. However, the importance of subnational health expenditures has often been overlooked in international discussions on health financing and aid. Fragmentation of donor assistance also remains a feature of the global health landscape, stretching the capacity of fragile and low-income countries, including their subnational governments, to manage the priorities and programmes of multiple global health actors effectively. This paper looks at the adequacy and complementarity of national and international financing for subnational health services in Uganda over a three-year period (2015–2018), based on research conducted by ODI for the Government of Uganda. ODI found that national fiscal transfers for subnational health care delivery were inequitably distributed between Local Governments, and that their inadequacy was constraining the ability of Local Governments to achieve health outputs. ODI found that donors provided significant levels of health funding to Local Governments outside of the government fiscal transfer system. However, this funding was provided in a fragmented manner that reinforced the distributional inequities found in the fiscal transfers without necessarily improving their efficiency. This paper concludes with lessons for policy-makers.

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How to cite: Davies, F., Geddes, M. and Wabwire, M. (2021) *Equity of local government health financing in Uganda*. ODI Working paper. London: ODI ([www.odi.org/equity-of-local-government-health-financing-in-uganda](http://www.odi.org/equity-of-local-government-health-financing-in-uganda)).

# Acknowledgements

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The authors would like to thank Gerald Twijuke and Khasifa Kabenge for their assistance during the fieldwork, and Emmanuel Ssewankambo for the overall guidance he provided to the research. We would also like to thank: colleagues in the Government of Uganda for their support and invaluable feedback on the preliminary study findings; Sierd Hadley for co-ordinating the production of this paper; Freddie Ssenooba for initial comments and inputs; and Gundula Loeffler and Dorcus Kiwanuka-Henriksson for their peer review. Thank you, too, to Megan Jones and Sara Hussain for project and communications support, respectively.

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# Acronyms/Glossary

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<b>CCI</b>	Comprehensive Coverage Index
<b>DHIS</b>	District Health Information System
<b>GDP</b>	Gross Domestic Product
<b>HMIS</b>	Health Management Information System
<b>LG</b>	Local Government
<b>LMIC</b>	low- and middle-income country
<b>MFPEd</b>	Ministry of Finance, Planning and Economic Development
<b>MoH</b>	Ministry of Health
<b>NWR</b>	non-wage recurrent
<b>OPM</b>	Office of the Prime Minister
<b>QBPR</b>	Quarterly Budget Performance Report
<b>RBF</b>	results-based financing
<b>SUO</b>	Standard Unit of Output
<b>UHC</b>	universal health coverage

# 1 Introduction

The international community has set ambitious goals for introducing universal health coverage (UHC) as part of the 2030 Agenda for Sustainable Development. It has also pledged to leave no one behind in the ambition to support access to good-quality health and other services. However, aid is expected to play a smaller role in delivering these aims than was envisaged in the Millennium Development Goals (Xu et al., 2018). While some sectors may rely on a stronger private sector provision of services, it is clear that achieving UHC will require effective domestic government financing, with aid playing an important supporting role in lower-income and fragile states (Cotlear et al., 2015).

The importance of subnational health expenditures has often been overlooked in international discussions on health financing and aid. Many global health funders have tended to work mainly with central governments, and regional inequities have often been ignored (Glassman and Sakuma, 2014). Yet, subnational health financing is critically important, as the majority of public health spending in many low- and middle-income countries (LMICs) is executed by subnational governments. Efforts to increase health spending significantly to achieve UHC therefore need to take into account the efficiency and effectiveness of health spending at the subnational level (Fan et al., 2014). Inequalities within countries must also be addressed (Manuel et al., 2019).

At the same time, the global health landscape remains characterised by fragmented donor assistance. Global health actors and programme implementers are under pressure to deliver health results that can be attributed to their efforts. This makes bilateral programmes which measure rapid results attributable to specific inputs more attractive than multilateral approaches or efforts to strengthen health systems with longer-term, unclear outcomes (Spicer et al., 2020). Historically, donor assistance for health has also tended to be highly volatile, with significant fluctuations from one year to another, and poorly coordinated between donors, increasing transaction costs for governments (WHO, 2009). Low-income and fragile states with weak health systems, low capacities, weak institutions and often high levels of corruption tend to have limited latitude to manage the priorities and programmes of multiple, competing global health actors and their implementers (Spicer et al., 2020).

Against this backdrop, this paper looks at the adequacy and complementarity of national and international financing for subnational health services in Uganda, based on research conducted by ODI for the Government of Uganda (GoU). Uganda, like many other LMIC countries, has adopted a decentralised approach to service delivery, whereby Local Governments are responsible for primary health care delivery and the provision of hospital services at district level. Management of referral hospitals and the purchase of essential medicines and supplies remain the responsibility of the national Ministry of Health (MoH). Uganda faces a triad of challenges in financing its health programmes –

mobilising adequate domestic tax revenues; the effective allocation and use of fiscal transfers; and a rapid growth in local administrative units and the health care needs of the population (Republic of Uganda, 2020).

Uganda is a low-income country, with a relatively small share of the domestic budget allocated to health. It has allocated approximately 8% of the national budget to health for the last five years. These allocations only account for 15% of total health expenditures (USAID and Ministry of Health Uganda, 2018). Uganda's annual Gross Domestic Product (GDP) growth has averaged between 5% and 7% for the last seven years (Republic of Uganda, 2020), yet the government has been unable to cover the multiple and expanding pressures on the domestic budget. As a consequence, there is a growing debt burden – the nominal value of national debt amounted to 41% of GDP in June 2020 (MFPED, 2020), as compared to 26% five years previously (MFPED, 2015). Estimates indicate that the economy has to grow by double digits for over a decade to catch up with expenditure demands (Barroy et al., 2018; Republic of Uganda, 2020; IMF, 2020).

Uganda's population growth remains the highest in the region and one of the highest in the world. Its young population requires costly recurrent health services such as childhood vaccinations, and the health care burden for malaria and respiratory infections is increasing (Benova et al., 2018; National Population Council, 2020). These problems have been eased by donor funding, and external aid for health has reached new highs in Uganda in the last decades (Stierman et al., 2013). However, at a subnational level aid has not been targeted to localities with the worst health conditions (Odokonyero et al., 2015).

Nonetheless, calls for more and effective domestic financing of the health sector in LMICs such as Uganda have become louder, and 'transition planning' – preparing to replace external aid with domestic financing – is high on the development agenda (Wilhelm et al., 2019; Kanya et al., 2021). At the same time, there is a policy push to reduce the impoverishing effects of out-of-pocket payments by service users (Ssengooba, 2018). These trends have brought renewed focus to how national revenues and fiscal transfer systems can be strengthened to improve the level and quality of health services (Glassman and Sakuma, 2014; Munyambonera and Lwanga, 2015; Wandera, 2017).

In 2016 the GoU initiated a multi-year intergovernmental fiscal transfer reform programme which aimed to increase the adequacy, equity and efficiency of central government transfers to Local Governments, including health transfers. During the previous decade, the share of local government financing in the national budget had declined from approximately 25% to 15%. Overall funding to Local Governments had remained stagnant in real per capita terms, while some types of grant financing, such as non-wage recurrent grants and unconditional grants, had declined. These trends gave rise to concerns about the adequacy and equity of local government financing, associated declines in poverty reduction and service delivery outcomes and inequities in services between local governments (Local Government Finance Commission, 2012; World Bank, 2013). The situation was made more acute for Local Governments by the fact that their

own source revenues had also declined substantially following the phasing out of the graduated tax in the mid-2000s (Tidemand et al., 2017), further constraining their ability to allocate funds to local priorities.

Although the 2016 intergovernmental fiscal reform programme committed the GoU to improving the adequacy of fiscal transfers, the Ministry of Finance, Planning and Economic Development (MFPED) remained concerned about the provision of donor health financing to Local Governments outside of the government fiscal transfer system, over which it had limited visibility. It was concerned that this financing could potentially undermine the equity and efficiency of fiscal transfers, while undermining the rationale for a scale-up in government fiscal transfer funding in health. In 2018, MFPED asked ODI to undertake a study on health transfers to Local Governments in the context of other health financing flows, notably from development partners, in advance of the introduction of a new transfer formula.

## 2 Methodology

ODI's study combined quantitative data on financing and service delivery performance from a range of sources with qualitative data from in-depth stakeholder interviews at the national and local government level, as summarised in Table 1. Research was conducted over a period of nine months in 2018, and was followed by extensive consultations with national stakeholders in MFPED, the Ministry of Health and health development partners in Uganda.

**Table 1** Research methods

Research question	Main study unit	Methods and data collated
Question 1: What are the historical trends in government and donor health financing in Uganda?	<ul style="list-style-type: none"> <li>• Overall government and donor budget allocations</li> </ul>	<ul style="list-style-type: none"> <li>• Government budget allocations to health over a 20-year period</li> <li>• Donor budget allocations to health over a 20-year period</li> <li>• Donor off-budget allocations to health over a 10-year period</li> </ul>
Question 2: Are government non-wage recurrent health fiscal transfers to Local Governments adequate and are they equitably distributed?	<ul style="list-style-type: none"> <li>• Government funding provided through the fiscal transfer system</li> <li>• Standard Units of Output for each Local Government as a health service output measure</li> </ul>	<ul style="list-style-type: none"> <li>• Non-wage fiscal transfers from government to all local government (districts) 2015/16–2017/18</li> <li>• District-level service data from DHISII database 2017/18</li> </ul>
Question 3: Does donor funding help mitigate inequalities in fiscal transfers to subnational level and improve service delivery at district level?	<ul style="list-style-type: none"> <li>• Donor funding provided outside of the fiscal transfer system</li> <li>• Standard Units of Output for each Local Government as a health service output measure</li> </ul>	<ul style="list-style-type: none"> <li>• Stakeholder meetings to identify major challenges in health financing to Local Governments and major donor projects providing subnational funding</li> <li>• Collation of Local Government funding data from six major donor projects that do not use the fiscal transfer system, 2015/16–2017/18 (source: individual projects)</li> <li>• Collation of data on all donor funds received by 16 districts in all four main subnational regions</li> <li>• Fieldwork in the 16 districts</li> <li>• District-level service data from DHISII database 2017/18</li> </ul>

Note: DHIS, District Health Information System

Source: Government of Uganda budget; quarterly district budget performance reports 2015/16–2017/18; Ministry of Health; MFPED loans and grant reports

ODI first analysed overall trends in public health financing in Uganda over a 20-year period, using publicly available data.<sup>1</sup> This analysis looked at the overall levels of government and donor funding, trends in centralised and decentralised allocations, and the composition of decentralised allocations. ODI then proceeded to analyse non-wage recurrent health funding provided to individual Local Governments between 2015/16–2017/18 from two main channels: government funding provided through the fiscal transfer system, and donor funding provided outside of the fiscal transfer system. ODI did not examine the provision of goods in kind, such as essential medicines, vaccines, pharmaceutical supplies and bed nets. These goods are provided by both government and donors, but no information is publicly available on the volume or value provided to each Local Government.<sup>2</sup>

In order to analyse funding to Local Governments through the fiscal transfer system, ODI compiled data on non-wage recurrent fiscal transfers for health programmes to Local Governments as appropriated in the national budget from FY 2015/16–FY 2017/18.<sup>3</sup> In order to analyse donor funding to Local Governments outside of the fiscal transfer system, ODI conducted stakeholder interviews to identify Local Governments' challenges in health financing and the role of donor funding in addressing these challenges. Based on the feedback from the interviews, ODI identified six major donor funding streams<sup>4</sup> that had disbursed funds to multiple Local Governments and/or Local Government health facilities outside of the fiscal transfer system between 2015/16–2017/18. With the support of the Ministry of Health, ODI collected data on the disbursements made by each donor funding stream to individual Local Governments.

ODI merged the data from the six donor funding streams with the non-wage fiscal transfer data in order to examine their impact on funding distribution between Local Governments and the achievement of health outputs. The distributional analysis compared the allocation of the different types of financing with population and poverty data from publicly available data for the period 2015/16–2017/18. The study also examined the correlation between the value of each Local Government's fiscal transfers and its achievement of health outputs in 2017/18. The Ministry of Health uses data from the District Health Information System (DHIS)<sup>5</sup> to compute Standard Units

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1 [www.budget.go.ug](http://www.budget.go.ug).

2 Local Governments stated during the fieldwork that the supplies they receive are not necessarily aligned to their needs.

3 For purposes of data management, funding to municipalities was combined with funding to district administrations to establish a single funding figure per Local Government.

4 These funding streams included three that were on-budget (GAVI, Global Fund, ENABEL Results-Based Financing in West Nile and Toro regions), one that was off-budget but overseen by the Ministry of Health (World Bank/SIDA maternal health voucher scheme, implemented by Marie Stopes) and two that were wholly off-budget (UNICEF health funding and United States Agency for International Development (USAID) maternal health voucher scheme in Northern and Eastern Uganda, implemented by Abt Associates).

5 Every Local Government has a DHIS which it uses to record facility-level data on health service delivery, which in turn feeds into the national Health Management Information System (HMIS).

of Output (SUO) for higher-level facilities each year.<sup>6</sup> ODI used FY 2017/18 facility-level data from the DHIS to compute an SUO<sup>7</sup> for each Local Government, to enable a comparison of district-level outputs with the levels of non-wage recurrent funding.

To complement the national-level data, ODI identified a sample of 16 districts in all four major regions of Uganda (North, East, West and Central) to ascertain the total amount of health funding the Local Governments had received from all donor sources between 2015/16–2017/18. The selection included districts that are refugee-hosting and/or hard to reach, as well as districts that received relatively more or less funding from the six identified donor funding streams (see Appendix 1 for a list of districts). ODI collected the Quarterly Budget Performance Reports (QBPRs) for all 16 Local Governments for FY 2015/16–FY 2017/18 and compiled their total reported donor health funding.<sup>8</sup> It then combined the donor data from the QBPRs with the national fiscal transfer data in order to examine their cumulative impact on overall health funding to the individual Local Governments over the three-year period. Fieldwork was conducted in all 16 districts to validate the data presented in the QBPRs, collect qualitative information on the impact of donor support to health at Local Government level, and solicit Local Government views on the current challenges they face in financing health service delivery.

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6 The Standard Unit of Output converts all outputs to outpatient equivalents and allows for a fair comparison of volumes of output between facilities that have varying capacities in providing different types of patient care services.

7 The following formula was used:  $SUO(h) = L[(15 \times Total Admissions) + (1 \times Total OPD attendances) + (5 \times Total deliveries) + (0.2 \times Total Immunisation Attendances) + (0.5 \times Total Ante Natal Care attendances) + (0.5 \times Total Post Natal Care Attendances) + (0.5 \times Total Family Planning Attendances)]$

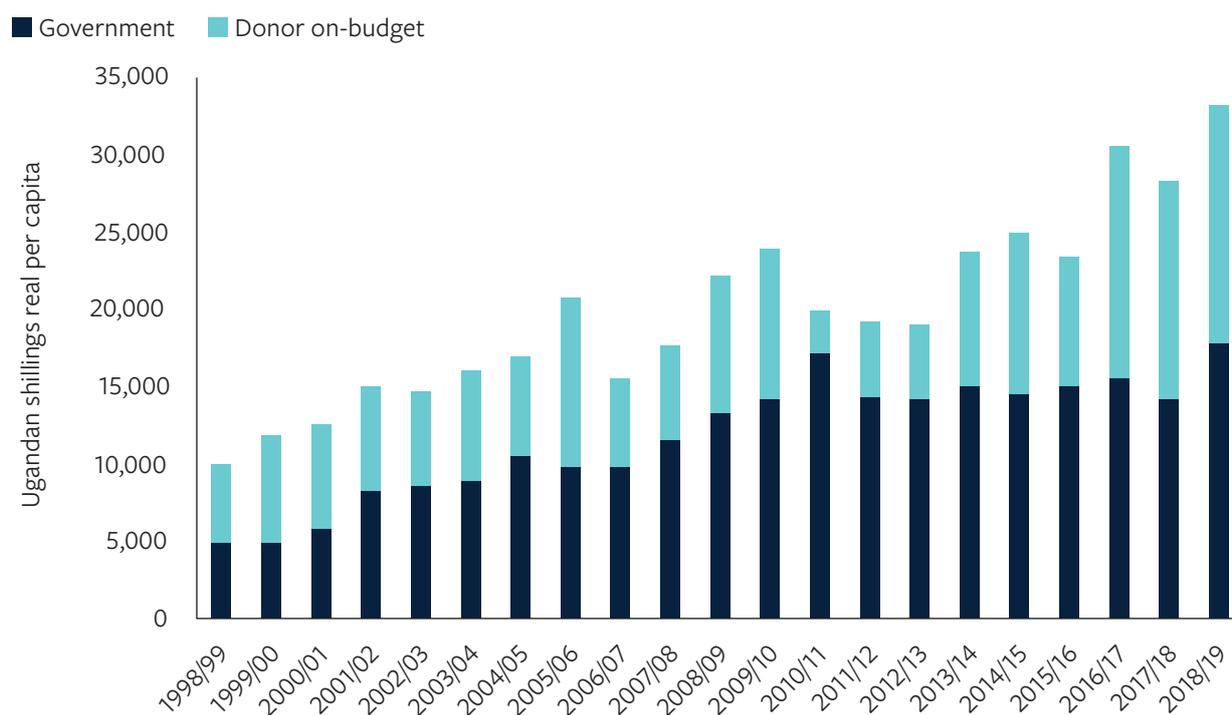
8 Local Governments stated during the fieldwork that the QBPRs reflect off-budget funding that is disbursed through the district. However, they do not capture funding that is provided direct by a donor or implementing partner to a health facility.

## 3 Trends and structure of health financing in Uganda

### 3.1 Overall health sector financing

Uganda's public health expenditures are funded by a combination of government and donor funding. On average, 59% of the public health budget was financed by government resources between 1998/99–2018/19, while the remainder was funded by donors. In real per capita terms, total health budget allocations increased more than threefold over 20 years (Figure 1), although gains made in individual years were at times subject to temporary reversal in subsequent years. However, health allocations fell as a share of the budget (Figure 2), reflecting a shift in government expenditure priorities over time away from service delivery and towards infrastructure and productive sector expenditures.

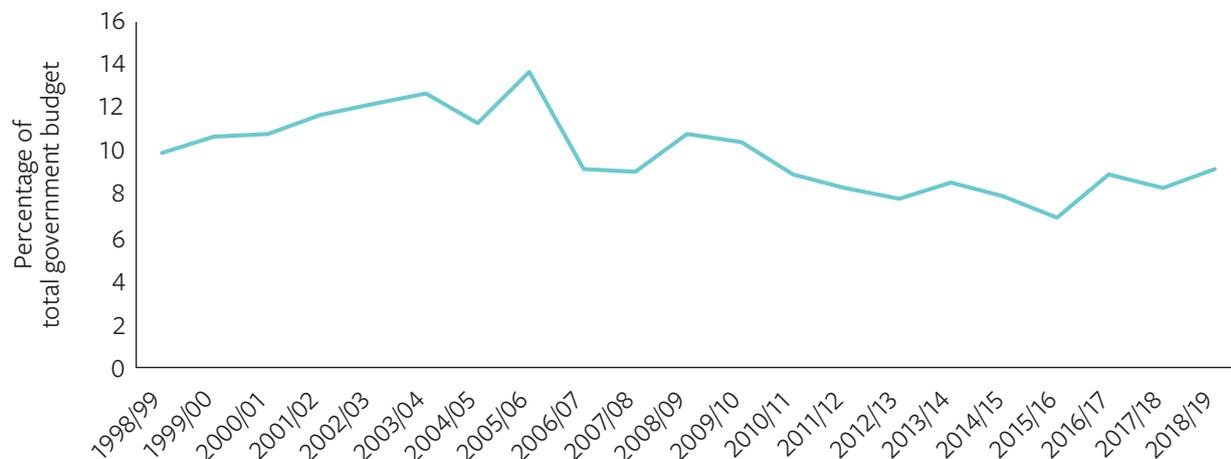
**Figure 1** Uganda health budget allocations in real per capita terms



Note: shs 2009/10 = 100.

Source: MFPED

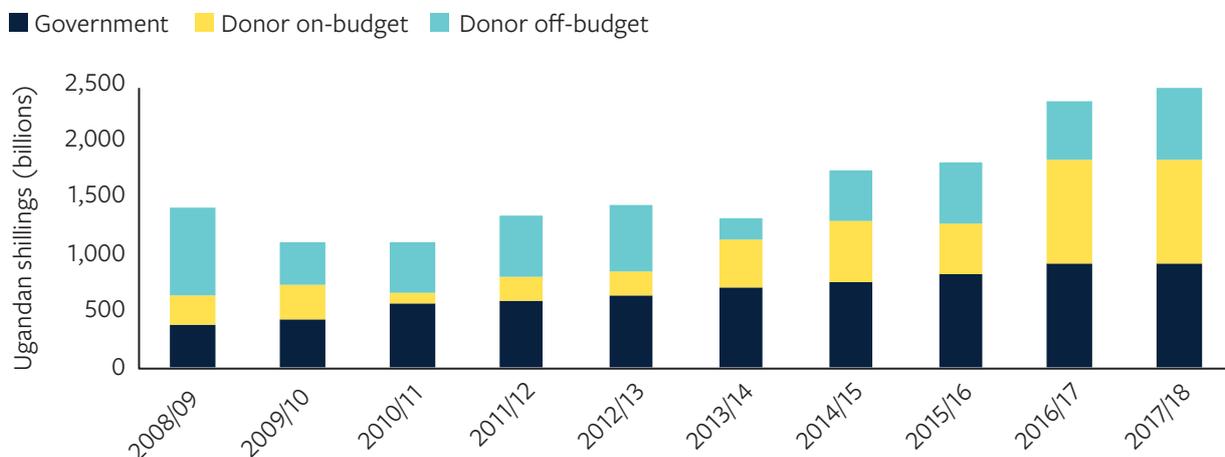
**Figure 2** Uganda health budget allocations as a percentage of the total government budget, 1998/99–2018/19



Source: MFPED

Donors also provide health sector funding outside of the national budget. These funds are managed directly by third-party implementers and do not pass through the central government. Although ‘off-budget’ flows are reported to be substantial (MFPED, 2018), publicly available data on their volume and distribution is limited in scope and fragmented. Based on data published by the Ministry of Finance (MFPED, 2013, 2016, 2018), 54% of donor health sector funding in Uganda is estimated to have been provided off-budget between FY 2008/09 and FY 2017/18, serving to increase overall health sector funding by a third on average (Figure 3). These figures capture in-country donor funding to specific health projects, but do not include health funding provided through multi-sector projects and humanitarian support, or funding provided to non-governmental organisations (NGOs) and other third-party implementers by donors not based in Uganda. As a result, they are likely to be considerably understated.

**Figure 3** Health sector funding including donor off-budget allocations

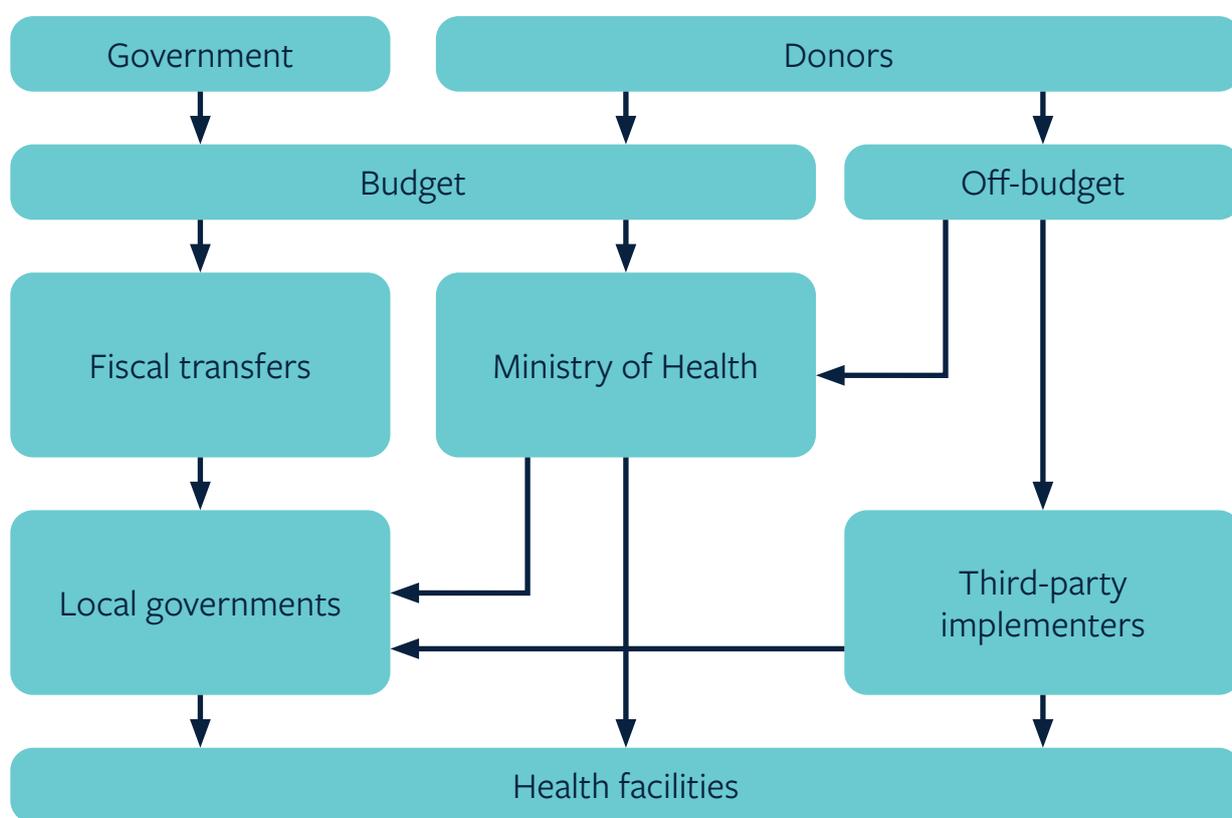


Source: MFPED and author’s calculations

### 3.2 Health financing to local governments

Local Governments receive health financing through multiple channels, as shown in Figure 4. Fiscal transfers are a major component of Local Government health financing, and the national budget indicates the amount allocated for each Local Government.<sup>9</sup> Local Governments also receive funding directly from central government agencies, particularly the Ministry of Health, and from off-budget donor projects. Limited information is publicly available on the distribution of these funds to individual Local Governments.

**Figure 4** Health funding flows in Uganda

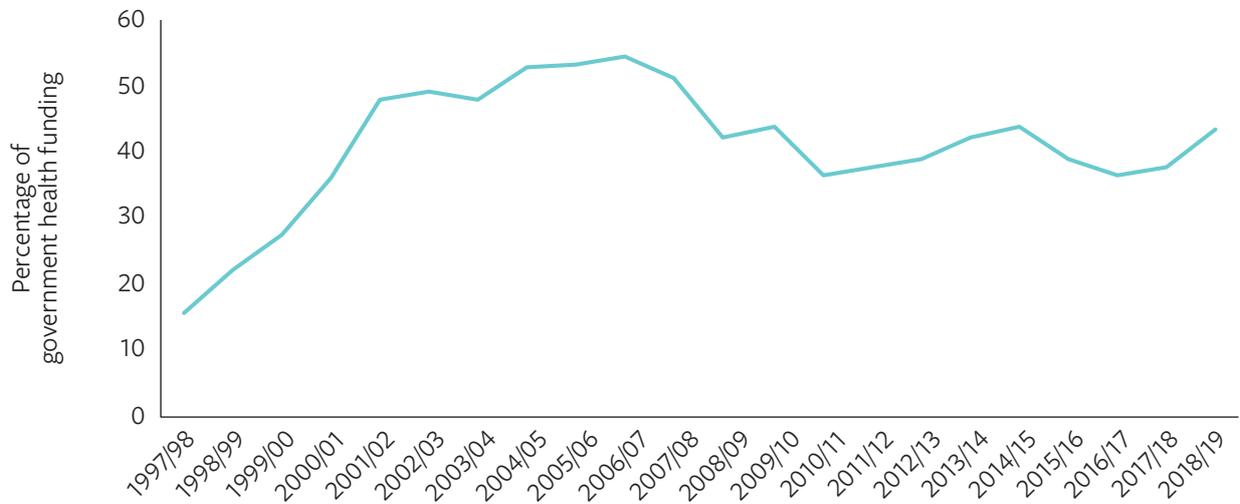


#### 3.2.1 Fiscal transfers

Local Governments receive fiscal transfers earmarked for health through the national budget. Fiscal transfers to Local Governments account for a significant portion of government-funded health spending (Figure 5). In the early 2000s, transfers to Local Governments accounted for over 50% of GoU funding to the health budget. The percentage has declined since, but transfers still accounted for approximately 40% of government health funding by FY 2018/19.

<sup>9</sup> Laid out in Volume II of the National Budget Estimates.

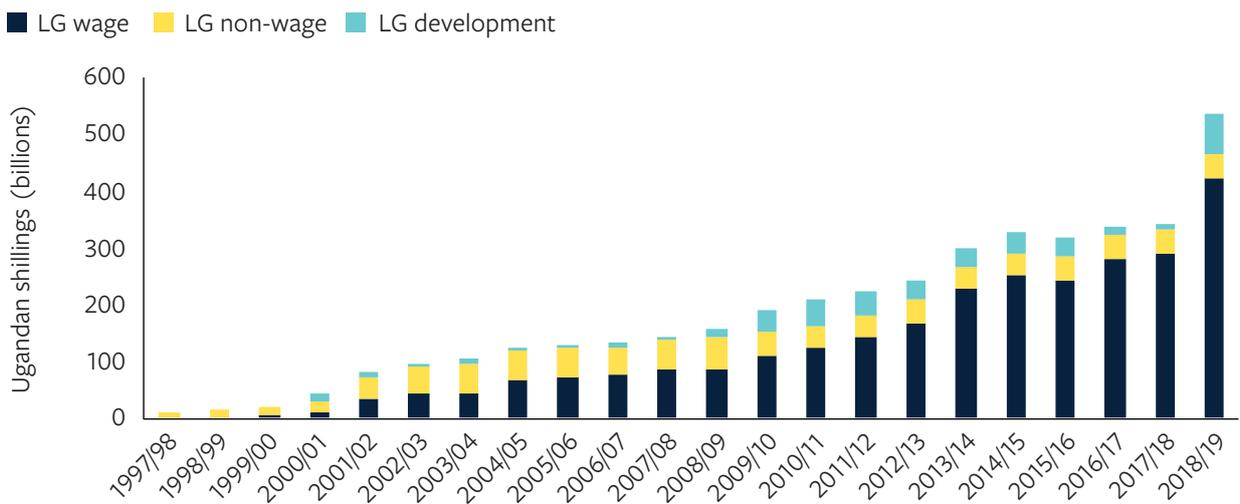
**Figure 5** Fiscal transfers to Local Governments as a percentage of government-funded health allocations



Source: MFPED

Health fiscal transfers are sub-divided into wage, non-wage recurrent and development spending (Figure 6). Wages constitute the largest component of health fiscal transfers to Local Governments, and their proportion has been increasing over time.<sup>10</sup> By FY 2018/19, wages accounted for 79% of total health fiscal transfers. The increase was primarily driven by additional health worker recruitment, in line with the Ministry of Health’s target to raise staffing levels in public sector facilities from 69% of established posts in 2014 to 80% in 2018 (Ministry of Health, 2018a).

**Figure 6** Health transfers to Local Governments



Note: LG, Local Government

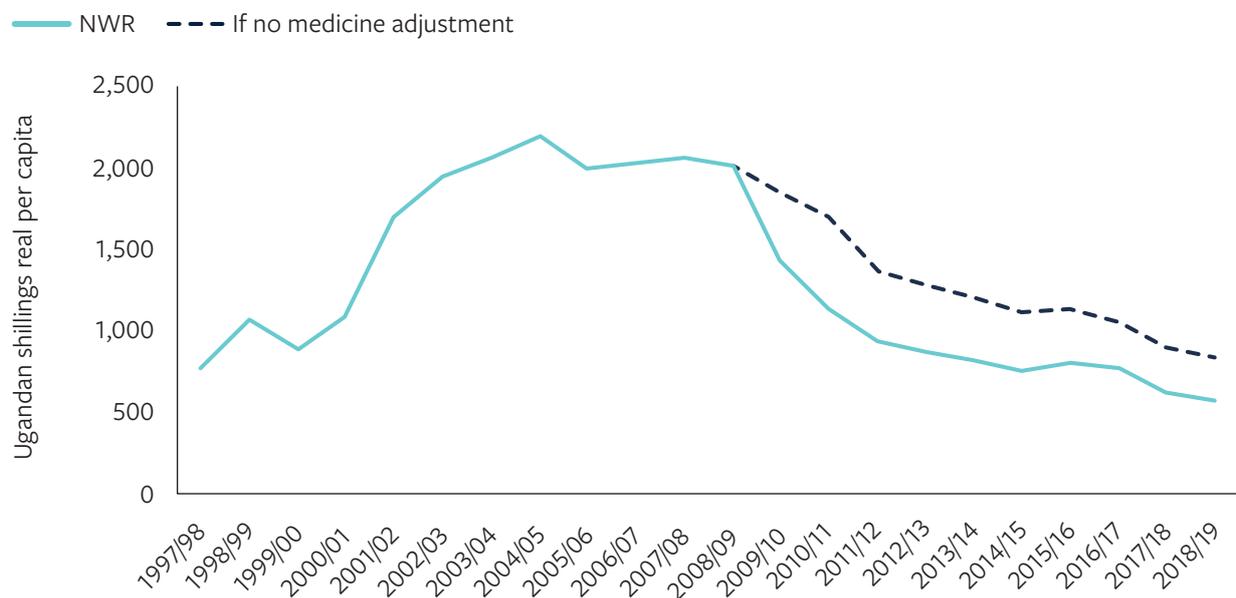
Source: MFPED

<sup>10</sup> Local Government wage transfers are warranted (authorised) by the Local Government and then paid directly by the central government to the individual payees.

Health development fiscal transfers cater for infrastructure development and maintenance. They were generally minimal until FY 2007/08, when the government started to invest in the rehabilitation of health facilities, first in districts affected by the Lord's Resistance Army insurgency, and then in all sub-counties nationwide.<sup>11</sup> By FY 2018/19, allocations to development transfers accounted for 14% of total Local Government health transfers.

Non-wage recurrent fiscal transfers cater for the operating costs of Local Government health facilities and the District Health Office.<sup>12</sup> They fell sharply as a percentage of overall health fiscal transfers, from an average of 46% in the first half of the 2000s to just 7% in FY 2018/19. Part of the decline is attributable to a policy shift on medicine procurement in FY 2009/10. Local Governments had previously received funds through their fiscal transfers with which to purchase medicines, but in FY 2009/10 the purchase of medicines was centralised under the National Medical Stores, leading to a reduction in fiscal transfers. However, the main driver of the decline was the lack of adjustment of transfer allocations for inflation and population growth. In real per capita terms, non-wage recurrent fiscal transfers to Local Governments declined by 75% over a 15-year period (Figure 7). In nominal terms, non-wage recurrent funding to Local Governments in FY 2018/19 was equivalent to just \$0.32 per person per year.

**Figure 7** Non-wage recurrent fiscal transfers to Local Governments in real per capita terms



Note: shs 2009/10 = 100. NWR, non-wage recurrent.

Source: MFPED and authors' calculations

11 A sub-county is an administrative unit within a district. Each district has several sub-counties. In 2016, the GoU established a policy of ensuring that every sub-county has a Health Centre III.

12 Non-wage recurrent costs are split between the Local Government District Health Office (15%) and health facilities (85%). Health facilities' non-wage recurrent transfers are warranted (authorised) by the Local Government and then paid directly by the Central Government to their accounts.

According to Uganda’s Ministry of Health, by 2018 non-wage recurrent transfers to Local Governments had fallen far below the level required to ensure quality service delivery at health facilities (Ministry of Health, 2018a). The ministry considered inadequate Local Government non-wage recurrent funding to be a contributing factor to several of the major challenges facing the health sector, including an influx of patients at referral-level facilities, in part due to inadequate funding for services at lower-level facilities (Ministry of Health, 2018b); weaknesses in local-level vaccine management systems, in part due to lack of funding for maintenance of medical equipment (Ministry of Health, 2014a); and a growing burden of preventable diseases, including micronutrient deficiencies in children, in part due to inadequate and irregular financial support for scheduled health promotion and disease prevention outreach (Ministry of Health, 2018a, 2018b).

### 3.2.2 On-budget funding from central government agencies

Local Governments receive health financing directly from the budgets of the Ministry of Health and, occasionally, the Office of the Prime Minister. Financing provided through the Ministry of Health budget is funded by a mix of the government’s own resources and on-budget donor projects. In some cases, the Ministry of Health budget indicates the total amount of funds that will be disbursed to Local Governments during the financial year. However, in these cases it rarely provides a breakdown of the amounts by Local Government. In other cases, funding is not clearly identified as being intended for Local Governments, and is instead budgeted against the item to be purchased (e.g. ‘medical supplies’). The level of recurrent funding provided to Local Governments through the Ministry of Health budget is significant, and in 2017/18 it exceeded the amount provided through non-wage fiscal transfers.

**Table 2** Ministry of Health recurrent funding to Local Governments, 2015/16–2017/18 (shs billion)

	<b>Coded as LG transfers</b>	<b>Coded against other budget items but transferred to LGs</b>	<b>Total</b>	<b>Total as percentage of non-wage recurrent fiscal transfers</b>
2015/16	12.84	17.18	30.02	69%
2016/17	16.09	6.13	22.22	48%
2017/18	28.83	13.17	41.99	105%

Note: LG, Local Government.

Source: MFPED and MoH

In most cases, Local Governments reflect the funding they receive directly from the Ministry of Health in their own budgets, even though a breakdown by Local Government is not provided in the national budget. However, in some cases donor projects managed by the Ministry of Health have provided financing directly to health facilities, and the funding has not been reflected in the Local Government budget. This was the case between 2015/16–2017/18 for components of donor-funded results-based financing.

The Office of the Prime Minister (OPM) is responsible for managing Uganda’s refugee response. It sometimes receives on-budget donor funding to support refugee-hosting Local Governments. In these cases, allocations within the OPM budget are not usually earmarked by sector, as recipient Local Governments and local communities are responsible for deciding how the funds they receive are spent according to their needs, within the parameters established by the OPM. In FY 2017/18, health allocations by two refugee-hosting Local Governments using OPM funding were two to three times larger than their health non-wage fiscal transfers (CSBAG, 2018). The funds were largely focused on infrastructure and equipment rather than non-wage recurrent items.

### 3.2.3 Off-budget financing

Local Governments receive financing from ‘off-budget’ donor projects managed by third-party implementers. These funds are not appropriated in the national budget.<sup>13</sup> However, if the funds are disbursed to the Local Government, then the Local Government will reflect the funding in its own budget, and report on actual disbursements in its Quarterly Budget Performance Report. Funds that are classified as ‘off-budget’ at central government level may therefore be ‘on-budget’ at Local Government level. However, some off-budget donor projects managed by third-party implementers disburse funds directly to health facilities, bypassing Local Governments. In these cases, the funding is off-budget at both national and Local Government level. Local Governments submit their budgets and their Quarterly Budget Performance Reports to the Ministry of Finance. However, the ministry does not use the data provided to develop an aggregated picture of ‘off-budget’ flows to Local Governments.

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13 In some cases between FY 2015/16–2017/18, the Ministry of Health oversaw the implementation of donor projects which were not reflected in the national budget.

## 4 Analysis of government and donor funding flows to individual LGs

### 4.1 Fiscal transfers

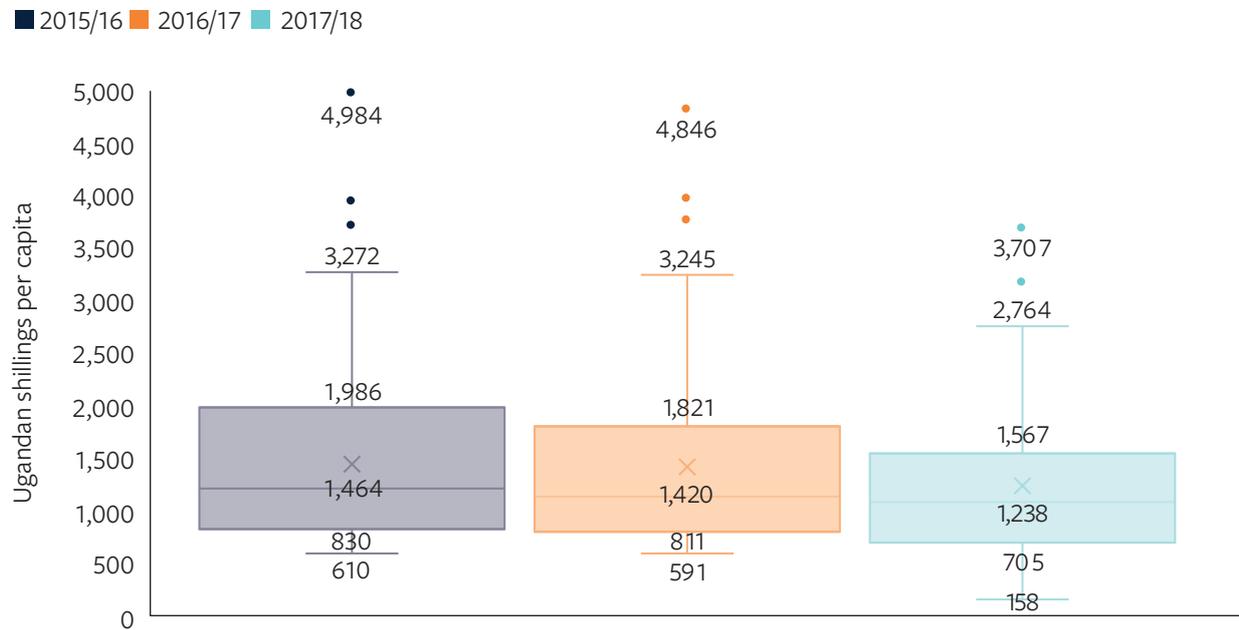
Between FY 2015/16–2017/18, health non-wage recurrent fiscal transfers to Local Governments had two main components: support for primary health care facilities and support for district hospitals, including both government and NGO (private-not-for-profit) facilities. While all Local Governments have primary health care facilities of different levels, only half of districts have a hospital facility.

The distribution of primary health care funding was based on a formula established by the Ministry of Health that included a fixed allocation for all Local Governments, a special allocation for hard-to-reach Local Governments and a variable allocation based on parameters such as local population, birth rates and infant and child mortality. However, the split between the fixed and variable elements of the formula, and the weights attached to some of the variable elements, were not made publicly available (Ministry of Health, 2014b). The basis for the distribution of hospital funding was not made public.

According to the Ministry of Health, the distribution of non-wage recurrent allocations between Local Governments remained largely unchanged between FY 2015/16–FY 2017/18, apart from adjustments arising from the creation of new Local Governments and certain internal funding reallocations from private-not-for-profit to government hospital facilities (Ministry of Health, 2018c). The aggregate amount of non-wage recurrent transfers rose slightly, from shs 43.7 billion in FY 2015/16 to shs 45.9 billion in 2016/17, before falling to shs 39.9 billion in FY 2017/18, as the MoH recentralised shs 6 billion in order to procure uniforms and other items for use at Local Government level.

On a per capita basis, non-wage recurrent transfers to individual Local Governments varied considerably in all three financial years, with the highest-funded Local Governments receiving at least eight times more funding per capita than the lowest-funded Local Governments. Since the Ministry of Health did not publish detailed information on the transfer allocation formula, the reasons for these variations are not clear. However, it is possible that they were partially driven by fixed allocations to health facilities, including hospitals, meaning that Local Governments with more health infrastructure received more non-wage recurrent funding. Local Governments in the highest funding quartile received per capita allocations that were between 30% and 125% more than the national average (Figure 8). Local Governments in the lowest funding quartile received at least 40% less funding per capita than the national average.

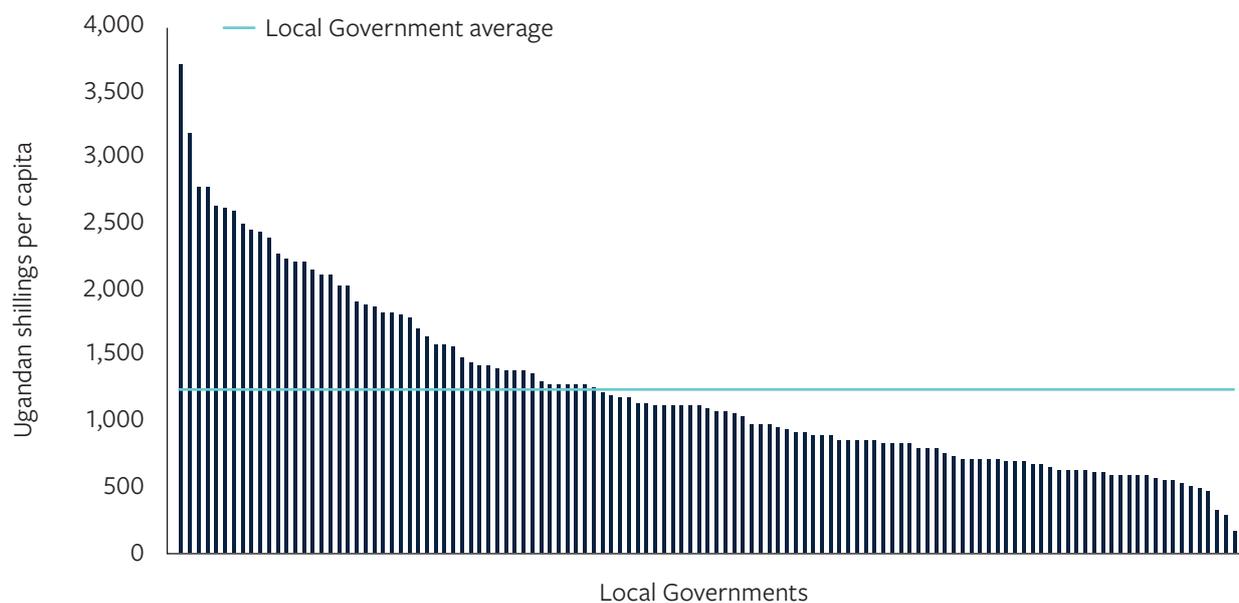
**Figure 8** Distribution of per capita non-wage recurrent fiscal transfers to Local Governments, FY 2015/16–FY 2017/18



Source: MFPED

In FY 2017/18, the highest-funded Local Government received 22 times more funding than the lowest-funded Local Government (Figure 9), and Local Governments in the lowest funding quartile received the equivalent of between \$0.04 and \$0.19 funding per capita.

**Figure 9** Distribution of non-wage recurrent fiscal transfers per capita across all Local Governments, FY 2017/18



Source: MFPED

## 4.2 Donor funding

Total donor funding to Local Governments from the six funding streams identified by ODI averaged shs 28.4 billion per year between FY 2015/16–2017/18 and amounted to shs 85.3 billion in total (Table 3). The funding supported non-wage recurrent expenditures, and was equivalent to two-thirds of government’s non-wage recurrent health transfers over the same period.<sup>14</sup> UNICEF was the largest funder across the six funding streams, accounting for 48% of all donor flows. Its assistance was provided entirely off-budget.

**Table 3** Characteristics of the six donor funding streams, 2015/16–2017/18

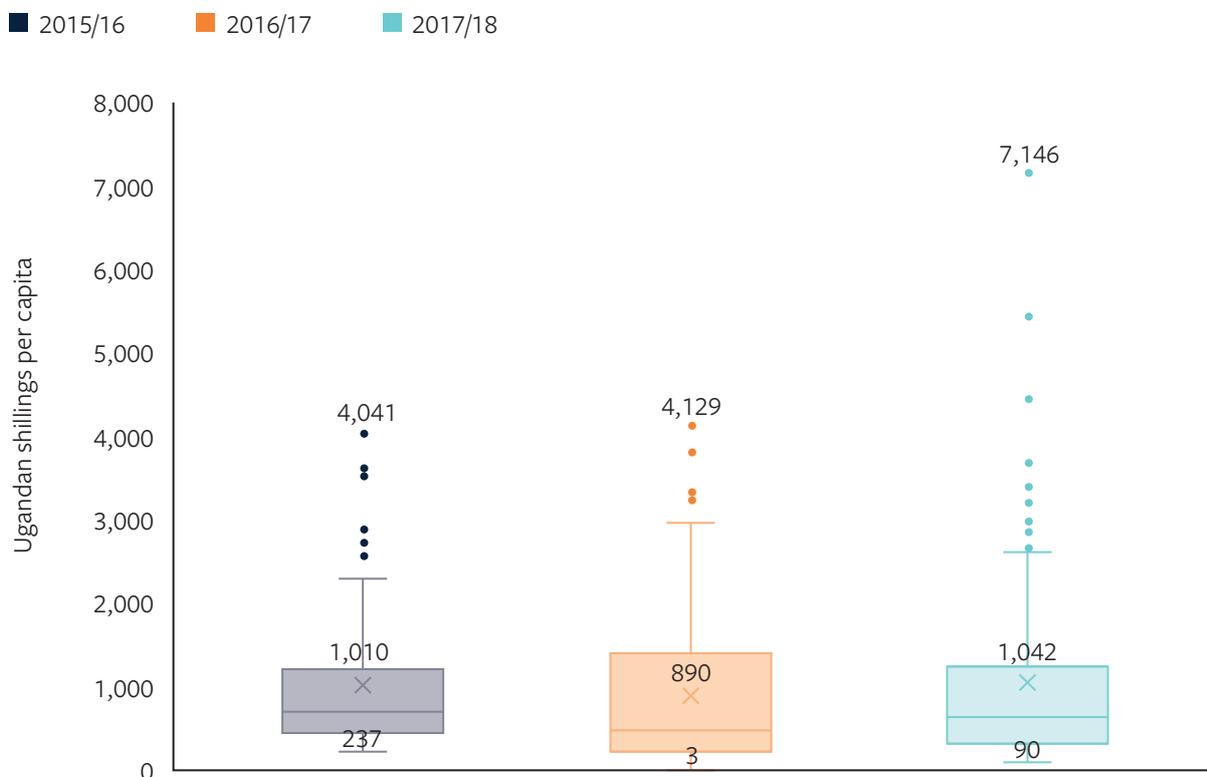
Funding stream	Implementer	Modality	No. of LGs supported	Amount of funding (shs billion)
Enabel Results-Based Financing	Enabel/MoH	Partially on-budget, partially off-budget	16	12.09
GAVI	MoH	On-budget	120	14.47
Global Fund	MoH	On-budget	60	9.92
UNICEF	UNICEF	Off-budget	114	40.82
USAID Maternal Voucher Scheme	Abt Associates	Off-budget	30	4.85
World Bank/Sida Maternal Voucher Scheme	Marie Stopes	Off-budget	23	3.15

Note: USAID voucher scheme data is for FY 2017/18 only. LG, Local Government.

Funding from the six funding streams was concentrated in relatively few Local Governments, and had much greater variation in distribution between Local Governments than fiscal transfers (Figure 10). Across the three years, over half of donor funding was concentrated in less than a fifth of Local Governments. Local Governments in the highest funding quartile received donor per capita allocations that were at least a third higher than the average, while Local Governments in the lowest funding quartile received at least two-thirds less than the average. In FY 2017/18, across the six funding streams, the best-funded Local Government received almost 80 times more funding per capita than the lowest-funded Local Government.

<sup>14</sup> Total non-wage recurrent fiscal transfers amounted to shs 129 billion in total over the three-year period, an average of shs 43 billion per year.

**Figure 10** Distribution of per capita donor funding from six funding streams to Local Governments, FY 2015/16–FY 2017/18



Source: ODI

Each funding stream used different criteria to select which Local Governments they provided support to. For Enabel Results-Based Financing (RBF) and the USAID Maternal Voucher Scheme, the selection was geographic, targeting Local Governments that belonged to particular sub-regions.<sup>15</sup> For UNICEF, targeting focused on Local Governments in particular sub-regions<sup>16</sup> and on Local Governments with high levels of child deprivation. The World Bank Maternal Voucher Scheme and the Global Fund used a number of health indicators to select which Local Governments they supported. Only GAVI provided funds to all Local Governments. No mechanism was in place to coordinate allocations between funding streams.

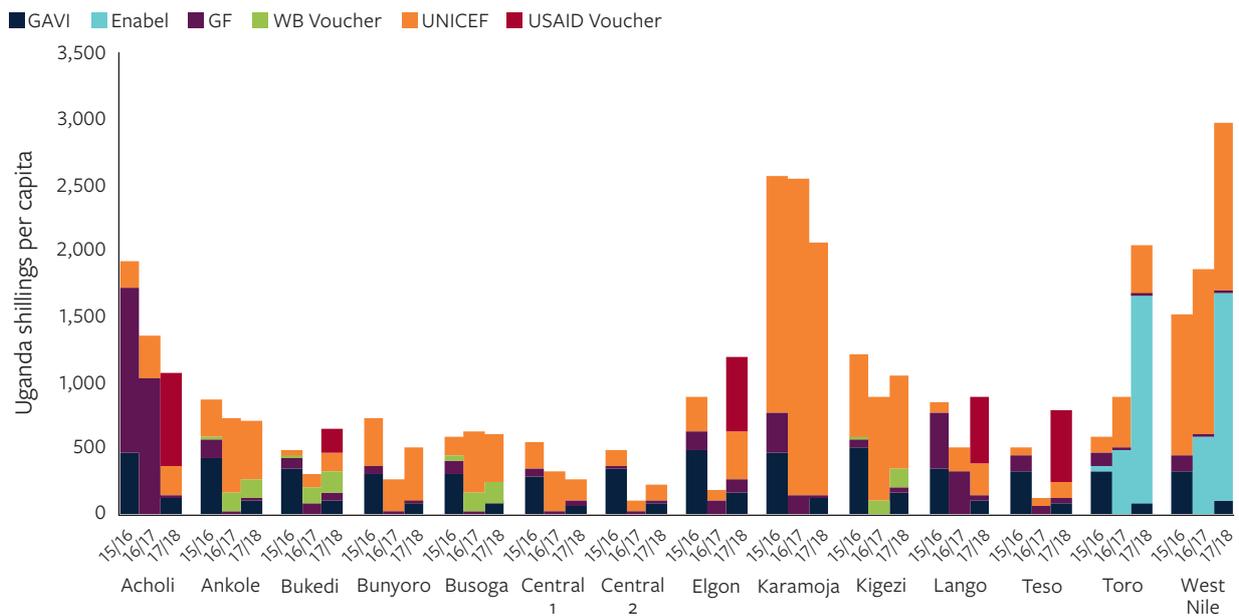
Some sub-regions received considerably more donor funding than others over the three-year period (Figure 11), but without a clear rationale for the variation in allocations. On an average per capita basis, the Karamoja sub-region, which is the poorest in Uganda (Uganda Bureau of Statistics, 2018), received the highest level of funding. Overall, however, there was relatively limited correlation

15 Local Governments are grouped into 14 geographic sub-regions for statistical and planning purposes. Enabel targeted the Toro and West Nile sub-regions; USAID targeted the Acholi, Lango, Teso, Bukedi and Elgon sub-regions.

16 Karamoja sub-region and refugee-hosting districts in West Nile sub-region.

between the level of poverty of a sub-region and the amount of funding it received from across the six funding streams, suggesting that donor funding might have limited efficiency in reducing out-of-pocket expenditures for the poorest service users. For example, in 2017/18 some sub-regions with relatively high poverty levels received relatively little donor funding per capita (e.g. Acholi, Lango, Teso). Other sub-regions with relatively low poverty levels received relatively high levels of donor funding per capita (e.g. Toro, Kigezi). Likewise, donor funding was not systematically targeted towards sub-regions with weaker levels of health care, as measured by the Comprehensive Coverage Index<sup>17</sup> (CCI) produced by the Ministry of Health (Ministry of Health, 2018d). An analysis of donor funding across the six funding streams in FY 2017/18 showed no discernible correlation between donor per capita funding levels in a particular sub-region and its sub-regional CCI performance,<sup>18</sup> suggesting there might be limitations to the role that donor funding could play in reducing service inequalities. Donors did not appear to take into account the amount of funding being provided through the fiscal transfer system, as relatively well-resourced and strongly performing sub-regions such as Kigezi received more donor funding per capita than relatively under-resourced and poorly performing sub-regions such as Teso and Elgon (Figure 12).

**Figure 11** Donor flows to sub-regions from six funding streams, FY 2015/16–2017/18



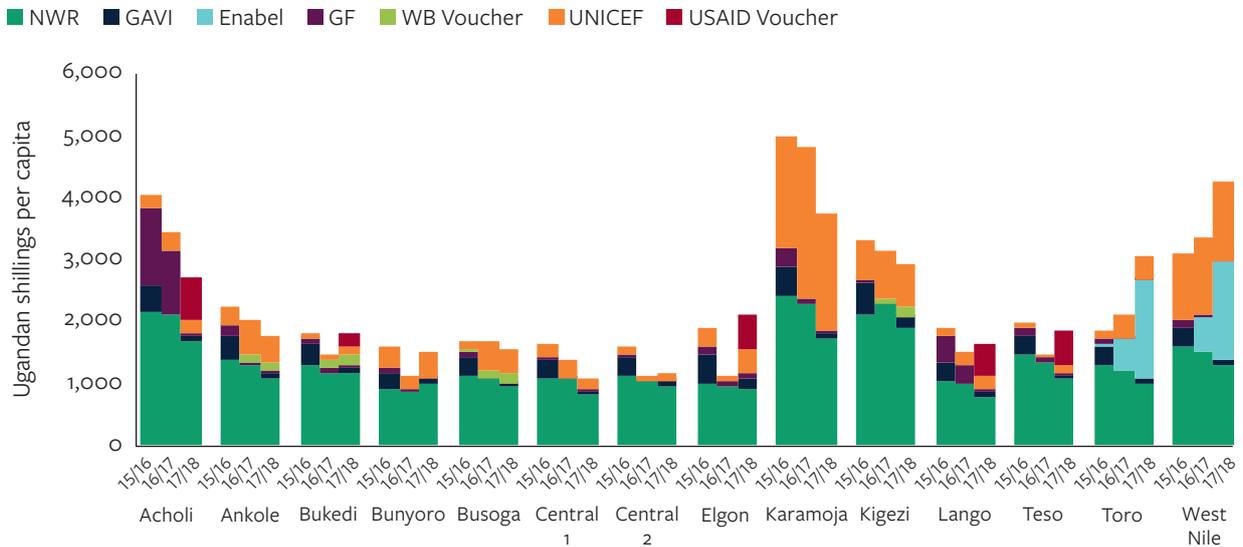
Note: USAID data available for FY 2017/18 only.

Source: ODI

17 The Ministry of Health periodically computes a sub-regional Comprehensive Coverage Index (CCI), which measures the quality of eight Reproductive, Maternal, Neonatal and Child Health (RMNCH) interventions along four stages of the continuum of care. Its analysis for 2016 found that health care inequalities in Uganda have generally reduced over time, but that sizeable inequality gaps by region, residence and socioeconomic status remain.

18 Out of the 14 sub-regions, Kigezi was assessed to have the best level of health care coverage in 2016, with a score of 71.6 on the CCI index, while Teso and Elgon were assessed to have the lowest, with a score of 62.3 on the CCI index.

**Figure 12** Non-wage recurrent fiscal transfers and donor flows from six funding streams to sub-regions, FY 2015/16–2017/18

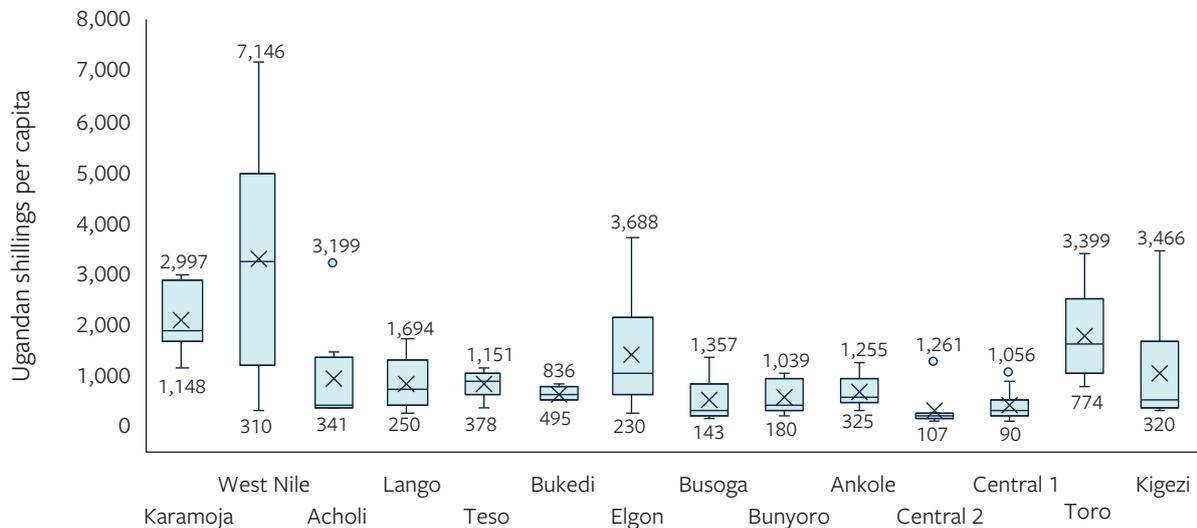


Note: USAID data available for FY 2017/18 only. NWR, non-wage recurrent.

Source: ODI

Donor funding levels per capita also varied significantly between Local Governments within a sub-region (Figure 13). In some cases, donor funding streams operating within a particular sub-region targeted their support towards Local Governments with greater absorptive capacity for spending their funds, whilst in others, variations in funding to individual Local Governments within a sub-region arose as a result of differences in targeted health indicators. For example, in FY 2017/18, ENABEL’s RBF funding was concentrated in four out of seven districts of West Nile, and five out of eight districts in Toro, largely on account of the capacity of the health facilities in these districts.

**Figure 13** Distribution of donor funding to Local Governments by sub-region, FY 2017/18

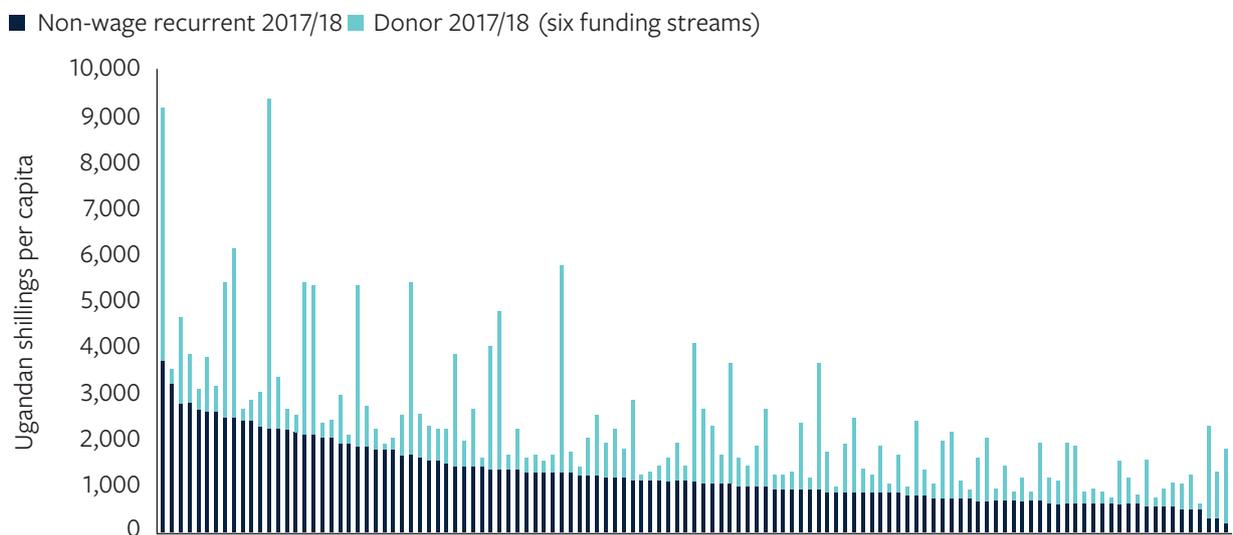


Source: ODI

In the most extreme cases, the best-funded Local Government within a sub-region could receive at least 10 times more donor funding than the least-funded Local Government within the same sub-region.

Donor funding was not found to help offset the variance in government funding to Local Governments from the fiscal transfer system (Figure 14). In a few cases, donors provided additional funding on a per capita basis to Local Governments with relatively low fiscal transfer allocations. However, in a number of other cases donors provided significant levels of per capita funding to Local Governments which were already relatively well resourced through the fiscal transfer system, thereby reinforcing variances in allocations.

**Figure 14** Distribution of donor funding and non-wage recurrent fiscal transfers across Local Governments, FY 2017/18



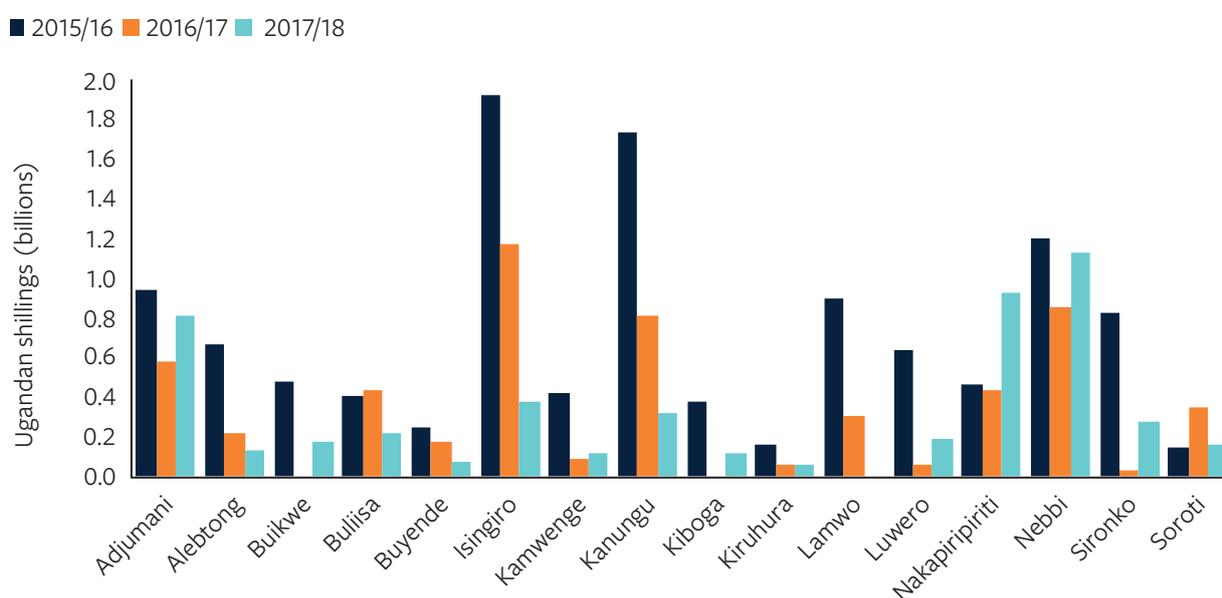
Source: MFPED, ODI

Overall, the analysis of the six donor funding streams showed that donors provided significant levels of health funding to Local Governments outside of the government fiscal transfer system. However, the per capita volumes varied considerably between Local Governments and sub-regions. Donor funding did not appear to be correlated with key sub-regional indicators such as income poverty or health care coverage, nor was it found to play a role in equalising non-wage recurrent health funding per capita between Local Governments, instead exacerbating the variations in some cases.

A similar picture was seen in the donor data collated from the QBPRs of the study's 16 fieldwork Local Governments. These Local Governments reported receiving shs 22.2 billion in donor health financing between FY 2015/16–FY 2017/18. By comparison, they received shs 16.6 billion in non-wage recurrent transfers during the same period, meaning that total donor flows were a third greater than their non-wage recurrent funding from government. Out of the total donor flows reported, the overwhelming majority (shs 19 billion, or 86%) was attributed to partners whose funding was not reflected in the Ministry of Health budget.

Over 20 different partners were found to be active in providing health financing directly to the 16 Local Governments. On average, each Local Government had six partners providing health financing in any given year. The amounts of health funding reported by individual Local Governments varied considerably (Figure 15). Most Local Governments also experienced considerable variations in the level of funding they received year on year. Three Local Governments reported receiving no donor funding for health at all in certain financial years. Lack of advance information on donor funding flows, coupled with limited predictability in the timing and amounts of disbursements, was cited as a major challenge by most Local Governments during the fieldwork interviews.

**Figure 15** Annual direct donor health funding reported by 16 Local Governments, FY 2015/16–FY 2017/18



Source: Local Government QBPRs

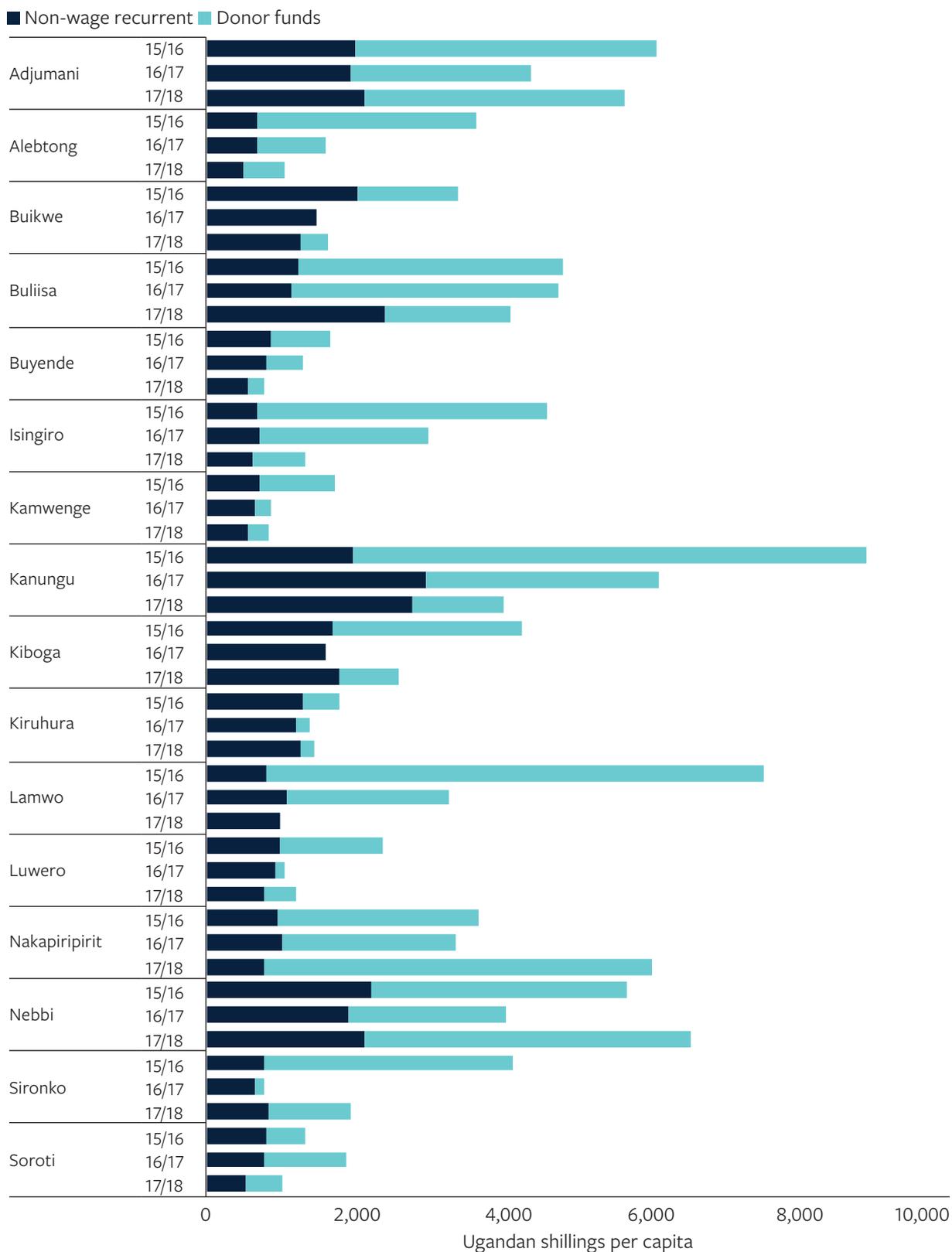
While some Local Governments consistently reported receiving more health funding from donor sources than they did from their fiscal transfers, a number of others continued to rely on fiscal transfers as their major source of funding. For the remainder, health funding from donors exceeded funding from fiscal transfers in some years, but not in others (Figure 16). Almost all Local Governments reported during the fieldwork that donor funding could not fully compensate for shortfalls in government non-wage recurrent funding, due to limitations on its fungibility.

Of the 16 fieldwork Local Governments, one<sup>19</sup> was among the 10 best-funded Local Governments nationwide in FY 2017/18 in terms of GoU non-wage recurrent fiscal transfers per capita, while three<sup>20</sup> featured among the 10 lowest-funded. Donor funding was found to reinforce these disparities, with the best-funded Local Government in terms of fiscal transfers receiving considerably more donor funding per capita than the lowest-funded.

<sup>19</sup> Kanungu.

<sup>20</sup> Kamwenge, Buyende and Alebtong.

**Figure 16** Non-wage recurrent fiscal transfers and donor health funding reported by 16 Local Governments, FY 2015/16 – FY 2017/18



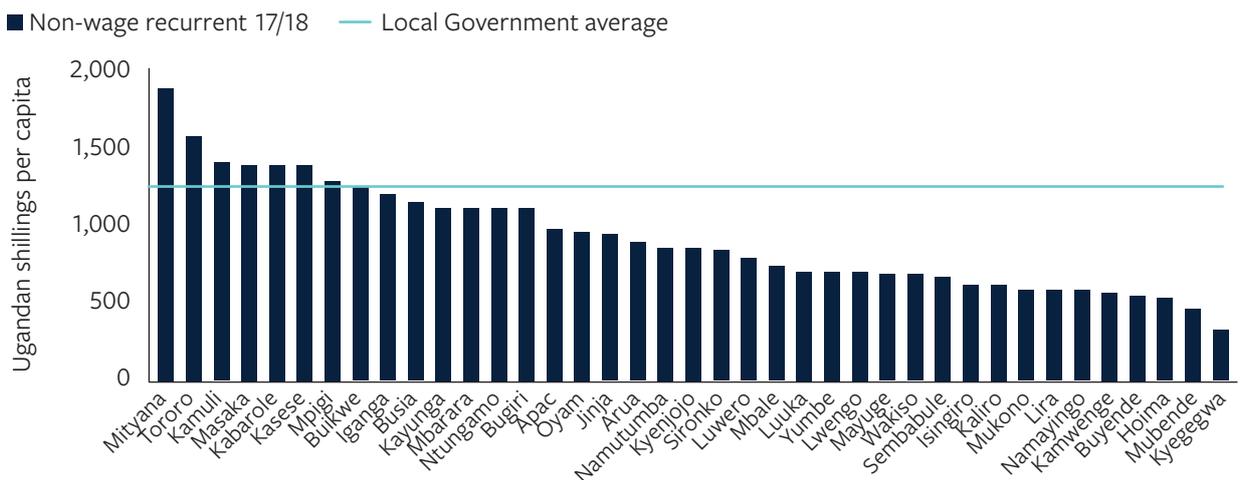
Source: Local Government QBPRs

Overall, the findings from the 16 fieldwork Local Governments were consistent with the analysis of the distribution of funding to all Local Governments from across the six centrally collected funding streams. Donor funding is often substantial relative to non-wage recurrent fiscal transfers, but the majority of it is off-budget. Funding is not predictable year-to-year and it does not play a role in equalising health funding between districts. In some cases, it reinforces existing variations in the distribution of non-wage recurrent transfers. Each donor project appears to have its own rationale for selecting which districts and sub-regions it operates in. The Ministry of Health and health development partners do not have a comprehensive system in place for monitoring the distribution of donor funds across Local Governments and assessing whether there are significant gaps in support in certain places.<sup>21</sup>

### 4.3 Inequities in resource allocations and service delivery

Initial evidence suggests that non-wage recurrent funding constraints have negatively impacted Local Governments’ capacity for health service delivery. In April 2018, 263,400 children were reported as unimmunised in Uganda, despite a general availability of vaccines (Ministry of Health, 2018b). Two-thirds of these children were concentrated in just a third of Uganda’s districts. Almost all of these 40 districts received below-average levels of health non-wage recurrent per capita from the government fiscal transfer system (Figure 17). While not conclusive, this suggests that inadequate levels of fiscal transfer funding may have negatively impacted immunisation levels, through lack of availability of funding to conduct activities such as community outreach.

**Figure 17** Non-wage recurrent fiscal transfer funding to the 40 Local Governments with the greatest percentage of unimmunised children compared to the LG average, FY 2017/18

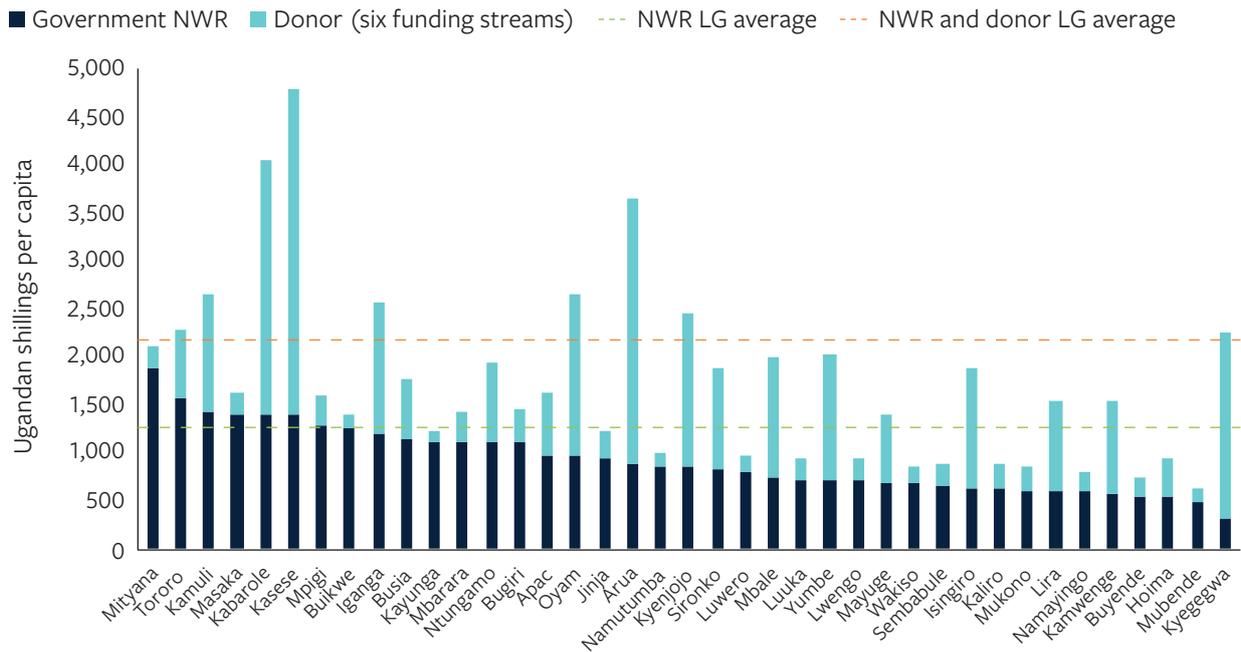


Source: MFPED and MoH

21 Efforts were apparently made in 2018 to develop a comprehensive picture of health funding in the West Nile and Rwenzori (Toro) regions (UN Pulse Lab funded by ENABEL), but the results were not made available to the study team.

Looking at the data from the six donor funding streams in FY 2017/18, the majority of these 40 Local Governments also received below-average levels of donor funding (Figure 18). This illustrates the way in which the distribution of donor funding to Local Governments can reinforce inequities in the fiscal transfer system.

**Figure 18** Fiscal transfer and donor funding to Local Governments with the highest number of unimmunised children, FY 2017/18

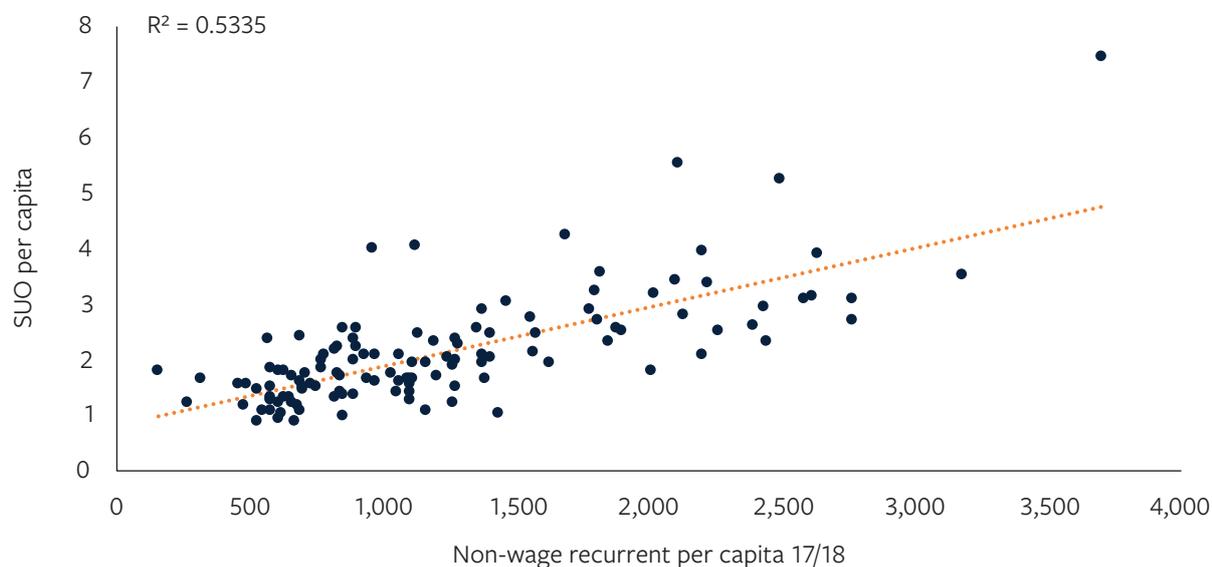


Note: NWR, non-wage recurrent; LG, local government.

Source: MFPED, MoH and authors’ calculations

Local Governments’ health service delivery can also be measured in terms of Standard Units of Output. The SUO is computed using data from the District Health Information System and provides a measure of Local Government attainment of health outputs across a range of primary health care services, including facility admissions, outpatient attendance, immunisations, family planning and maternal and child health care (Ministry of Health, 2018a). A comparison of the number of Standard Units of Output each Local Government achieved per capita in FY 2017/18 with their per capita non-wage recurrent transfers from the government fiscal transfer system indicates a reasonably clear correlation between funding levels and service delivery ( $R^2=0.5335$ ); Local Governments with relatively low levels of per capita non-wage recurrent transfers were constrained in their ability to deliver health outputs. Local Governments which received less than shs 500 (\$0.14) per capita of non-wage recurrent funding were unable to deliver more than two Standard Units of Output per capita. By contrast, with one exception, all Local Governments that received more than shs 2,000 (\$0.55) per capita were able to deliver more than two Standard Units of Output per capita (Figure 19).

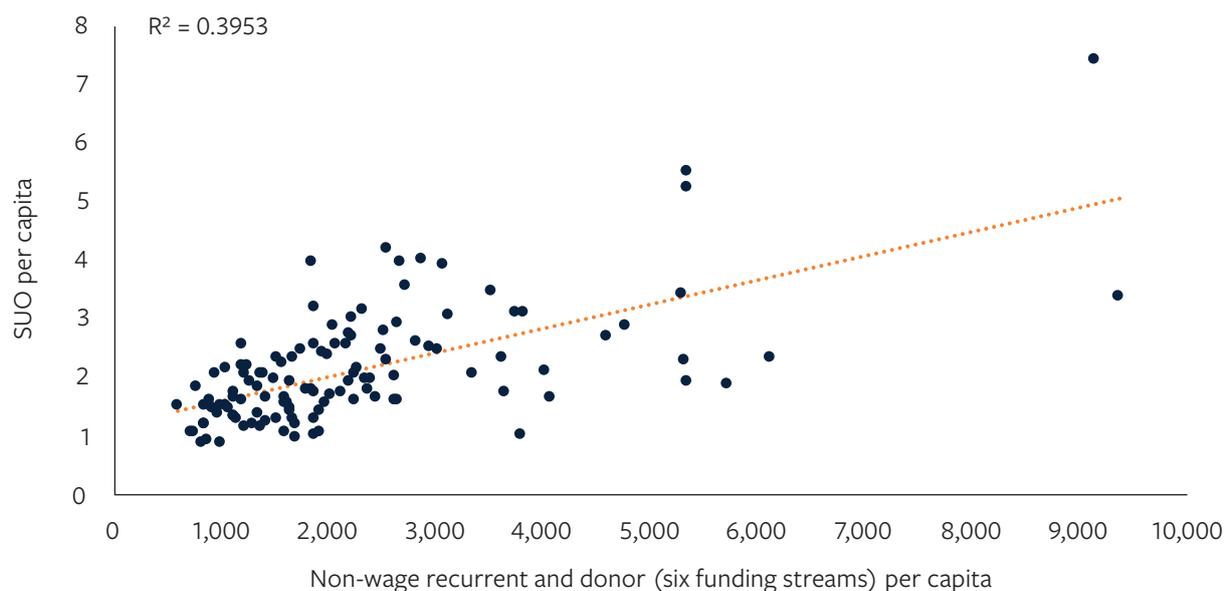
**Figure 19** Local Government Standard Unit of Outputs (SUOs) per capita plotted against non-wage recurrent fiscal transfer funding per capita, FY 2017/18



Source: MFPED, MoH and authors' calculations

When per capita funding from the six selected donor funding streams in FY 2017/18 was added to Local Governments' non-wage recurrent fiscal transfers, the correlation between funding and the achievement of health outputs (as measured by the Standard Unit of Output per capita) declined (to  $R^2=0.3953$ ; see Figure 20).

**Figure 20** Local Government Standard Unit of Output (SUO) per capita plotted against non-wage recurrent funding per capita plus donor funding per capita (six funding streams), FY 2017/18



Source: MFPE, MoH and authors' calculations

This suggests that inefficiencies and/or constraints in donor funding limit the ability of Local Governments to use donor funding to achieve health outputs as measured by the SUO. This appears consistent with the study's qualitative finding from the interviews and fieldwork that donor funding to Local Governments is not generally able to compensate for shortfalls in non-wage recurrent funding through the fiscal transfer system, due to significant limitations on its usage.

Local Governments reported that they had almost no discretion over how they could use their donor funding, which was generally strictly earmarked to specific activities. Donor support targeted to interventions such as HIV/AIDS, malaria and neglected tropical diseases is unlikely to contribute significantly to the attainment of the Standard Unit of Output, based as it is on facility admissions, outpatient attendance, immunisations, family planning and maternal and child health care. However, even when donor funding was provided to health services related to the SUO variables, Local Governments reported that it was often provided to relatively few health facilities, and in many cases still faced significant restrictions on its usage. The need for clear accountability to the donor reportedly makes it difficult for health facilities to add additional government-funded outreach activities to a donor-funded outreach (e.g. carrying out antenatal care and micronutrient distribution during a donor-funded immunisation outreach). The way in which donor funding is provided, in particular the lack of discretion afforded to Local Governments in its usage, therefore appears to limit the operational efficiency of health service delivery at district level. Box 1 provides an overview of the main constraints on donor funding reported during the study interviews.

### Box 1 Main reported constraints on donor funding

1. Donor funding is often provided in support of disease-specific interventions – e.g. malaria, HIV/AIDS, neglected tropical diseases
  - Many donors do not allow the community outreach they fund to support the delivery of unrelated interventions at the same time
  - Some donors are willing to support combined outreach as long as their specific activity is still covered, but the timing of their outreach activities may not match that of the facility
2. Donor support is often earmarked for staff allowances, and cannot be used to meet other needs
  - In some cases, donors are willing to support non-wage recurrent costs as long as this primarily benefits the groups that their support is targeted towards (e.g. people living with HIV/AIDS, expectant mothers)
3. Donor support is targeted to specific facilities within a district
  - It is difficult to reallocate donor funds between facilities, and not all facilities within a district receive donor support
4. Donor funding is provided for activities that are not consistent with the Local Government's priorities, or are not included in a facility's work plan
5. Local Governments and facilities have limited/no foresight over the amounts and timing of donor support, making it difficult to integrate activities, even if fungibility is possible

## 4.4 Results-based financing

In 2016, the MoH developed a 10-year Health Financing Strategy which introduced results-based financing as a major reform to improve access to quality health care and equity for attainment of UHC country-wide (Ministry of Health, 2016). RBF aims to encourage improved service delivery by remunerating health facilities on the basis of the quality and volume of services offered. The MoH's 2016 Results-Based Financing Strategy states that a combination of input-based funding and RBF is preferable to using only one method of financing. RBF aims to complement input-based funding through the fiscal transfer system, rather than replace it. It generally has fewer limits to its fungibility than donor funding earmarked to specific project activities, enabling health facilities to use it to offset some of the gaps in their government non-wage recurrent funding.

Given that Local Governments' achievement of health outputs appears to be correlated with the amount of non-wage recurrent funding available to them (see Section 4.3), the introduction of RBF could play an important role in strengthening Local Governments' health service delivery. However, ODI found that the way in which RBF was being introduced in Uganda potentially placed constraints on its ability to improve health performance across Local Governments.

By the time of ODI's study in 2018, RBF roll-out in Uganda was still at a pilot stage, funded by donors rather than GoU.<sup>22</sup> ODI found that donor RBF funding could be expected to increase funding levels in recipient Local Governments by at least 50% relative to non-wage recurrent funding through the fiscal transfer system, and in some cases by considerably more. A certain proportion of the RBF funds could be used to top up staff wages, while the remainder could be spent on eligible non-wage recurrent costs.<sup>23</sup> This volume of funding, and its degree of fungibility, could therefore potentially significantly help with the achievement of health outputs at Local Government level.

However, ODI also found that RBF resources were concentrated in a relatively limited number of qualifying health facilities in each Local Government. RBF qualification depends on a health facility's performance against a standardised health facility quality assessment tool that has several hundred pre-qualification criteria.<sup>24</sup> Overall, 22% of eligible health facilities qualified for Enabel RBF, while four districts were eventually dropped as funding recipients due to their small number of qualifying health facilities. Under the World Bank project, only 37% of facilities

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22 ENABEL commenced an RBF project in 2016. By 2017/18 it was providing funding in 16 districts in West Nile and Toro sub-regions. ENABEL RBF funding was one of the six donor funding streams analysed by ODI across the period FY 2015/16–2017/18 (see Section 4.2). In addition, in FY 2018/19 a World Bank project managed by the Ministry of Health commenced the roll-out of RBF to 27 Local Governments plus the Kampala metropolitan area, with plans to expand it to a larger number of Local Governments over time.

23 40% of World Bank RBF funds and 25% of ENABEL RBF funds could be used to top-up wages.

24 Under ENABEL RBF, health facilities were required to score 85% or more against the standardised health facility quality assessment tool in order to qualify. Under the World Bank RBF, health facilities were required to score 65% or more against the standardised health facility quality assessment tool in order to qualify.

in the 27 districts excluding Kampala initially met the qualification criteria. Depending on their performance, ODI estimated that qualifying facilities could expect RBF funding to provide anywhere between double and quadruple the level of their non-wage fiscal transfers.

Such sizeable funding levels can certainly be expected to alleviate the funding constraints faced by individual facilities. However, the significant concentration of RBF funding in relatively few health facilities in a sub-set of Local Governments also raises the prospect of increasing inequities in resource availability within and between Local Governments, and widening gaps in the level and quality of service provision. This risk is particularly acute if patients are unable to afford to travel a greater distance to better-resourced facilities. It highlights the importance of investing in weaker health facilities so that they are able to meet the qualifying criteria,<sup>25</sup> and in ensuring that RBF is rolled out on a national basis.

How to sustain RBF funding is also a key policy question. ODI estimated that, at 2018 costing levels, full RBF roll-out to all health facilities would require over shs 100 billion in additional financing each year, aside from the investments needed to help non-qualifying facilities meet RBF standards. This would require a significant and permanent increase in budget allocations for Local Government health funding compared to FY 2017/18 levels.

Finally, while RBF was conceived by the MoH as a complement to input-based funding, ODI found that there was no integration between the fiscal transfer system and RBF funding. The MoH budget did not list the Local Governments that were receiving RBF funds under the Enabel and World Bank projects, nor did it indicate the amounts that each Local Government could expect to receive each year, assuming full performance by qualifying health facilities. RBF payments were released by MoH directly to health facilities and were not captured in the Local Government budget or expenditure reports. This lack of integration significantly undermined transparency, hindering the ability of policy-makers, both at Local Government and policy level, to understand the total amount of resources available for health care delivery and their distribution, and to monitor performance.

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25 According to the Ministry of Health's Results-Based Financing Framework, improving the functionality of health facilities alongside RBF is a precondition for the successful RBF implementation in Uganda.

## 5 Conclusions and lessons for policy-makers

Uganda, like many other LMIC countries, has adopted a decentralised approach to health service delivery, whereby Local Governments are responsible for primary health care and the provision of hospital services at district level. During the study period, non-wage recurrent funding provided by the national government through the fiscal transfer system constituted the bedrock of subnational health financing. It provided Local Governments with the greatest degree of discretion over their expenditures, and was the only form of funding that reached every health facility. However, Local Governments faced the twin challenges of distributional inequities in the allocation of non-wage recurrent fiscal transfers<sup>26</sup> and significant funding constraints, which impeded their delivery of health outputs.

Donors provided substantial volumes of health funding to Local Governments during the study period, but it was not found to alleviate funding constraints or distributional inequalities. Donor funding to the subnational level, whether provided on- or off-budget, was not coordinated with government funding through the fiscal transfer system, and there was no commonly agreed basis for donor funding allocations. In some cases, it unintentionally reinforced the distributional inequalities found in the fiscal transfer system. Contrary to the assumption of health policy-makers at national level that donor funding can substitute for fiscal transfers, it was not found to be particularly fungible; tight earmarking, both geographically and in terms of types of expenditure, limited the ability of Local Governments to use donor funds to supplement their limited fiscal transfer funding. In the case of off-budget donor funding, funds often bypassed systems at Local Government level altogether, thus preventing local planning entirely. Lack of coordination of donor funding, combined in many cases with strict limitations on its usage, prevented it from enhancing the overall efficiency, effectiveness and equity of subnational health expenditures.

Coordination was impeded both by the absence of any overall guiding framework for donor subnational allocation decisions, and the absence of any consolidated information on subnational donor support. Donor projects, including projects executed by the Ministry of Health, did not provide information on the amount of funding they were providing to individual Local Governments for consolidation with fiscal transfer data. The donor funding data presented in this study was obtained through primary data collection. Individual Local Governments provided regular reports to the Ministry of Finance on the donor health funding they had received, including funding that is off-budget at the national level.<sup>27</sup> However, the Ministry of Finance did

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26 The Ministry of Finance has since worked with the Ministry of Health to address these inequities through the introduction of a new fiscal transfer formula, commencing in FY 2019/20.

27 These reports do not capture donor funding that bypasses Local Government administrations and is provided directly with health facilities and communities.

not consolidate the information received from Local Governments. The lack of comprehensive information on how much health funding is effectively available, and to which Local Governments, makes it very difficult to ensure the overall efficiency and equity of subnational resource allocations, and to hold Local Governments to account for the performance of health services under their supervision.

Consistent with the international literature, fragmentation of donor support in Uganda exacerbates the challenge of coordination. There are multiple donor projects providing subnational funding for different aspects of health care delivery, many of them operating independently of the central government. While the study primarily focused on six major donor funding streams providing subnational funding, the fieldwork analysis indicated that as many as 20 different partners were providing health financing directly to the 16 Local Governments included in this study. Almost all their funding was off-budget at central government level.

However, it is also apparent from the study findings that lack of coordination is not just a donor fragmentation and off-budget aid problem. Coordination is also lacking within government. The study found that the Ministry of Health did not indicate how much funding it was providing to individual Local Governments through its budget, much of it financed by on-budget donor projects, even though the amounts involved were significant. This suggests that health donors and policy-makers, including the Ministry of Health, do not consider it important to align their funding with health fiscal transfers in order to ensure that overall resource allocations to Local Governments are equitable. Their main focus appears to be on the achievement of measurable and attributable results through individual vertical funding streams, rather than on strengthening the ability of Local Governments as subnational units to deliver health care services in line with local needs and priorities, or ensuring resource equity across Local Governments.

In all of this, it is apparent that the autonomy and discretion of the Local Government as a service delivery unit is severely limited. Local Governments lack substantial own-source revenues with which to meet their own priorities, and their fiscal transfers have reduced in real terms over time. They have extremely limited discretion over their use of donor funds, and in some cases are bypassed in the allocation and budgeting process entirely. While the study only looked at non-wage financing to Local Governments, it is possible that they face similar difficulties in the management of other inputs such as drugs and medical supplies, staff and infrastructure. The introduction of RBF may go some way to addressing the difficulties currently faced by Local Governments, but only if it is clearly integrated with the input-based financing provided by the fiscal transfer system and is rolled out country-wide. Otherwise, it risks increasing inequities in resource availability within and between Local Governments and widening gaps in the level and quality of service provision.

The study provides a number of lessons for decentralised financing of health care programmes:

1. There needs to be a shift in thinking by donors and national health policy-makers on subnational health funding, away from vertical programme delivery towards equity in subnational financing and supporting the ability of Local Governments as decentralised units to deliver health care services. Efficiency arising from addressing local priorities is likely to be missed if funding is tightly earmarked by national government and donors seeking to address their own objectives at subnational level.
2. Fiscal transfers are a mainstay of recurrent cost provision for subnational health care delivery, providing a degree of geographic coverage, predictability and fungibility that is not matched by other funding mechanisms. National health policy-makers and donors need to ensure that programming for other funding mechanisms, including RBF, is explicitly coordinated with fiscal transfers. Allocation decisions for donor funding need to take into account the amount of funding that Local Governments receive from their fiscal transfers, to avoid creating or reinforcing distributional inequities, while objective parameters should be identified to justify sub-regional variations in donor support. Transfers to Local Governments funded by on-budget donor projects should be clearly identified in the national budget alongside fiscal transfers. Donors providing off-budget financing to Local Governments should consider bringing their funding on-budget, and disbursing it through the Treasury, to enhance overall coordination and transparency.
3. Information on subnational flows from all funding mechanisms should be routinely collected and collated, to enable active monitoring of the overall distribution of funds across subnational units. This is a complex task, made all the harder by the fragmentation of subnational health funding and the preponderance of off-budget funding. Nonetheless, donors can invest in supporting the Ministry of Finance to collate the information received from Local Governments, in order to start developing an information management and monitoring tool that could be used collectively by the Ministry of Finance, Ministry of Health and donors. Digitalisation of reporting systems may help, but cannot on its own drive the routines of policy-making and budget oversight.
4. Local needs and priorities need to be elevated in the design of subnational funding mechanisms and subnational funding decisions. Local Governments should document their own needs and priorities in order to guide support from off-budget partners, whilst funding mechanisms need to create space for discretionary spending within a Local Government accountability framework.

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# Appendix 1 Fieldwork districts

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Local government	Region
Adjumani	Northern
Nebbi	Northern
Bulisa	Western
Kiboga	Central
Lamwo	Northern
Buyende	Eastern
Sironko	Eastern
Nakapiripirit	Karamoja
Alebtong	Northern
Soroti	Eastern
Kamwenge	Western
Kanungu	Western
Luwero	Central
Kiruhura	Western
Isingiro	Western
Buikwe	Central